

**Section Q. CONDITIONS AND IMPAIRMENTS**

**Read to respondent – Now tell me if you have any of these eye conditions, even if you have mentioned them before.**

<b>1. Do you NOW have –</b>			<b>5</b>
<b>a. Cataracts?</b>	1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No	9 <input type="checkbox"/> DK
<b>b. Glaucoma?</b>	1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No	9 <input type="checkbox"/> DK
<b>c. Color blindness?</b>	1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No	9 <input type="checkbox"/> DK
<b>d. A detached retina or any other condition of the retina?</b> <i>Circle appropriate condition</i>	1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No	9 <input type="checkbox"/> DK
<b>e. Blindness in one or both eyes?</b> <i>If "Yes," ask: Which – one or both?</i>	Yes 0 <input type="checkbox"/> One	2 <input type="checkbox"/> No	9 <input type="checkbox"/> DK
	1 <input type="checkbox"/> Both (Q1)		
<b>f. Any other trouble seeing with one or both eyes EVEN when wearing glasses?</b>	1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No	9 <input type="checkbox"/> DK
<b>Q1</b>	<i>Refer to answers in 1a–f</i>	1 <input type="checkbox"/> All "No" or "DK" in 1a–f (2) 0 <input type="checkbox"/> Other – Enter "Yes" responses in EYE LTR box on Condition Summary Chart, THEN Q2	<b>11</b>
<b>Q2</b>	<i>Blindness in BOTH eyes reported in 1e</i>	1 <input type="checkbox"/> Yes (4a THEN 9) 2 <input type="checkbox"/> No (2)	<b>12</b>
<b>2a. Do you use eyeglasses? Include eyeglasses that just magnify.</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (3)		<b>13</b>
<b>b. Were these eyeglasses prescribed for you?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		<b>14</b>
<b>3. Do you use contact lenses?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		<b>15</b>
<b>4a. Have you ever had an operation for cataracts?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)		<b>16</b>
<b>b. Do you have a lens implant?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		<b>17</b>
<b>5. Do you use a magnifying glass to read or to do other close work?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		<b>18</b>
<b>Read to respondent – The next few questions are about how well you can see (wearing your [glasses/(or) contact lenses] if that's how you see best).</b>			
<b>6a. Can you see well enough to recognize the features of people if they are within two or three feet?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		<b>19</b>
<b>b. Can you see well enough to watch T.V. 8 to 12 feet away?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		<b>20</b>
<b>c. Can you see well enough to read newspaper print?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		<b>21</b>
<b>7a. Can you see well enough to step off a curb or down a step?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		<b>22</b>
<b>b. Can you see well enough to recognize a friend walking on the other side of the street?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		<b>23</b>
<b>8. Which statement best describes your vision (wearing [glasses/(or) contact lenses]) – no trouble seeing, a little trouble, or a lot of trouble?</b>	1 <input type="checkbox"/> No trouble 2 <input type="checkbox"/> Little trouble 3 <input type="checkbox"/> Lot of trouble		<b>24</b>

