

A. HOUSEHOLD COMPOSITION PAGE		1
<p>1a. What are the names of all persons living or staying here? Start with the name of the person or one of the persons who owns or rents this home. Enter name in REFERENCE PERSON column.</p> <p>b. What are the names of all other persons living or staying here? Enter names in columns.</p> <p>c. I have listed (read names). Have I missed: - any babies or small children? - any lodgers, boarders, or persons you employ who live here? - anyone who USUALLY lives here but is now away from home traveling or in a hospital? - anyone else staying here?</p> <p>d. Do all of the persons you have named usually live here? <input type="checkbox"/> Yes (2) <input type="checkbox"/> No (APPLY HOUSEHOLD MEMBERSHIP RULES. Delete nonhousehold members by an "X" from 1-C2 and enter reason.)</p> <p>Probe if necessary: Does --- usually live somewhere else? Ask for all persons beginning with column 2:</p>		<p>1. First name _____ Age _____ Last name _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>2. Relationship REFERENCE PERSON _____</p> <p>3. Date of birth _____ Month _____ Date _____ Year _____</p> <p>C1 HOSP. WORK RD 2-WK. DV 00 <input type="checkbox"/> None 1 <input type="checkbox"/> Wa <input type="checkbox"/> Yes 00 <input type="checkbox"/> None Number 2 <input type="checkbox"/> Wb <input type="checkbox"/> No Number</p> <p>C2 LA RA DV INJ CL LTR HS COND LA RA DV INJ CL LTR HS COND LA RA DV INJ CL LTR HS COND LA RA DV INJ CL LTR HS COND </p>
<p>2. What is --- relationship to (reference person)?</p> <p>3. What is --- date of birth? (Enter date and age and mark sex.)</p>		
REFERENCE PERIODS		
A1	2-WEEK PERIOD _____	
	12-MONTH DATE _____	
	13-MONTH HOSPITAL DATE _____	
A2	ASK CONDITION LIST _____	
A3	Refer to ages of all related HH members.	A3
<p>4a. Are any of the persons in this family now on full-time active duty with the Armed Forces of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No (5)</p> <p>b. Who is this? _____ Delete column number(s) _____ by an "X" from 1 - C2.</p> <p>c. Anyone else? _____ <input type="checkbox"/> Yes (Reask 4b and c) <input type="checkbox"/> No</p> <p>Ask for each person in Armed Forces: d. Where does --- usually live and sleep, here or somewhere else? Mark box in person's column.</p>		<p><input type="checkbox"/> All persons 65 and over (5) <input type="checkbox"/> Other (4)</p> <p>4d. <input type="checkbox"/> Living at home <input type="checkbox"/> Not living at home</p>
<p>If related persons 17 and over are listed in addition to the respondent and are not present, say: 5. We would like to have all adult family members who are at home take part in the interview. Are (names of persons 17 and over) at home now? If "Yes," ask: Could they join us? (Allow time)</p> <p>Read to respondent(s): This survey is being conducted to collect information on the nation's health. I will ask about hospitalizations, disability, visits to doctors, illness in the family, and other health related items.</p>		
HOSPITAL PROBE		
<p>6a. Since (13-month hospital date) a year ago, was --- a patient in a hospital OVERNIGHT?</p> <p>b. How many different times did --- stay in any hospital overnight or longer since (13-month hospital date) a year ago?</p>		<p>6a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Mark "HOSP." box, THEN NP)</p> <p>b. _____ } (Make entry in "HOSP." box, THEN NP) Number of times</p>
<p>Ask for each child under one: 7a. Was --- born in a hospital?</p> <p>Ask for mother and child: b. Have you included this hospitalization in the number you gave me for ---?</p>		<p>7a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)</p> <p>b. <input type="checkbox"/> Yes (NP) <input type="checkbox"/> No (Correct 6 and "HOSP." box)</p>
FOOTNOTES		

B. LIMITATION OF ACTIVITIES PAGE			
B1	Refer to age.	B1	1 <input type="checkbox"/> 18-70 (1) 2 <input type="checkbox"/> Other (NP)
1. What was -- doing MOST OF THE PAST 12 MONTHS; working at a job or business, keeping house, going to school, or something else? Priority if 2 or more activities reported: (1) Spent the most time doing; (2) Considers the most important.		1.	1 <input type="checkbox"/> Working (2) 2 <input type="checkbox"/> Keeping house (3) 3 <input type="checkbox"/> Going to school (5) 4 <input type="checkbox"/> Something else (5)
2a. Does any impairment or health problem NOW keep -- from working at a job or business?		2a.	1 <input type="checkbox"/> Yes (7) <input type="checkbox"/> No
b. Is -- limited in the kind OR amount of work -- can do because of any impairment or health problem?		b.	2 <input type="checkbox"/> Yes (7) 3 <input type="checkbox"/> No (8)
3a. Does any impairment or health problem NOW keep -- from doing any housework at all?		3a.	4 <input type="checkbox"/> Yes (4) <input type="checkbox"/> No
b. Is -- limited in the kind OR amount of housework -- can do because of any impairment or health problem?		b.	5 <input type="checkbox"/> Yes (4) 6 <input type="checkbox"/> No (5)
4a. What (other) condition causes this? Ask if injury or operation: When did [the (injury) occur?/--have the operation?] Ask if operation over 3 months ago: For what condition did -- have the operation? If pregnancy/delivery or 0-3 months injury or operation -- Reask question 3 where limitation reported, saying: Except for -- (condition), ...? OR reask 4b/c.		4a.	(Enter condition in C2, THEN 4b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 4c)
b. Besides (condition) is there any other condition that causes this limitation?		b.	<input type="checkbox"/> Yes (Reask 4a and b) <input type="checkbox"/> No (4c)
c. Is this limitation caused by any (other) specific condition?		c.	<input type="checkbox"/> Yes (Reask 4a and b) <input type="checkbox"/> No
d. Which of these conditions would you say is the MAIN cause of this limitation?		d.	<input type="checkbox"/> Only 1 condition Main cause _____
5a. Does any impairment or health problem keep -- from working at a job or business?		5a.	1 <input type="checkbox"/> Yes (7) <input type="checkbox"/> No
b. Is -- limited in the kind OR amount of work -- could do because of any impairment or health problem?		b.	2 <input type="checkbox"/> Yes (7) 3 <input type="checkbox"/> No
B2	Refer to questions 3a and 3b.	B2	1 <input type="checkbox"/> "Yes" in 3a or 3b (NP) 2 <input type="checkbox"/> Other (8)
6a. Is -- limited in ANY WAY in any activities because of an impairment or health problem?		6a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)
b. In what way is -- limited? Record limitation, not condition.		b.	Limitation _____
7a. What (other) condition causes this? Ask if injury or operation: When did [the (injury) occur?/--have the operation?] Ask if operation over 3 months ago: For what condition did -- have the operation? If pregnancy/delivery or 0-3 months injury or operation -- Reask question 2, 5, or 6 where limitation reported, saying: Except for -- (condition), ...? OR reask 7b/c.		7a.	(Enter condition in C2, THEN 7b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 7c)
b. Besides (condition) is there any other condition that causes this limitation?		b.	<input type="checkbox"/> Yes (Reask 7a and b) <input type="checkbox"/> No (7d)
c. Is this limitation caused by any (other) specific condition?		c.	<input type="checkbox"/> Yes (Reask 7a and b) <input type="checkbox"/> No
d. Which of these conditions would you say is the MAIN cause of this limitation?		d.	<input type="checkbox"/> Only 1 condition Main cause _____

