

<p>K1 Refer to RD and C2. <input type="checkbox"/> "Yes" in "RD" box AND more than 1 condition in C2 (6) <input type="checkbox"/> Other (K2)</p> <p>6a. During the 2 weeks outlined in red on that calendar, did -- (condition) cause -- to cut down on the things -- usually does? <input type="checkbox"/> Yes <input type="checkbox"/> No (K2)</p> <p>b. During that period, how many days did -- cut down for more than half of the day? 00 <input type="checkbox"/> None (K2) _____ Days</p> <p>7. During those 2 weeks, how many days did -- stay in bed for more than half of the day because of this condition? 00 <input type="checkbox"/> None _____ Days</p> <p>Ask if "Wa/Wb" box marked in C1: 8. During those 2 weeks, how many days did -- miss more than half of the day from -- job or business because of this condition? 00 <input type="checkbox"/> None _____ Days</p> <p>Ask if age 5-17: 9. During those 2 weeks, how many days did -- miss more than half of the day from school because of this condition? 00 <input type="checkbox"/> None _____ Days</p> <p>K2 <input type="checkbox"/> Condition has "CL LTR" in C2 as source (10) <input type="checkbox"/> Condition does not have "CL LTR" in C2 as source (K4)</p> <p>10. About how many days since (12-month date) a year ago, has this condition kept -- in bed more than half of the day? (Include days while an overnight patient in a hospital.) 000 <input type="checkbox"/> None _____ Days</p> <p>11. Was -- ever hospitalized for -- (condition in 3b)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>K3 <input type="checkbox"/> Missing extremity or organ (K4) <input type="checkbox"/> Other (12)</p> <p>12a. Does -- still have this condition? 1 <input type="checkbox"/> Yes (K4) <input type="checkbox"/> No</p> <p>b. Is this condition completely cured or is it under control? 2 <input type="checkbox"/> Cured <input type="checkbox"/> Other (Specify) _____ 3 <input type="checkbox"/> Under control (K4) _____ (K4)</p> <p>c. About how long did -- have this condition before it was cured? <input type="checkbox"/> Less than 1 month OR Number { <input type="checkbox"/> Months <input type="checkbox"/> Years</p> <p>d. Was this condition present at any time during the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>K4 0 <input type="checkbox"/> Not an accident/injury (NC) 1 <input type="checkbox"/> First accident/injury for this person (14) 2 <input type="checkbox"/> Other (13)</p>	<p>13. Is this (condition in 3b) the result of the same accident you already told me about? <input type="checkbox"/> Yes (Record condition page number where accident questions first completed.) → _____ (NC) Page No <input type="checkbox"/> No</p> <p>14. 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>Work box if under 18. <input type="checkbox"/> Under 18 (16) 15a. Was -- under 18 when the accident happened? 1 <input type="checkbox"/> Yes (16) <input type="checkbox"/> No</p> <p>b. Was -- in the Armed Forces when the accident happened? 2 <input type="checkbox"/> Yes (16) <input type="checkbox"/> No</p> <p>c. Was -- at work at -- job or business when the accident happened? 3 <input type="checkbox"/> Yes 4 <input type="checkbox"/> No</p> <p>16a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (17)</p> <p>b. Was more than one vehicle involved? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>c. Was [it/either one] moving at the time? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>17a. At the time of the accident what part of the body was hurt? What kind of injury was it? Anything else? <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> <tr><td> </td><td> </td></tr> </tbody> </table> <p>Ask if box 3, 4, or 5 marked in Q.5: b. What part of the body is affected now? How is -- (part of body) affected? Is -- affected in any other way? <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> <tr><td> </td><td> </td></tr> </tbody> </table> <p>* Enter part of body in same detail as for 3g. ** If multiple present effects, enter in C2 each one that is not the same as 3b or C2 and complete a separate condition page for it.</p> </p></p>	Part(s) of body *	Kind of injury							Part(s) of body *	Present effects **						
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