Section Q. CONDITIONS AND IMPAIRMENTS, Continued		
Read to respondent — These next questions are about hearing.		26
9. Do you NOW have —		
a. Tinnitus or ringing in the ears? Circle appropriate condition.	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK	26
b. Deafness in one or both ears? If "Yes," ask: Which — one or both?	Yes 0 <input type="checkbox"/> One      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK 1 <input type="checkbox"/> Both (Q3)	27
c. Any other trouble hearing with one or both ears?	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK	28
<b>Q3</b> Refer to answers in 9a—c	1 <input type="checkbox"/> All "No" or "DK" in 9a—c (10) 8 <input type="checkbox"/> Other — Enter "Yes" responses in EAR LTR box on Condition Summary Chart. THEN 10	
10a. Do you use a hearing aid?		
	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	29
b. (With your hearing aid) Can you hear MOST of the things people say?	1 <input type="checkbox"/> Yes (11) 2 <input type="checkbox"/> No	30
c. (With your hearing aid) Can you hear ONLY A FEW WORDS people say or LOUD noises?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	31
11. Which statement best describes your hearing (with your hearing aid) — no trouble hearing, a little trouble, or a lot of trouble?		
	1 <input type="checkbox"/> No trouble 2 <input type="checkbox"/> Little trouble 3 <input type="checkbox"/> Lot of trouble	32
Read to respondent — Please tell me if you have EVER had any of the following conditions, even if you have mentioned them before.		
12. Have you EVER had —		
a. Osteoporosis, sometimes called fragile or soft bones? (os tee o po ro' sis)	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK	33
b. A broken hip?	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK	34
c. Hardening of the arteries or arteriosclerosis? Circle appropriate condition	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK	35
d. Hypertension, sometimes called high blood pressure?	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK	36
e. Rheumatic fever?	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK	37
f. Rheumatic heart disease?	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK	38
g. Coronary heart disease?	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK	39
h. Angina pectoris? (pek' to ris)	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK	40
i. A myocardial infarction?	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK	41
j. Any other heart attack?	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK	42
k. A stroke or a cerebrovascular accident? (ser' a-bro vas ku lar) Circle appropriate condition	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK	43
l. Alzheimer's disease? (al' zi mers)	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK	44
m. Cancer of any kind?	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK	45
<b>Q4</b> Refer to answers in 12a—m	1 <input type="checkbox"/> All "No" or "DK" in 12a—m (13) 8 <input type="checkbox"/> Other — Enter "Yes" responses in EVER LTR box on Condition Summary Chart, THEN 13	46

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**Section Q. CONDITIONS AND IMPAIRMENTS, Continued**

<p><b>13. During the PAST 12 MONTHS, did you have --</b></p> <p><b>a. Arthritis of any kind or rheumatism?</b> <i>Circle appropriate condition</i></p> <p><b>b. Diabetes?</b></p> <p><b>c. An aneurysm?</b> (an' yoo rizm)</p> <p><b>d. Any blood clots?</b></p> <p><b>e. Varicose veins?</b></p>	<p>1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK</p> <p>1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK</p> <p>1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK</p> <p>1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK</p> <p>1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> DK</p>	<p>47</p> <p>48</p> <p>49</p> <p>50</p> <p>51</p>						