FORM HIR-1 (1982) (4-6-82)

B. LIMITATION OF ACTIVITIES PAGE, Continued		
B3	Refer to age.	B3 <input type="checkbox"/> Under 5 (10) <input type="checkbox"/> 60-71 (14) <input type="checkbox"/> 5-17 (11) <input type="checkbox"/> 71 and over (8) <input type="checkbox"/> 18-59 (B4)
8. What was -- doing MOST OF THE PAST 12 MONTHS; working at a job or business, keeping house, going to school, or something else? Priority if 2 or more activities reported: (1) Spent the most time doing; (2) Considers the most important.	8.	<input type="checkbox"/> Working <input type="checkbox"/> Keeping house <input type="checkbox"/> Going to school <input type="checkbox"/> Something else
9a. Because of any impairment or health problem, does -- need the help of other persons with -- personal care needs, such as eating, bathing, dressing, or getting around this home?	9a.	<input type="checkbox"/> Yes (13) <input type="checkbox"/> No
b. Because of any impairment or health problem, does -- need the help of other persons in handling -- routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?	b.	<input type="checkbox"/> Yes (13) <input type="checkbox"/> No (12)
10a. Is -- able to take part AT ALL in the usual kinds of play activities done by most children -- age?	10a.	<input type="checkbox"/> Yes <input type="checkbox"/> No (13)
b. Is -- limited in the kind OR amount of play activities -- can do because of any impairment or health problem?	b.	<input type="checkbox"/> Yes (13) <input type="checkbox"/> No (12)
11a. Does any impairment or health problem NOW keep -- from attending school?	11a.	<input type="checkbox"/> Yes (13) <input type="checkbox"/> No
b. Does -- attend a special school or special classes because of any impairment or health problem?	b.	<input type="checkbox"/> Yes (13) <input type="checkbox"/> No
c. Does -- need to attend a special school or special classes because of any impairment or health problem?	c.	<input type="checkbox"/> Yes (13) <input type="checkbox"/> No
d. Is -- limited in school attendance because of -- health?	d.	<input type="checkbox"/> Yes (13) <input type="checkbox"/> No
12a. Is -- limited in ANY WAY in any activities because of an impairment or health problem?	12a.	<input type="checkbox"/> Yes <input type="checkbox"/> No (NP)
b. In what way is -- limited? Record limitation, not condition.	b.	 Limitation
13a. What (other) condition causes this? Ask if injury or operation: When did [he (injury) occur?/--have the operation?] Ask if operation over 3 months ago: For what condition did -- have the operation? If pregnancy/delivery or 0-3 months injury or operation -- Reask question where limitation reported, saying: Except for -- (condition), . . . ? OR reask 13b/c.	13a.	(Enter condition in C2, THEN 13b) <input type="checkbox"/> Old age (Mark "Old age" box, THEN 13c)
b. Besides (condition) is there any other condition that causes this limitation?	b.	<input type="checkbox"/> Yes (Reask 13a and b) <input type="checkbox"/> No (13d)
c. Is this limitation caused by any (other) specific condition?	c.	<input type="checkbox"/> Yes (Reask 13a and b) <input type="checkbox"/> No
Mark box if only one condition. d. Which of these conditions would you say is the MAIN cause of this limitation?	d.	<input type="checkbox"/> Only 1 condition Main cause
B4	Refer to "Age," "Old age," and "LA" boxes. Mark first appropriate box.	B4 <input type="checkbox"/> 5-59 and "Old age" box marked (14) <input type="checkbox"/> 5-59 and entry in "LA" box (14) <input type="checkbox"/> Other (NP)
14a. Because of any impairment or health problem, does -- need the help of other persons with -- personal care needs, such as eating, bathing, dressing, or getting around this home? Ask if age 18 and over.	14a.	<input type="checkbox"/> Yes (NP) <input type="checkbox"/> No
b. Because of any impairment or health problem, does -- need the help of other persons in handling -- routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?	b.	<input type="checkbox"/> Yes <input type="checkbox"/> No

FORM HIR-1 (1982) (4-9-82)

