

CONDITION 1																																						
1. Person number	Name of condition																																					
2. When did -- last see or talk to a doctor about his . . . ? <input type="checkbox"/> In interview week (Reask 2) <input type="checkbox"/> Past 2 wks. (Item C) <input type="checkbox"/> 2 wks.-6 mos. <input type="checkbox"/> Over 6-12 mos. <input type="checkbox"/> 1 yr. <input type="checkbox"/> 2-4 yrs. <input type="checkbox"/> 5+ yrs. <input type="checkbox"/> Never <input type="checkbox"/> DK if Dr. seen <input type="checkbox"/> DK when Dr. seen																																						
A1	Examine "Name of condition" entry and mark <input type="checkbox"/> Color blindness (NC) <input type="checkbox"/> On Card C (A2) <input type="checkbox"/> Accident or injury (A2) <input type="checkbox"/> Neither (3a)																																					
	If "Doctor not talked to," transcribe entry from item 1. If "Doctor talked to," ask: 3a. What did the doctor say it was? - Did he give it a medical name? <hr/> Do not ask for Cancer <input type="checkbox"/> On Card C (A2) b. What was the cause of . . . ? <input type="checkbox"/> Accident or injury (A2) <hr/> If the entry in 3a or 3b includes the words: <table style="width: 100%; border: none;"> <tr> <td style="width: 25%;">Ailment</td> <td style="width: 25%;">Condition</td> <td style="width: 25%;">Disorder</td> <td style="width: 25%;">Rupture</td> <td rowspan="5" style="font-size: 2em; vertical-align: middle;">} Ask c:</td> </tr> <tr> <td>Anemia</td> <td>Cyst</td> <td>Growth</td> <td>Trouble</td> </tr> <tr> <td>Asthma</td> <td>Defect</td> <td>Measles</td> <td>Tumor</td> </tr> <tr> <td>Attack</td> <td>Disease</td> <td>Problem</td> <td>Ulcer</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>	Ailment	Condition	Disorder	Rupture	} Ask c:	Anemia	Cyst	Growth	Trouble	Asthma	Defect	Measles	Tumor	Attack	Disease	Problem	Ulcer																				
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	d. How does the allergy (stroke) affect him? <hr/> For allergy or stroke, ask: <hr/> If in 3a-d there is an impairment or any of the following entries: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Abscess</td> <td style="width: 33%;">Damage</td> <td style="width: 33%;">Paralysis</td> <td rowspan="12" style="font-size: 2em; vertical-align: middle;">} Ask e:</td> </tr> <tr> <td>Ache (except head or ear)</td> <td>Growth</td> <td>Rupture</td> </tr> <tr> <td>Bleeding</td> <td>Hemorrhage</td> <td>Sore(ness)</td> </tr> <tr> <td>Blood clot</td> <td>Infection</td> <td>Stiff(ness)</td> </tr> <tr> <td>Boil</td> <td>Inflammation</td> <td>Tumor</td> </tr> <tr> <td>Cancer</td> <td>Neuralgia</td> <td>Ulcer</td> </tr> <tr> <td>Cramps (except menstrual)</td> <td>Neuritis</td> <td>Varicose veins</td> </tr> <tr> <td>Cyst</td> <td>Pain</td> <td>Weak(ness)</td> </tr> <tr> <td></td> <td>Palsy</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>	Abscess	Damage	Paralysis	} Ask e:	Ache (except head or ear)	Growth	Rupture	Bleeding	Hemorrhage	Sore(ness)	Blood clot	Infection	Stiff(ness)	Boil	Inflammation	Tumor	Cancer	Neuralgia	Ulcer	Cramps (except menstrual)	Neuritis	Varicose veins	Cyst	Pain	Weak(ness)		Palsy										
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	e. What part of the body is affected? _____ Specify _____ Show the following detail: Head skull, scalp, face Back/spine/vertebrae upper, middle, lower Side left or right Ear inner or outer; left, right, or both Eye left, right, or both Arm shoulder, upper, elbow, lower or wrist; left, right, or both Hand entire hand or fingers only; left, right, or both Leg hip, upper, knee, lower, or ankle; left, right, or both Foot entire foot, arch, or toes only; left, right, or both																																					