<p><b>Q5</b>      <i>Refer to answers in 13a-e</i></p>	<p>1 <input type="checkbox"/> All "No" or "DK" in 13a-e (14)</p> <p>9 <input type="checkbox"/> Other - Enter "Yes" responses in 12-MO LTR box on Condition Summary Chart, THEN 14</p>	<p>52</p>						
<p><b>14a. During the past 12 months, that is, since (12-month date) a year ago, have you fallen?</b></p> <p><b>b. How many times?</b></p> <p><b>c. [Did you fall/Were any of these falls] because you felt dizzy?</b></p> <p><b>d. Do you sometimes have trouble with dizziness?</b></p> <p><b>e. Does dizziness prevent you in any way from doing things you otherwise could do?</b></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (14d)</p> <p>1 <input type="checkbox"/> One 2 <input type="checkbox"/> More than one</p> <p>1 <input type="checkbox"/> Yes (14e) 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (15)</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>53</p> <p>54</p> <p>55</p> <p>56</p> <p>57</p>						
<p><b>15. Do you have trouble biting or chewing any kinds of food, such as firm meat or apples?</b> <i>If asked -- includes wearing false teeth/dentures.</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>58</p>						
<p><b>Read to respondent</b> - In order to determine how health practices and conditions are related to how long people live, we would like to refer to statistical records maintained by the National Center for Health Statistics.</p>		<p>RT 69 3-4 5-11</p>						
<p><b>16a. I have your date of birth as (birthdate from item 3 on HIS-1 Household Composition page). Is that correct?</b></p>	<p>Date of birth</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">Month</td> <td style="width:33%;">Date</td> <td style="width:33%;">Year</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> </tr> </table>	Month	Date	Year				<p>5-11</p>
Month	Date	Year						
<p><b>b. In what State or country were you born?</b></p> <p><i>Write in the full name of the State or mark the appropriate box if the sample person was not born in the United States.</i></p>	<p>99 <input type="checkbox"/> DK</p> <p>_____ State</p> <p>01 <input type="checkbox"/> Puerto Rico      05 <input type="checkbox"/> Cuba          02 <input type="checkbox"/> Virgin Islands      06 <input type="checkbox"/> Mexico          03 <input type="checkbox"/> Guam      98 <input type="checkbox"/> All other countries          04 <input type="checkbox"/> Canada</p>	<p>12-13</p>						
<p><b>c. To verify the spelling, what is your full name, including middle initial?</b></p>	<p>Last</p> <p>_____</p> <p>First</p> <p>_____</p> <p>Middle initial</p> <p>_____</p>	<p>14-33</p> <p>34-48</p> <p>49</p>						
<p><b>d. What was your father's LAST name?</b> <i>Verify spelling. DO NOT write "Same."</i></p>	<p>_____ Father's LAST name</p>	<p>60-69</p>						
<p><b>Read to respondent</b> - We also need your Social Security Number. This information is voluntary and collected under the authority of the Public Health Service Act. There will be no effect on your benefits and no information will be given to any other government or nongovernment agency.</p> <p><b>Read if necessary</b> - The Public Health Service Act is title 42, United States Code, section 242k.</p>	<p>99999999 <input type="checkbox"/> DK</p> <p>____ - ____ - _____</p> <p>Social Security Number</p>	<p>70-78</p>						
<p><b>e. What is your Social Security Number?</b></p>	<p>Mark if number obtained from → 1 <input type="checkbox"/> Memory 2 <input type="checkbox"/> Records</p>	<p>79</p>						