D. RESTRICTED ACTIVITY PAGE PERSON 1	
<p style="margin: 0;"><i>Hand calendar.</i> (The next questions refer to the 2 weeks outlined in red on that calendar, beginning Monday, <u>date</u> and ending this past Sunday <u>date</u>.)</p>	
D1	<p>Refer to age.</p> <p><input type="checkbox"/> Under 5 (4) <input type="checkbox"/> 5-17 (3) <input type="checkbox"/> 18 and over (1)</p>
<p>1a. DURING THOSE 2 WEEKS, did -- work at any time at a job or business, not counting work around the house? (Include unpaid work in the family [farm/business].)</p> <p>1 <input type="checkbox"/> Yes (Mark "Wa" box, THEN 2) 2 <input type="checkbox"/> No</p> <hr/> <p>b. Even though -- did not work during those 2 weeks, did -- have a job or business?</p> <p>1 <input type="checkbox"/> Yes (Mark "Wb" box, THEN 2) 2 <input type="checkbox"/> No (4)</p>	
<p>2a. During those 2 weeks, did -- miss any time from a job or business because of illness or injury?</p> <p><input type="checkbox"/> Yes 00 <input type="checkbox"/> No (4)</p> <hr/> <p>b. During that 2-week period, how many days did -- miss more than half of the day from -- job or business because of illness or injury?</p> <p>00 <input type="checkbox"/> None (4) No. of work-loss days (4)</p>	
<p>3a. During those 2 weeks, did -- miss any time from school because of illness or injury?</p> <p><input type="checkbox"/> Yes 00 <input type="checkbox"/> No (4)</p> <hr/> <p>b. During that 2-week period, how many days did -- miss more than half of the day from school because of illness or injury?</p> <p>00 <input type="checkbox"/> None No. of school-loss days</p>	
<p>4a. During those 2 weeks, did -- stay in bed because of illness or injury?</p> <p><input type="checkbox"/> Yes 00 <input type="checkbox"/> No (6)</p> <hr/> <p>b. During that 2-week period, how many days did -- stay in bed more than half of the day because of illness or injury?</p> <p>00 <input type="checkbox"/> None (6) No. of bed days</p>	
D2	<p>Refer to 2b and 3b.</p> <p><input type="checkbox"/> No days in 2b or 3b (6) <input type="checkbox"/> 1 or more days in 2b or 3b (5)</p>
<p>5. On how many of the (number in 2b or 3b) days missed from [work/school] did -- stay in bed more than half of the day because of illness or injury?</p> <p>00 <input type="checkbox"/> None No. of days</p>	
<p>Refer to 2b, 3b, and 4b.</p> <p>6a. (Not counting the day(s) [missed from work missed from school (and) in bed],</p> <p>Was there any (OTHER) time during those 2 weeks that -- cut down on the things -- usually does because of illness or injury?</p> <p><input type="checkbox"/> Yes 00 <input type="checkbox"/> No (D3)</p> <hr/> <p>b. (Again, not counting the day(s) [missed from work missed from school (and) in bed],</p> <p>During that period, how many (OTHER) days did -- cut down for more than half of the day because of illness or injury?</p> <p>00 <input type="checkbox"/> None No. of cut-down days</p>	
D3	<p>Refer to 2-6.</p> <p><input type="checkbox"/> No days in 2-6 (Mark "No" in RD, THEN NP) <input type="checkbox"/> 1 or more days in 2-6 (Mark "Yes" in RD, THEN 7)</p>
<p>Refer to 2b, 3b, 4b, and 6b.</p> <p>7a. What (other) condition caused -- to [miss work miss school (or) stay in bed (or) cut down] during those 2 weeks?</p> <p>(Enter condition in C2, THEN 7b)</p> <hr/> <p>b. Did any other condition cause -- to [miss work miss school (or) stay in bed (or) cut down] during that period?</p> <p>1 <input type="checkbox"/> Yes (Reask 7a and b) 2 <input type="checkbox"/> No</p>	
<p>FOOTNOTES</p>	

FORM HIS-1 (1982) (4-6-82)

G. HEALTH INDICATOR PAGE

<p>1a. During the 2-week period outlined in red on that calendar, has anyone in the family had an injury from an accident or other cause that you have not yet told me about? <input type="checkbox"/> Yes <input type="checkbox"/> No (2)</p> <p>b. Who was this? Mark "Injury" box in person's column.</p> <p>c. What was -- injury? Enter injury(ies) in person's column.</p> <p>d. Did anyone have any other injuries during that period? <input type="checkbox"/> Yes (Reask 1b, c, and d) <input type="checkbox"/> No</p> <p><i>Ask for each injury in 1c:</i> e. As a result of the (injury in 1c) did [---/anyone] see or talk to a medical doctor or assistant (about ---) or did --- cut down on --- usual activities for more than half of a day?</p>		<p>1b. <input type="checkbox"/> Injury</p> <p>c. _____ Injury</p> <p>e. <input type="checkbox"/> Yes (Enter injury in C2, THEN 1e for next injury) <input type="checkbox"/> No (1e for next injury)</p>
<p>2. During the past 12 months, (that is, since (12-month date) a year ago) ABOUT how many days did illness or injury keep --- in bed more than half of the day? (Include days while an overnight patient in a hospital.)</p>	<p>2. 000 <input type="checkbox"/> None _____ No. of days</p>	
<p>3a. During the past 12 months, ABOUT how many times did [---/anyone] see or talk to a medical doctor or assistant (about ---)? (Do not count doctors seen while an overnight patient in a hospital.) (Include the (number in 2-WK DV box) visit(s) you already told me about.)</p>	<p>3a. 000 <input type="checkbox"/> None (3b) 000 <input type="checkbox"/> Only when overnight patient in hospital _____ } (NP) No. of visits</p>	
<p>b. About how long has it been since [---/anyone] last saw or talked to a medical doctor or assistant (about ---)? Include doctors seen while a patient in a hospital.</p>	<p>b. 1 <input type="checkbox"/> Interview week (Reask 3b) 2 <input type="checkbox"/> Less than 1 yr. (Reask 3a) 3 <input type="checkbox"/> 1 yr., less than 2 yrs. 4 <input type="checkbox"/> 2 yrs., less than 5 yrs. 5 <input type="checkbox"/> 5 yrs. or more 0 <input type="checkbox"/> Never</p>	
<p>4. Would you say --- health in general is excellent, very good, good, fair, or poor?</p>	<p>4. 1 <input type="checkbox"/> Excellent 4 <input type="checkbox"/> Fair 2 <input type="checkbox"/> Very good 5 <input type="checkbox"/> Poor 3 <input type="checkbox"/> Good</p>	
<p><i>Mark box if under 18.</i> 5a. About how tall is --- without shoes?</p>	<p>5a. <input type="checkbox"/> Under 18 (NP) _____ Feet _____ Inches</p>	
<p>b. About how much does --- weigh without shoes?</p>	<p>b. _____ Pounds</p>	
<p>FOOTNOTES</p>		

FORM HIS-1 (1982) (4-6-82)

H. CONDITION LISTS 1 AND 2

Read to respondent(s) and ask list specified in A2:
Now I am going to read a list of medical conditions. Tell me if anyone in the family has any of these conditions, even if you have mentioned them before.