Except for eyes, ears, or internal organs, ask if there are any of the following entries in 3a-d: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Infection</td> <td style="width: 33%;">Sore</td> <td style="width: 33%;">Soreness</td> </tr> </table> f. What part of the (part of body in 3e) is affected by the (infection/sore/soreness) - the skin, muscle, bone, or some other part? Specify <hr/> Ask if there are any of the following entries in 3a-d: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Tumor</td> <td style="width: 33%;">Cyst</td> <td style="width: 33%;">Growth</td> </tr> </table> g. Is this (tumor/cyst/growth) malignant or benign? 1 <input type="checkbox"/> Malignant 2 <input type="checkbox"/> Benign 9 <input type="checkbox"/> DK		Infection	Sore	Soreness	Tumor	Cyst	Growth																															
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A2	Ask remaining questions as appropriate for the condition entered in: 1 <input type="checkbox"/> Item 1 3 <input type="checkbox"/> Q. 3b 5 <input type="checkbox"/> Q. 3d 2 <input type="checkbox"/> Q. 3a 4 <input type="checkbox"/> Q. 3c 6 <input type="checkbox"/> Q. 3e																																					
	4. During the past 2 weeks, did his . . . cause him to cut down on the things he usually does? 1 Y 2 N (9)																																					
	5. During that period, how many days did he cut down for as much as a day? ___ Days 00 <input type="checkbox"/> None (9)																																					
	6. During that 2-week period, how many days did his . . . keep him in bed all or most of the day? ___ Days 00 <input type="checkbox"/> None																																					
	Ask if 17+ years: 7. How many days did his . . . keep him from work during that 2-week period? (For females): not counting work around the house? ___ Days (9) 00 <input type="checkbox"/> None (9)																																					
	Ask if 6-16 years: 8. How many days did his . . . keep him from school during that 2-week period? ___ Days 00 <input type="checkbox"/> None																																					
	9. When did -- first notice his . . . ? 1 <input type="checkbox"/> Last week 4 <input type="checkbox"/> 2 weeks-3 months 2 <input type="checkbox"/> Week before 5 <input type="checkbox"/> Over 3-12 months 3 <input type="checkbox"/> Past 2 weeks-DK which 6 <input type="checkbox"/> More than 12 months ago (Was it during the past 12 months or before that time?) (Was it during the past 3 months or before that time?) (Was it during the past 2 weeks or before that time?)																																					
A3	1 <input type="checkbox"/> Not an eye cond. (AA) 3 <input type="checkbox"/> First eye cond. (6+ yrs.) 2 <input type="checkbox"/> First eye cond. (under 6) (AA) 4 <input type="checkbox"/> Not first eye cond. (AA)																																					
	10. Can -- see well enough to read ordinary newspaper print WITH GLASSES with his <table style="display: inline-table; vertical-align: middle;"> <tr> <td rowspan="2" style="font-size: 2em; vertical-align: middle;">{</td> <td style="padding: 0 5px;">left</td> <td>eye? . . . 1 Y 2 N</td> </tr> <tr> <td style="padding: 0 5px;">right</td> <td>eye? . . . 1 Y 2 N</td> </tr> </table>	{	left	eye? . . . 1 Y 2 N	right	eye? . . . 1 Y 2 N																																
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<p>AA</p> <p>1 <input type="checkbox"/> Missing extremity (A4) 2 <input type="checkbox"/> Condition in C2 does not have a letter as source (A4) 3 <input type="checkbox"/> Condition in C2 has a letter as source, Doctor seen (11) 4 <input type="checkbox"/> Condition in C2 has a letter as source, Doctor not seen (15)</p> <p>11a. Does --- NOW take any medicine or treatment for his . . . ? 1 Y 2 N (12)</p> <p>b. Was any of this medicine or treatment recommended by a doctor? 1 Y 2 N</p> <p>12. Has he ever had surgery for this condition? 