**Section R1. ACTIVITIES OF DAILY LIVING (ADL'S)**

Read to respondent — The next questions are about how well you are able to do certain activities — by yourself and without using special equipment.

<b>1. Because of a health or physical problem, do you have ANY difficulty —</b> Ask if "Doesn't do": <b>Is this because of a HEALTH or PHYSICAL problem?</b> If "Yes," mark box 1; if "No," mark box 3	(1) <b>5</b>	(2) <b>22</b>	(3) <b>39</b>
	<b>Bathing or showering?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason	<b>Dressing?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason	<b>Eating?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason
Ask 2-5 for each ADL marked "Yes" in 1.	<b>6</b>	<b>23</b>	<b>40</b>
<b>2. By yourself and without using special equipment, how much difficulty do you have (ADL), some, a lot, or are you unable to do it?</b>	1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable	1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable	1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable
<b>3. Do you receive help from another person in (ADL)?</b>	<b>7</b>	<b>24</b>	<b>41</b>
<b>4a. Who gives this help?</b> Anyone else? Mark the S/C/P box without asking if ONLY help is from spouse/children/parents. <b>b. Is this help paid for?</b> Ask if necessary: Which helpers are paid?	<b>4a. Source of help</b> <b>4b. Paid</b> 8-11      12-15 HH member      0 <input type="checkbox"/> S/C/P (5) 1 <input type="checkbox"/> Relative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Non-HH member 3 <input type="checkbox"/> Relative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	<b>4a. Source of help</b> <b>4b. Paid</b> 25-28      29-32 HH member      0 <input type="checkbox"/> S/C/P (5) 1 <input type="checkbox"/> Relative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Non-HH member 3 <input type="checkbox"/> Relative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	<b>4a. Source of help</b> <b>4b. Paid</b> 42-45      46-49 HH member      0 <input type="checkbox"/> S/C/P (5) 1 <input type="checkbox"/> Relative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Non-HH member 3 <input type="checkbox"/> Relative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
<b>5a. Do you use any special equipment or aids in (ADL)?</b>	<b>16</b>	<b>33</b>	<b>50</b>
<b>b. What special equipment or aids do you use?</b> Anything else?	Special equipment or aids _____ <b>17-18</b> _____ <b>19-20</b>	Special equipment or aids _____ <b>34-35</b> _____ <b>36-37</b>	Special equipment or aids _____ <b>51-52</b> _____ <b>53-54</b>
Ask 6 if any ADL marked "Yes" in 1. <b>6a. What (other) condition causes the trouble in (read ADL(s))?</b> Ask if injury or operation: When did [the (injury) occur? / you have the operation?] Enter injury if over 3 months ago. Ask or reask 6b, if 0-3 months injury or operation. Ask if operation over 3 months ago: For what condition did you have the operation? Enter condition.	<input type="checkbox"/> Old age (6c)		
<b>b. Besides (condition), is there any other condition which causes this trouble in (read ADL(s))?</b>	<input type="checkbox"/> Yes (Reask 6a and b) <input type="checkbox"/> No (6d)		
<b>c. Is this trouble in (read ADL(s)) caused by any (other) specific condition?</b>	<input type="checkbox"/> Yes (Reask 6a and b) <input type="checkbox"/> No		
If multiple conditions, including old age, are listed in 6a, ask 6d for each ADL with a "Yes" in 1. Otherwise, mark appropriate box or transcribe the only listed condition for each ADL. <b>d. Which of these conditions, that is (read conditions in 6a) would you say is the MAIN cause of the trouble in (ADL)?</b>	(1) <b>21</b>	(2) <b>38</b>	(3) <b>55</b>
	1 <input type="checkbox"/> 0-3 month Inj/Op ONLY 2 <input type="checkbox"/> Old age 3 <input type="checkbox"/> _____ Ask 6d for next ADL with "Yes" in 1. Condition — Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.	1 <input type="checkbox"/> 0-3 month Inj/Op ONLY 2 <input type="checkbox"/> Old age 3 <input type="checkbox"/> _____ Ask 6d for next ADL with "Yes" in 1. Condition — Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.	1 <input type="checkbox"/> 0-3 month Inj/Op ONLY 2 <input type="checkbox"/> Old age 3 <input type="checkbox"/> _____ Ask 6d for next ADL with "Yes" in 1. Condition — Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.
<b>FOOTNOTES</b>			