<p>1</p> <p>1a. Does anyone in the family (read names) NOW have – If "Yes," ask 1b and c. b. Who is this? c. Does anyone else NOW have – Enter condition and letter in appropriate person's column.</p> <p>A. PERMANENT stiffness or any deformity of the foot, leg, fingers, arm, or back? (Permanent stiffness – joints will not move at all.)</p> <p>B. Paralysis of any kind?</p> <p>1d. DURING THE PAST 12 MONTHS, did anyone in the family have – If "Yes," ask 1e and f. e. Who was this? f. DURING THE PAST 12 MONTHS, did anyone else have – Enter condition and letter in appropriate person's column. Conditions C–N and V are conditions affecting the bone and muscle. Conditions O–U and W–Z are conditions affecting the skin.</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 50%;">C. Arthritis of any kind or Rheumatism?</td> <td style="width: 50%;">Reask 1d P. Eczema or Psoriasis? (ek'sa-ma) or (so-rye-uh-sis)</td> </tr> <tr> <td>D. Gout?</td> <td>Q. TROUBLE with dry or itching skin?</td> </tr> <tr> <td>E. Lumbago?</td> <td>R. TROUBLE with acne?</td> </tr> <tr> <td>F. Osteomyelitis? (os-tee-oh-my-uh-lye'tis)</td> <td>S. A skin ulcer?</td> </tr> <tr> <td>G. A bone cyst or bone spur?</td> <td>T. Any kind of skin allergy?</td> </tr> <tr> <td>H. Any other disease of the bone or cartilage?</td> <td>U. Dermatitis or any other skin trouble?</td> </tr> <tr> <td>I. A trick knee?</td> <td>V. TROUBLE with fallen arches, flatfeet, or clubfoot?</td> </tr> <tr> <td>J. A slipped or ruptured disc?</td> <td>W. TROUBLE with ingrown toenails or fingernails?</td> </tr> <tr> <td>K. Curvature of the spine?</td> <td>X. TROUBLE with bunions, corns, or calluses?</td> </tr> <tr> <td>L. REPEATED trouble with neck, back, or spine?</td> <td>Y. Any disease of the hair or scalp?</td> </tr> <tr> <td>M. Bursitis or Synovitis? (sin-oh-vye'tis)</td> <td>Z. Any disease of the lymph or sweat glands?</td> </tr> <tr> <td>N. Any disease of the muscles or tendons?</td> <td></td> </tr> <tr> <td>O. A tumor, cyst, or growth of the skin?</td> <td></td> </tr> </table>	C. Arthritis of any kind or Rheumatism?	Reask 1d P. Eczema or Psoriasis? (ek'sa-ma) or (so-rye-uh-sis)	D. Gout?	Q. TROUBLE with dry or itching skin?	E. Lumbago?	R. TROUBLE with acne?	F. Osteomyelitis? (os-tee-oh-my-uh-lye'tis)	S. A skin ulcer?	G. A bone cyst or bone spur?	T. Any kind of skin allergy?	H. Any other disease of the bone or cartilage?	U. Dermatitis or any other skin trouble?	I. A trick knee?	V. TROUBLE with fallen arches, flatfeet, or clubfoot?	J. A slipped or ruptured disc?	W. TROUBLE with ingrown toenails or fingernails?	K. Curvature of the spine?	X. TROUBLE with bunions, corns, or calluses?	L. REPEATED trouble with neck, back, or spine?	Y. Any disease of the hair or scalp?	M. Bursitis or Synovitis? (sin-oh-vye'tis)	Z. Any disease of the lymph or sweat glands?	N. Any disease of the muscles or tendons?		O. A tumor, cyst, or growth of the skin?		<p>2</p> <p>2a. Does anyone in the family (read names) NOW have – If "Yes," ask 2b and c. b. Who is this? c. Does anyone else NOW have – Enter condition and letter in appropriate person's column.</p> <p>A–L are conditions affecting <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>Hearing</td></tr><tr><td>Vision</td></tr><tr><td>Speech</td></tr></table></p> <p>Conditions O–W are impairments. Conditions Y and Z affect the nervous system.</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 50%;">A. Deafness in one or both ears?</td> <td style="width: 50%;">Reask 2a O. Palsy or Cerebral palsy? (ser'a-bral)</td> </tr> <tr> <td>B. Any other trouble hearing with one or both ears?</td> <td>P. Paralysis of any kind?</td> </tr> <tr> <td>C. Tinnitus or ringing in the ears?</td> <td>Q. Curvature of the spine?</td> </tr> <tr> <td>D. Blindness in one or both eyes?</td> <td>R. REPEATED trouble with back or spine?</td> </tr> <tr> <td>E. Cataracts?</td> <td>S. Any TROUBLE with fallen arches or flatfeet?</td> </tr> <tr> <td>F. Glaucoma?</td> <td>T. A clubfoot?</td> </tr> <tr> <td>G. Color blindness?</td> <td>U. PERMANENT stiffness or any deformity of the foot, leg, or back? (Permanent stiffness – joints will not move at all.)</td> </tr> <tr> <td>H. A detached retina or any other condition of the retina?</td> <td>V. PERMANENT stiffness or any deformity of the fingers, hand, or arm?</td> </tr> <tr> <td>I. Any other trouble seeing with one or both eyes EVEN when wearing glasses?</td> <td>W. Mental retardation?</td> </tr> <tr> <td>J. A cleft palate or Harelip?</td> <td>X. Any condition caused by an accident or injury which happened more than 3 months ago? If "Yes," ask: What is the condition?</td> </tr> <tr> <td>K. Stammering or Stuttering?</td> <td>Y. Epilepsy?</td> </tr> <tr> <td>L. Any other speech defect?</td> <td>Z. REPEATED convulsions, seizures, or blackouts?</td> </tr> <tr> <td>M. A missing finger, hand, or arm; toe, foot, or leg?</td> <td></td> </tr> <tr> <td>N. A missing (breast), kidney, or lung?</td> <td></td> </tr> </table>	Hearing	Vision	Speech	A. Deafness in one or both ears?	Reask 2a O. Palsy or Cerebral palsy? (ser'a-bral)	B. Any other trouble hearing with one or both ears?	P. Paralysis of any kind?	C. Tinnitus or ringing in the ears?	Q. Curvature of the spine?	D. Blindness in one or both eyes?	R. REPEATED trouble with back or spine?	E. Cataracts?	S. Any TROUBLE with fallen arches or flatfeet?	F. Glaucoma?	T. A clubfoot?	G. Color blindness?	U. PERMANENT stiffness or any deformity of the foot, leg, or back? (Permanent stiffness – joints will not move at all.)	H. A detached retina or any other condition of the retina?	V. PERMANENT stiffness or any deformity of the fingers, hand, or arm?	I. Any other trouble seeing with one or both eyes EVEN when wearing glasses?	W. Mental retardation?	J. A cleft palate or Harelip?	X. Any condition caused by an accident or injury which happened more than 3 months ago? If "Yes," ask: What is the condition?	K. Stammering or Stuttering?	Y. Epilepsy?	L. Any other speech defect?	Z. REPEATED convulsions, seizures, or blackouts?	M. A missing finger, hand, or arm; toe, foot, or leg?		N. A missing (breast), kidney, or lung?	
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Vision																																																										
Speech																																																										
A. Deafness in one or both ears?	Reask 2a O. Palsy or Cerebral palsy? (ser'a-bral)																																																									
B. Any other trouble hearing with one or both ears?	P. Paralysis of any kind?																																																									
C. Tinnitus or ringing in the ears?	Q. Curvature of the spine?																																																									
D. Blindness in one or both eyes?	R. REPEATED trouble with back or spine?																																																									
E. Cataracts?	S. Any TROUBLE with fallen arches or flatfeet?																																																									
F. Glaucoma?	T. A clubfoot?																																																									
G. Color blindness?	U. PERMANENT stiffness or any deformity of the foot, leg, or back? (Permanent stiffness – joints will not move at all.)																																																									
H. A detached retina or any other condition of the retina?	V. PERMANENT stiffness or any deformity of the fingers, hand, or arm?																																																									
I. Any other trouble seeing with one or both eyes EVEN when wearing glasses?	W. Mental retardation?																																																									
J. A cleft palate or Harelip?	X. Any condition caused by an accident or injury which happened more than 3 months ago? If "Yes," ask: What is the condition?																																																									
K. Stammering or Stuttering?	Y. Epilepsy?																																																									
L. Any other speech defect?	Z. REPEATED convulsions, seizures, or blackouts?																																																									
M. A missing finger, hand, or arm; toe, foot, or leg?																																																										
N. A missing (breast), kidney, or lung?																																																										