1 Y 2 N</p> <p>13. Was he ever hospitalized for this condition? 1 Y 2 N</p> <p>14. During the past 12 months, about how many times has --- seen or talked to a doctor about his . . . ? _____ Times (Do not count visits while a patient in a hospital.) 000 <input type="checkbox"/> None</p> <p>15a. About how many days during the past 12 months has this condition kept him in bed all or most of the day? _____ Days 000 <input type="checkbox"/> None</p> <p>Ask if 17+ years:</p> <p>b. About how many days during the past 12 months has this condition kept him from work? _____ Days For females: Not counting work around the house? 000 <input type="checkbox"/> None</p> <p>16a. How often does his . . . bother him - all of the time, often, once in a while, or never? 1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Often 3 <input type="checkbox"/> Once in a while 0 <input type="checkbox"/> Never (16c) 4 <input type="checkbox"/> Other - Specify _____</p> <p>b. When it does bother him, is he bothered a great deal, some, or very little? 1 <input type="checkbox"/> Great deal 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Very little 4 <input type="checkbox"/> Other - Specify _____</p> <p><input type="checkbox"/> All the time in 16a OR condition list 4 asked (A4)</p> <p>c. Does --- still have this condition? 1 Y (A4) N</p> <p>d. Is this condition completely cured or is it under control? 2 <input type="checkbox"/> Cured 3 <input type="checkbox"/> Under control (A4) 4 <input type="checkbox"/> Other - Specify _____ (A4)</p> <p>e. About how long did --- have this condition before it was cured? 0 <input type="checkbox"/> Less than one month _____ Months _____ Years</p>	<p>A4</p> <p><input type="checkbox"/> Accident or injury <input type="checkbox"/> Other (NC)</p> <p>17a. Did the accident happen during the past 2 years or before that time? <input type="checkbox"/> During the past 2 years <input type="checkbox"/> Before 2 years (18a)</p> <p>b. When did the accident happen? <input type="checkbox"/> Last week <input type="checkbox"/> Over 3-12 months <input type="checkbox"/> Week before <input type="checkbox"/> 1-2 years <input type="checkbox"/> 2 weeks-3 months</p> <p>18a. At the time of the accident what part of the body was hurt? What kind of injury was it? Anything else?</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:50%;">Part(s) of body</th> <th style="width:50%;">Kind of injury</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </tbody> </table> <p>If accident happened more than 3 months ago, ask:</p> <p>b. What part of the body is affected now? How is his --- affected? Is he affected in any other way?</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:50%;">Part(s) of body</th> <th style="width:50%;">Present effects</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </tbody> </table> <p>19. Where did the accident happen? 1 <input type="checkbox"/> At home (inside house) 2 <input type="checkbox"/> At home (adjacent premises) 3 <input type="checkbox"/> Street and highway (includes roadway and public sidewalk) 4 <input type="checkbox"/> Farm 5 <input type="checkbox"/> Industrial place (includes premises) 6 <input type="checkbox"/> School (includes premises) 7 <input type="checkbox"/> Place of recreation and sports, except at school 8 <input type="checkbox"/> Other - Specify _____</p> <p>20. Was --- at work at his job or business when the accident happened? 1 Y 3 <input type="checkbox"/> While in Armed Services 2 N 4 <input type="checkbox"/> Under 17 at time of accident</p> <p>21a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way? 1 Y 2 N (NC)</p> <p>b. Was more than one vehicle involved? Y N</p> <p>c. Was it (either one) moving at the time? 1 Y 2 N</p>	Part(s) of body	Kind of injury					Part(s) of body	Present effects				
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