**Section R1. ACTIVITIES OF DAILY LIVING (ADL'S), Continued**

RT 21  
3-4

(4) <span style="float: right;">56</span> <b>Task 1</b> <b>Getting in and out of bed or chairs?</b>  1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason				(5) <span style="float: right;">73</span> <b>Walking?</b>  1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason				(6) <span style="float: right;">80</span> <b>Getting outside?</b>  1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason				(7) <span style="float: right;">5</span> <b>Using the toilet, including getting to the toilet?</b>  1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason			
57 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable				74 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable				81 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable				6 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable			
58 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)				75 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)				92 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)				7 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)			
4a. Source of help <span style="float: right;">59-62</span>		4b. Paid <span style="float: right;">63-66</span>		4a. Source of help <span style="float: right;">76-79</span>		4b. Paid <span style="float: right;">80-83</span>		4a. Source of help <span style="float: right;">93-96</span>		4b. Paid <span style="float: right;">97-100</span>		4a. Source of help <span style="float: right;">8-11</span>		4b. Paid <span style="float: right;">12-15</span>	
HH member 1 <input type="checkbox"/> Relative . . . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		0 <input type="checkbox"/> S/C/P (5) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		HH member 1 <input type="checkbox"/> Relative . . . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		0 <input type="checkbox"/> S/C/P (5) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		HH member 1 <input type="checkbox"/> Relative . . . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		0 <input type="checkbox"/> S/C/P (5) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		HH member 1 <input type="checkbox"/> Relative . . . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		0 <input type="checkbox"/> S/C/P (5) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Non-HH member 3 <input type="checkbox"/> Relative . . . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Non-HH member 3 <input type="checkbox"/> Relative . . . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Non-HH member 3 <input type="checkbox"/> Relative . . . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Non-HH member 3 <input type="checkbox"/> Relative . . . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
67 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next ADL with "Yes" in 1)				84 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next ADL with "Yes" in 1)				101 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next ADL with "Yes" in 1)				18 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)			
Special equipment or aids _____ <span style="float: right;">68-69</span> _____ <span style="float: right;">70-71</span>				Special equipment or aids _____ <span style="float: right;">85-86</span> _____ <span style="float: right;">87-88</span>				Special equipment or aids _____ <span style="float: right;">102-103</span> _____ <span style="float: right;">104-106</span>				Special equipment or aids _____ <span style="float: right;">17-18</span> _____ <span style="float: right;">19-20</span>			
(4) <span style="float: right;">72</span> 1 <input type="checkbox"/> 0-3 month Inj/Op ONLY } 2 <input type="checkbox"/> Old age } Ask 6d for next ADL with "Yes" in 1  3 <input type="checkbox"/> _____ Condition - Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.				(5) <span style="float: right;">89</span> 1 <input type="checkbox"/> 0-3 month Inj/Op ONLY } 2 <input type="checkbox"/> Old age } Ask 6d for next ADL with "Yes" in 1  3 <input type="checkbox"/> _____ Condition - Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.				(6) <span style="float: right;">106</span> 1 <input type="checkbox"/> 0-3 month Inj/Op ONLY } 2 <input type="checkbox"/> Old age } Ask 6d for next ADL with "Yes" in 1  3 <input type="checkbox"/> _____ Condition - Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.				(7) <span style="float: right;">21</span> 1 <input type="checkbox"/> 0-3 month Inj/Op ONLY } (Next page) 2 <input type="checkbox"/> Old age } 3 <input type="checkbox"/> _____ Condition - Enter in ADL box on Condition Summary Chart, THEN next page.			
FOOTNOTES															