FORM HHS-111982 (4-6-62)

H. CONDITION LISTS 3 AND 4

Read to respondent(s) and ask list specified in A2:

Now I am going to read a list of medical conditions. Tell me if anyone in the family has had any of these conditions, even if you have mentioned them before.

3

3a. DURING THE PAST 12 MONTHS, did anyone in the family (read names) have -
If "Yes," ask 3b and c.
b. Who was this?
c. DURING THE PAST 12 MONTHS, did anyone else have -
Enter condition and letter in appropriate person's column.
Make no entry in item C2 for cold; flu; red, sore, or strep throat; or "virus" even if reported in this list.
Conditions affecting the digestive system.

	Reask 3a N. Any other stomach trouble?
A. Gallstones?	
B. Any other gallbladder trouble?	O. Enteritis?
C. Cirrhosis of the liver?	P. Diverticulitis? (Dye-ver-tic-yoo-lye'tis)
D. Fatty liver?	Q. Colitis?
E. Hepatitis?	R. A spastic colon?
F. Yellow jaundice?	S. FREQUENT constipation?
G. Any other liver trouble?	T. Any other bowel trouble?
H. Any disease of the pancreas?	U. Any other intestinal trouble?
I. An ulcer?	V. Cancer of the stomach, colon, or rectum?
J. A hernia or rupture?	W. During the past 12 months, did anyone (else) in the family have any other condition of the digestive system? If "Yes," ask: Who was this? - What was the condition? Enter in item C2. THEN reask W.
K. Any disease of the esophagus?	
L. Gastritis?	
M. FREQUENT indigestion?	

4

4a. DURING THE PAST 12 MONTHS, did anyone in the family (read names) have -
If "Yes," ask 4b and c.
b. Who was this?
c. DURING THE PAST 12 MONTHS, did anyone else have -
Enter condition and letter in appropriate person's column.

A. A goiter or other thyroid trouble?	} Glandular disorders
B. Diabetes?	
C. Cystic fibrosis?	
D. Anemia?	} Blood disorder
E. Epilepsy?	} Condition affecting the nervous system
F. Multiple sclerosis?	
G. Migraine?	
H. Neuralgia or Neuritis?	
I. Sciatica? (si-at i-kuh)	
J. Nephritis?	} Genito-urinary conditions
K. Kidney stones?	
L. Any other kidney trouble?	
M. Bladder trouble?	
N. Prostate trouble?	
O. Any disease of the uterus or ovary?	
P. Any other female trouble?	
Q. Cancer of any kind?	

H. CONDITION LISTS 5 AND 6

Read to respondent(s) and ask list specified in A2.

Now I am going to read a list of medical conditions. Tell me if anyone in the family has had any of these conditions, even if you have mentioned them before.

5	<p>5a. Has anyone in the family (<i>read names</i>) EVER had - If "Yes," ask 5b and c.</p> <p>b. Who was this?</p> <p>c. Has anyone else EVER had - Enter condition and letter in appropriate person's column. Conditions affecting the heart and circulatory system.</p>		6	<p>6a. DURING THE PAST 12 MONTHS, did anyone in the family (<i>read names</i>) have - If "Yes," ask 6b and c.</p> <p>b. Who was this?</p> <p>c. DURING THE PAST 12 MONTHS, did anyone else have - Enter condition and letter in appropriate person's column. Make no entry in item C2 for cold; flu; red, sore, or strep throat; or "virus" even if reported in this list. Conditions affecting the respiratory system.</p>	
	A. Rheumatic fever?	G. A stroke or a Cerebrovascular accident? (ser'a-bro vas ku-lar)		A. Bronchitis?	Reask 6a. K. Emphysema?
	B. Rheumatic heart disease?	H. A hemorrhage of the brain?		B. Bronchiectasis? (brong ke-ek tak-sis)	L. Pleurisy?
	C. Hardening of the arteries or Arteriosclerosis?	I. Angina pectoris? (pek'to-ris)		C. Asthma?	M. Tuberculosis?
	D. Congenital heart disease?	J. A myocardial infarction?		D. Hay fever?	N. An abscess of the lung?
	E. Coronary heart disease?	K. Any other heart attack?		E. A nasal polyp?	O. A tumor, cyst, or growth of the throat, larynx, or trachea?
	F. Hypertension, sometimes called High blood pressure?			F. Sinus trouble?	P. Any work-related respiratory condition such as dust on the lungs, silicosis or pneu-mo-co-ni-a-sis?
	<p>5d. DURING THE PAST 12 MONTHS, did anyone in the family have - If "Yes," ask 5e and f.</p> <p>e. Who was this?</p> <p>f. DURING THE PAST 12 MONTHS, did anyone else have - Enter condition and letter in appropriate person's column. Conditions affecting the heart and circulatory system.</p>			G. A deflected or deviated nasal septum?	Q. During the past 12 months did anyone (else) in the family have any other respiratory, lung, or pulmonary condition? If "Yes," ask: Who was this? What was the condition? Enter in item C2. THEN reask Q.
	L. Damaged heart valves?	R. Gôngrene?		H. *Tonsillitis or enlargement of the tonsils or adenoids?	
	M. Tachycardia or Rapid heart?	S. Varicose veins?		I. *Laryngitis?	
N. A heart murmur?	T. Hemorrhoids or Piles?	J. A tumor, cyst, or growth of the bronchial tube or lung?			
O. Any other heart trouble?	U. Phlebitis or Thrombophlebitis?	<p>*If reported in this list only, ask:</p> <p>1. How many times did -- have (<i>condition</i>) in the past 12 months? If 2 or more times, enter condition in item C2. If only 1 time, ask:</p> <p>2. How long did it last? If 1 month or longer, enter in item C2. If less than 1 month, do not record. If tonsils or adenoids were removed during past 12 months, enter the condition causing removal in item C2.</p>			
P. An aneurysm? (an yoo-riz-m)	V. Any other condition affecting blood circulation?				
Q. Any blood clots?					

FORM H15-1 (1982) (4-6-82)

L. DEMOGRAPHIC BACKGROUND PAGE

<p>L1 Refer to age.</p>	<p>L1 <input type="checkbox"/> Under 5 (NP) <input type="checkbox"/> 5-17 (2) <input type="checkbox"/> 18 and over (1)</p>																				
<p>1a. Did -- EVER serve on active duty in the Armed Forces of the United States?</p> <p>b. When did -- serve?</p> <p>Mark box in descending order of priority. Thus, if person served in Vietnam and in Korea, mark VN.</p> <table border="0"> <tr> <td>Vietnam Era (Aug. '64 to April '75)</td> <td>VN</td> </tr> <tr> <td>Korean War (June '50 to Jan. '55)</td> <td>KW</td> </tr> <tr> <td>World War II (Sept. '40 to July '47)</td> <td>WWII</td> </tr> <tr> <td>World War I (April '17 to Nov. '18)</td> <td>WWI</td> </tr> <tr> <td>Post Vietnam (May '75 to present)</td> <td>PVN</td> </tr> <tr> <td>Other Service (all other periods)</td> <td>OS</td> </tr> </table> <p>c. Was -- EVER an active member of a National Guard or military reserve unit?</p> <p>d. Was ALL of -- active duty service related to National Guard or military reserve training?</p>	Vietnam Era (Aug. '64 to April '75)	VN	Korean War (June '50 to Jan. '55)	KW	World War II (Sept. '40 to July '47)	WWII	World War I (April '17 to Nov. '18)	WWI	Post Vietnam (May '75 to present)	PVN	Other Service (all other periods)	OS	<p>1a. 1 <input type="checkbox"/> Yes (Mark "AF" box, THEN 1b) 2 <input type="checkbox"/> No (2)</p> <p>b.</p> <table border="0"> <tr> <td>1 <input type="checkbox"/> VN</td> <td>5 <input type="checkbox"/> PVN</td> </tr> <tr> <td>2 <input type="checkbox"/> KW</td> <td>6 <input type="checkbox"/> OS</td> </tr> <tr> <td>3 <input type="checkbox"/> WWII</td> <td>7 <input type="checkbox"/> DK</td> </tr> <tr> <td>4 <input type="checkbox"/> WWI</td> <td></td> </tr> </table> <p>c. <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2) 7 <input type="checkbox"/> DK (2)</p> <p>d. 1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	1 <input type="checkbox"/> VN	5 <input type="checkbox"/> PVN	2 <input type="checkbox"/> KW	6 <input type="checkbox"/> OS	3 <input type="checkbox"/> WWII	7 <input type="checkbox"/> DK	4 <input type="checkbox"/> WWI	
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1 <input type="checkbox"/> VN	5 <input type="checkbox"/> PVN																				
2 <input type="checkbox"/> KW	6 <input type="checkbox"/> OS																				
3 <input type="checkbox"/> WWII	7 <input type="checkbox"/> DK																				
4 <input type="checkbox"/> WWI																					
<p>2a. What is the highest grade or year of regular school -- has ever attended?</p> <p>b. Did -- finish the (number in 2a) [grade/year]?</p>	<p>2a. 00 <input type="checkbox"/> Never attended or kindergarten (NP) Elem: 1 2 3 4 5 6 7 8 High: 9 10 11 12 College: 1 2 3 4 5 6+</p> <p>b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																				
<p><i>Hand Card R. Ask first alternative for first person; ask second alternative for other persons.</i></p> <p>3a. [What is the number of the group or groups which represents -- race?] [What is -- race?]</p> <p>Circle all that apply</p> <table border="0"> <tr> <td>1 - Aleut, Eskimo, or American Indian</td> <td>4 - White</td> </tr> <tr> <td>2 - Asian or Pacific Islander</td> <td>5 - Another group not listed - Specify</td> </tr> <tr> <td>3 - Black</td> <td></td> </tr> </table> <p>Ask if multiple entries:</p> <p>b. Which of these groups; that is, (entries in 3a) would you say BEST represents -- race?</p> <p>c. Mark observed race of respondent(s) only.</p>	1 - Aleut, Eskimo, or American Indian	4 - White	2 - Asian or Pacific Islander	5 - Another group not listed - Specify	3 - Black		<p>3a. 1 2 3 4 5 _____ Specify</p> <p>b. 1 2 3 4 5 _____ Specify</p> <p>c. 1 <input type="checkbox"/> W 2 <input type="checkbox"/> B 3 <input type="checkbox"/> O</p>														
1 - Aleut, Eskimo, or American Indian	4 - White																				
2 - Asian or Pacific Islander	5 - Another group not listed - Specify																				
3 - Black																					
<p><i>Hand Card O.</i></p> <p>4a. Are any of these groups -- national origin or ancestry? (Where did -- ancestors come from?)</p> <p>b. Please give me the number of the group.</p> <p>Circle all that apply</p> <table border="0"> <tr> <td>1 - Puerto Rican</td> <td>5 - Chicano</td> </tr> <tr> <td>2 - Cuban</td> <td>6 - Other Latin American</td> </tr> <tr> <td>3 - Mexican/Mexicano</td> <td>7 - Other Spanish</td> </tr> <tr> <td>4 - Mexican American</td> <td></td> </tr> </table>	1 - Puerto Rican	5 - Chicano	2 - Cuban	6 - Other Latin American	3 - Mexican/Mexicano	7 - Other Spanish	4 - Mexican American		<p>4a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)</p> <p>b. 1 2 3 4 5 6 7</p>												
1 - Puerto Rican	5 - Chicano																				
2 - Cuban	6 - Other Latin American																				
3 - Mexican/Mexicano	7 - Other Spanish																				
4 - Mexican American																					