**Section R1. ACTIVITIES OF DAILY LIVING (ADL'S), Continued**

<p><b>7a. Do you have difficulty controlling your bowels?</b></p>	<p><input type="checkbox"/> Yes  <input type="checkbox"/> No (7c)</p>	<p><b>22</b></p>
<p><b>b. How frequently do you have this difficulty — daily, several times a week, once a week, or less than once a week?</b></p>	<p><input type="checkbox"/> Daily  <input type="checkbox"/> Several times a week  <input type="checkbox"/> Once a week  <input type="checkbox"/> Less than once a week  <input type="checkbox"/> DK</p>	<p><b>23</b></p>
<p><b>c. Do you have a colostomy or a device to help control bowel movements?</b></p>	<p><input type="checkbox"/> Yes  <input type="checkbox"/> No (8)</p>	<p><b>24</b></p>
<p><b>d. Do you need help from another person in taking care of this device?</b></p>	<p><input type="checkbox"/> Yes  <input type="checkbox"/> No</p>	<p><b>25</b></p>
<p><b>8a. Do you have difficulty controlling urination?</b></p>	<p><input type="checkbox"/> Yes  <input type="checkbox"/> No (8c)</p>	<p><b>26</b></p>
<p><b>b. How frequently do you have this difficulty — daily, several times a week, once a week, or less than once a week?</b></p>	<p><input type="checkbox"/> Daily  <input type="checkbox"/> Several times a week  <input type="checkbox"/> Once a week  <input type="checkbox"/> Less than once a week  <input type="checkbox"/> DK</p>	<p><b>27</b></p>
<p><b>c. Do you have a urinary catheter or a device to help control urination?</b></p>	<p><input type="checkbox"/> Yes  <input type="checkbox"/> No (R1)</p>	<p><b>28</b></p>
<p><b>d. Do you need help from another person in taking care of this device?</b></p>	<p><input type="checkbox"/> Yes  <input type="checkbox"/> No</p>	<p><b>29</b></p>
<p><b>R1</b>      <i>Mark first appropriate box</i></p>	<p><input type="checkbox"/> Respondent is a proxy  <input type="checkbox"/> Sample person has only been seen in a bed or chair  <input type="checkbox"/> Telephone interview  <input type="checkbox"/> All other (Next page)</p>	<p><b>30</b></p>
<p><i>Mark if known</i></p> <p><b>9. Because of a health or physical problem, do you usually —</b></p> <p><b>a. Stay in bed all or most of the time?</b></p>	<p><input type="checkbox"/> Yes (10)  <input type="checkbox"/> No</p>	<p><b>31</b></p>
<p><b>b. Stay in a chair all or most of the time?</b></p>	<p><input type="checkbox"/> Yes (10)  <input type="checkbox"/> No (Next page)</p>	<p><b>32</b></p>
<p><b>10a. What (other) condition causes you to stay in (bed/a chair)?</b></p> <p><i>Ask if injury or operation:  When did [the (injury) occur? / you have the operation?]  Enter injury if over 3 months ago.</i></p> <p><i>Ask or reask 10b, if 0–3 months injury or operation.</i></p> <p><i>Ask if operation over 3 months ago:  For what condition did you have the operation?  Enter condition.</i></p>	<p><input type="checkbox"/> Old age (10c)</p>	
<p><b>b. Besides (condition), is there any other condition which causes this?</b></p>	<p><input type="checkbox"/> Yes (Reask 10a and b)  <input type="checkbox"/> No (10d)</p>	
<p><b>c. Is this caused by any (other) specific condition?</b></p>	<p><input type="checkbox"/> Yes (Reask 10a and b)  <input type="checkbox"/> No</p>	
<p><i>Ask if multiple conditions, including old age, are listed in 10a. Otherwise, mark appropriate box or transcribe the only listed condition.</i></p> <p><b>d. Which of these conditions, that is (read conditions in 10a) would you say is the MAIN cause of your staying in (bed/a chair) all or most of the time?</b></p>	<p><input type="checkbox"/> 0–3 month Inj/Op ONLY } (Next page)  <input type="checkbox"/> Old age  <input type="checkbox"/> _____</p> <p>Condition — Enter "9" in ADL box on Condition Summary Chart, THEN next page.</p>	<p><b>33</b></p>

FORM HSE-1 (SR) (1984) (2-13-84)

**Section R2. INCIDENTAL ACTIVITIES OF DAILY LIVING (IADL'S)**

**Read to respondent — Now I will ask about some other activities. Tell me about doing them by yourself.**

<p><b>11. Because of a health or physical problem, do you have ANY difficulty —</b></p> <p>Ask if "Doesn't do":  <b>Is this because of a HEALTH or PHYSICAL problem?</b>                  If "Yes," mark box 1; if "No," mark box 3.</p>	(1)	34	(2)	46
<p><b>12. By yourself, how much difficulty do you have (IADL), some, a lot, or are you unable to do it?</b></p>	35	36	47	48
<p><b>13. Do you receive help from another person in (IADL)?</b></p>	38	39	49	50
<p><b>14a. Who gives this help?</b>                  Anyone else?</p> <p>Mark the S/C/P box without asking if ONLY help is from spouse, children/parents. THEN 12 for next IADL with "Yes" in 11.</p> <p><b>b. Is this help paid for?</b>                  Ask if necessary: Which helpers are paid?</p>	37-40	41-44	49-52	53-56
<p><b>15a. What (other) condition causes the trouble in (read IADL(s))?</b>                  Ask if injury or operation:                  When did (the injury) occur? / you have the operation?                  Enter injury if over 3 months ago.                  Ask or reask 15b, if 0-3 months injury or operation.                  Ask if operation over 3 months ago:                  For what condition did you have the operation?                  Enter condition.</p> <p><b>b. Besides (condition), is there any other condition which causes the trouble in (read IADL(s))?</b></p> <p><b>c. Is the trouble in (read IADL(s)) caused by any (other) specific condition?</b></p>	15c	15d	15e	15f
<p>If multiple conditions, including old age, are listed in 15a, ask 15d for each IADL with a "Yes" in 11. Otherwise, mark appropriate box or transcribe the only listed condition.</p> <p><b>d. Which of these conditions, that is (read conditions in 15a) would you say is the MAIN cause of the trouble in (IADL)?</b></p>	45	46	57	58