FORM HIR-1 (11982) (4-6-82)

L. DEMOGRAPHIC BACKGROUND PAGE, Continued

<p>L2</p>	<p>Refer to "Age" and "Wa/Wb" boxes in C1.</p>	<p>L2</p> <p>0 <input type="checkbox"/> Under 18 (NP) 1 <input type="checkbox"/> Wa box marked (6a) 2 <input type="checkbox"/> Wb box marked (5a) 3 <input type="checkbox"/> Neither box marked (5b)</p>																				
<p>5a. Earlier you said that -- has a job or business but did not work last week or the week before. Was -- looking for work or on layoff from a job during those 2 weeks?</p> <p>5b. Earlier you said that -- didn't have a job or business last week or the week before. Was -- looking for work or on layoff from a job during those 2 weeks?</p> <p>c. Which, looking for work or on layoff from a job?</p>		<p>5a. 1 <input type="checkbox"/> Yes (5c) 2 <input type="checkbox"/> No (6b)</p> <p>b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)</p> <p>c. 1 <input type="checkbox"/> Looking (6c) 3 <input type="checkbox"/> Both (6b) 2 <input type="checkbox"/> Layoff (6b)</p>																				
<p>6a. Earlier you said that -- worked last week or the week before. Ask 6b.</p> <p>b. For whom did -- work? Enter name of company, business, organization, or other employer.</p> <p>c. For whom did -- work at -- last full-time civilian job or business lasting 2 consecutive weeks or more? Enter name of company, business, organization, or other employer.</p> <p>d. What kind of business or industry is this? For example, TV and radio manufacturing, retail shoe store, State Labor Department, farm.</p> <p>e. What kind of work was -- doing? For example, electrical engineer, stock clerk, typist, farmer.</p> <p>f. What were -- most important activities or duties at that job? For example, types, keeps account books, files, sells cars, operates printing press, finishes concrete.</p> <p>Complete from entries in 6b-f. If not clear, ask: .</p> <p>g. Was --</p> <table border="0"> <tr> <td>An employee of a PRIVATE company, business or individual for wages, salary, or commission? P</td> <td>Self-employed in OWN business, professional practice, or farm?</td> </tr> <tr> <td>A FEDERAL government employee? F</td> <td>If not farm, ask: Is the business incorporated?</td> </tr> <tr> <td>A STATE government employee? S</td> <td>Yes I</td> </tr> <tr> <td>A LOCAL government employee? L</td> <td>No (or farm) SE</td> </tr> <tr> <td></td> <td>Working WITHOUT PAY in family business or farm? WP</td> </tr> <tr> <td></td> <td>- NEVER WORKED or never worked at a full-time civilian job lasting 2 weeks or more NEV</td> </tr> </table>		An employee of a PRIVATE company, business or individual for wages, salary, or commission? P	Self-employed in OWN business, professional practice, or farm?	A FEDERAL government employee? F	If not farm, ask: Is the business incorporated?	A STATE government employee? S	Yes I	A LOCAL government employee? L	No (or farm) SE		Working WITHOUT PAY in family business or farm? WP		- NEVER WORKED or never worked at a full-time civilian job lasting 2 weeks or more NEV	<p>6b. and c. Employer</p> <p>d. Industry</p> <p>e. Occupation</p> <p>f. Duties</p> <p>g. Class of worker</p> <table border="0"> <tr> <td>1 <input type="checkbox"/> P</td> <td>5 <input type="checkbox"/> I</td> </tr> <tr> <td>2 <input type="checkbox"/> F</td> <td>6 <input type="checkbox"/> SE</td> </tr> <tr> <td>3 <input type="checkbox"/> S</td> <td>7 <input type="checkbox"/> WP</td> </tr> <tr> <td>4 <input type="checkbox"/> L</td> <td>8 <input type="checkbox"/> NEV</td> </tr> </table>	1 <input type="checkbox"/> P	5 <input type="checkbox"/> I	2 <input type="checkbox"/> F	6 <input type="checkbox"/> SE	3 <input type="checkbox"/> S	7 <input type="checkbox"/> WP	4 <input type="checkbox"/> L	8 <input type="checkbox"/> NEV
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<p>FOOTNOTES</p>																						

FORM HIS-1 (1982) 16-4-821

L. DEMOGRAPHIC BACKGROUND PAGE, Continued																																
<p>Mark box if under 14. If "Married" refer to household composition and mark accordingly.</p> <p>7. Is -- new married, widowed, divorced, separated, or has -- never been married?</p>		<p>7.</p> <p>0 <input type="checkbox"/> Under 14 1 <input type="checkbox"/> Married -- spouse in HH 2 <input type="checkbox"/> Married -- spouse not in HH 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced 5 <input type="checkbox"/> Separated 6 <input type="checkbox"/> Never married</p>																														
<p>8a. Was the total combined FAMILY income during the past 12 months -- that is, yours, (read names, including Armed Forces members living at home) more or less than \$20,000? Include money from jobs, social security, retirement income, unemployment payments, public assistance, and so forth. Also include income from interest, dividends, net income from business, farm, or rent, and any other money income received.</p> <p>Read if necessary: Income is important in analyzing the health information we collect. For example, this information helps us to learn whether persons in one income group use certain types of medical care services or have certain conditions more or less often than those in another group.</p> <p>----- Read parenthetical phrase if Armed Forces member living at home or if necessary.</p> <p>b. Of these income groups, which letter best represents the total combined FAMILY income during the past 12 months (that is, yours, (read names, including Armed Forces members living at home)? Include wages, salaries, and the other items we just talked about.</p> <p>Read if necessary: Income is important in analyzing the health information we collect. For example, this information helps us to learn whether persons in one income group use certain types of medical care services or have certain conditions more or less often than those in another group.</p>		<p>8a.</p> <p>1 <input type="checkbox"/> \$20,000 or more (Hand Card I) 2 <input type="checkbox"/> Less than \$20,000 (Hand Card J)</p> <p>b.</p> <table border="0"> <tr><td>00 <input type="checkbox"/> A</td><td>10 <input type="checkbox"/> K</td><td>20 <input type="checkbox"/> U</td></tr> <tr><td>01 <input type="checkbox"/> B</td><td>11 <input type="checkbox"/> L</td><td>21 <input type="checkbox"/> V</td></tr> <tr><td>02 <input type="checkbox"/> C</td><td>12 <input type="checkbox"/> M</td><td>22 <input type="checkbox"/> W</td></tr> <tr><td>03 <input type="checkbox"/> D</td><td>13 <input type="checkbox"/> N</td><td>23 <input type="checkbox"/> X</td></tr> <tr><td>04 <input type="checkbox"/> E</td><td>14 <input type="checkbox"/> O</td><td>24 <input type="checkbox"/> Y</td></tr> <tr><td>05 <input type="checkbox"/> F</td><td>15 <input type="checkbox"/> P</td><td>25 <input type="checkbox"/> Z</td></tr> <tr><td>06 <input type="checkbox"/> G</td><td>16 <input type="checkbox"/> Q</td><td>26 <input type="checkbox"/> ZZ</td></tr> <tr><td>07 <input type="checkbox"/> H</td><td>17 <input type="checkbox"/> R</td><td></td></tr> <tr><td>08 <input type="checkbox"/> I</td><td>18 <input type="checkbox"/> S</td><td></td></tr> <tr><td>09 <input type="checkbox"/> J</td><td>19 <input type="checkbox"/> T</td><td></td></tr> </table>	00 <input type="checkbox"/> A	10 <input type="checkbox"/> K	20 <input type="checkbox"/> U	01 <input type="checkbox"/> B	11 <input type="checkbox"/> L	21 <input type="checkbox"/> V	02 <input type="checkbox"/> C	12 <input type="checkbox"/> M	22 <input type="checkbox"/> W	03 <input type="checkbox"/> D	13 <input type="checkbox"/> N	23 <input type="checkbox"/> X	04 <input type="checkbox"/> E	14 <input type="checkbox"/> O	24 <input type="checkbox"/> Y	05 <input type="checkbox"/> F	15 <input type="checkbox"/> P	25 <input type="checkbox"/> Z	06 <input type="checkbox"/> G	16 <input type="checkbox"/> Q	26 <input type="checkbox"/> ZZ	07 <input type="checkbox"/> H	17 <input type="checkbox"/> R		08 <input type="checkbox"/> I	18 <input type="checkbox"/> S		09 <input type="checkbox"/> J	19 <input type="checkbox"/> T	
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09 <input type="checkbox"/> J	19 <input type="checkbox"/> T																															
R	a. Mark first appropriate box.	<p>Ra.</p> <p>0 <input type="checkbox"/> Under 17 1 <input type="checkbox"/> Present for all questions 2 <input type="checkbox"/> Present for some questions 3 <input type="checkbox"/> Not present</p>																														
	b. Enter person number of respondent.	<p>b.</p> <p>Person number(s) of respondent(s)</p>																														
<p>FOOTNOTES</p>																																

FORM H10-1 (K) (1982) (4-6-82)

CARD R

1. Aleut, Eskimo, or American Indian
2. Asian or Pacific Islander
3. Black
4. White

CARD O

1. Puerto Rican
2. Cuban
3. Mexican/Mexicano
4. Mexican American
5. Chicano
6. Other Latin American
7. Other Spanish

CARD I

- U** 20,000 – 24,999
V 25,000 – 29,999
W 30,000 – 34,999
X 35,000 – 39,999
Y 40,000 – 44,999
Z 45,000 – 49,999
ZZ..... 50,000 and over

CARD J

- A** Less than 1,000 (including loss)
B 1,000 – 1,999
C 2,000 – 2,999
D 3,000 – 3,999
E 4,000 – 4,999
F 5,000 – 5,999
G 6,000 – 6,999
H 7,000 – 7,999
I 8,000 – 8,999
J 9,000 – 9,999
K 10,000 – 10,999
L 11,000 – 11,999
M 12,000 – 12,999
N..... 13,000 – 13,999
O 14,000 – 14,999
P 15,000 – 15,999
Q 16,000 – 16,999
R 17,000 – 17,999
S 18,000 – 18,999
T 19,000 – 19,999