FOOTNOTES

**Section R2. INCIDENTAL ACTIVITIES OF DAILY LIVING (IADL'S), Continued**

(3) <span style="float: right;">58</span>		(4) <span style="float: right;">70</span>		(5) <span style="float: right;">82</span>		(6) <span style="float: right;">84</span>	
Managing your money, (such as keeping track of expenses or paying bills)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		Reask 11 Using the telephone? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		Doing heavy housework, (like scrubbing floors, or washing windows)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		Doing light housework, (like doing dishes, straightening up, or light cleaning)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason	
59		71		83		85	
1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable	
60		72		84		86	
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (12 for next IADL with "Yes" in 11)		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (12 for next IADL with "Yes" in 11)		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (12 for next IADL with "Yes" in 11)		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (15)	
Source of help 14a.		Paid 14b.		Source of help 14a.		Paid 14b.	
61-64		65-68		73-76		77-80	
HH member      0 <input type="checkbox"/> S/C/P 1 <input type="checkbox"/> Relative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative    1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		HH member      0 <input type="checkbox"/> S/C/P 1 <input type="checkbox"/> Relative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative    1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		HH member      0 <input type="checkbox"/> S/C/P 1 <input type="checkbox"/> Relative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative    1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		HH member      0 <input type="checkbox"/> S/C/P 1 <input type="checkbox"/> Relative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative    1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Non-HH member 3 <input type="checkbox"/> Relative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative    1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Non-HH member 3 <input type="checkbox"/> Relative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative    1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Non-HH member 3 <input type="checkbox"/> Relative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative    1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Non-HH member 3 <input type="checkbox"/> Relative      1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative    1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
(3) <span style="float: right;">89</span>		(4) <span style="float: right;">81</span>		(5) <span style="float: right;">93</span>		(6) <span style="float: right;">105</span>	
1 <input type="checkbox"/> 0-3 month Inj/ Op ONLY 2 <input type="checkbox"/> Old age Ask 15d for next IADL with "Yes" in 11 3 <input type="checkbox"/> _____ Condition - Enter in IADL box on Condition Summary Chart, THEN ask 15d for next IADL with "Yes" in 11.		1 <input type="checkbox"/> 0-3 month Inj/ Op ONLY 2 <input type="checkbox"/> Old age Ask 15d for next IADL with "Yes" in 11 3 <input type="checkbox"/> _____ Condition - Enter in IADL box on Condition Summary Chart, THEN ask 15d for next IADL with "Yes" in 11.		1 <input type="checkbox"/> 0-3 month Inj/ Op ONLY 2 <input type="checkbox"/> Old age Ask 15d for next IADL with "Yes" in 11 3 <input type="checkbox"/> _____ Condition - Enter in IADL box on Condition Summary Chart, THEN ask 15d for next IADL with "Yes" in 11.		1 <input type="checkbox"/> 0-3 month Inj/ Op ONLY } Next page 2 <input type="checkbox"/> Old age } 3 <input type="checkbox"/> _____ Condition - Enter in IADL box on Condition Summary Chart, THEN next page.	
FOOTNOTES							

