

Section E – ENVIRONMENTAL HEALTH

<p>These next questions are about this home.</p>			5
<p>1. Does ANYONE smoke cigarettes, cigars, or pipes ANYWHERE INSIDE this home?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (3) 9 <input type="checkbox"/> DK }</p>		
<p>2. On the average, about how many days per week is there smoking ANYWHERE INSIDE this home?</p>	<p>0 <input type="checkbox"/> Less than 1 day per week/Rarely  ____ Days per week (Number) 9 <input type="checkbox"/> DK</p>		6
<p>3. Was your home built before 1950?</p>	<p>1 <input type="checkbox"/> Yes (4) 2 <input type="checkbox"/> No (5) 9 <input type="checkbox"/> DK (4)</p>		7
<p>4. Has paint from this home EVER been analyzed for lead content? <i>Read if necessary:</i> This can be done by sending paint chips to a laboratory for testing, having a measurement by an x-ray fluorescence or XRF machine or having a chemical spot test on the wall.</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>		8
<p>5. Have you ever heard of radon, a gas that is found in the air in some homes?</p>	<p>1 <input type="checkbox"/> Yes (6) 2 <input type="checkbox"/> No } (11) 9 <input type="checkbox"/> DK }</p>		9
<p>6. Has your household air been tested for the presence of radon?</p>	<p>1 <input type="checkbox"/> Yes (8) 2 <input type="checkbox"/> No } (7) 9 <input type="checkbox"/> DK }</p>		10
<p>7. Do you or anyone plan to have this home tested for radon within the next year?</p>	<p>1 <input type="checkbox"/> Yes } (11) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }</p>		11
<p>8a. What was the radon level from that last test BEFORE any corrective action was taken?</p>	<p>____ Picocuries per liter (E1) 9999 <input type="checkbox"/> DK (8b)</p>		12-15
<p>b. Was it above or below the EPA radon guideline of 4 picocuries (pi-ko-kurees) per liter?</p>	<p>1 <input type="checkbox"/> Above the EPA guideline (9) 2 <input type="checkbox"/> At or below the EPA guideline (11) 9 <input type="checkbox"/> DK (9)</p>		16
<p><b>ITEM E1</b></p>	<p>Refer to question 8a.</p>	<p>1 <input type="checkbox"/> Above 4 picocuries (9) 2 <input type="checkbox"/> At or below 4 picocuries (11)</p>	17
<p>9. Were followup tests conducted to verify the results of the first test?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>		18
<p>10a. Has anything been done in this home to reduce the level of radon exposure?</p>	<p>1 <input type="checkbox"/> Yes (10b) 2 <input type="checkbox"/> No } (10c) 9 <input type="checkbox"/> DK }</p>		19
<p>b. What has been done? <i>Mark all that apply.</i></p>	<p>1 <input type="checkbox"/> Increase ventilation by opening windows, doors, etc. 2 <input type="checkbox"/> Stopped or decreased smoking 3 <input type="checkbox"/> Moved out of or spend less time in the basement 4 <input type="checkbox"/> Modified home – sealed cracks, installed ventilation system, etc. 8 <input type="checkbox"/> Other – Specify ↴ _____ 9 <input type="checkbox"/> DK</p>	<p>20 21 22 23 24 25</p>	
<p>c. Do you or anyone plan to do anything (else) to reduce the radon level or radon exposure in this home?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> I did not think it was needed 9 <input type="checkbox"/> DK</p>		26
<p><i>Mark by observation or ask:</i></p> <p>11. Which of the following best describes your home? <i>Read answer categories, if necessary.</i></p>	<p>1 <input type="checkbox"/> Single home, duplex, townhouse 2 <input type="checkbox"/> Basement, first or second floor apartment or condominium 3 <input type="checkbox"/> Apartment or condominium above second floor 4 <input type="checkbox"/> Trailer/Mobile home 8 <input type="checkbox"/> Other – Specify ↴ _____ 9 <input type="checkbox"/> DK</p>		27

Section F — TOBACCO

ITEM F1

Refer to the "Sm" box on the HIS-1 for adult sample person.

- 1  Available, "Sm" box marked (22)
- 2  Available, Other (1)
- 3  Callback required (Household page)
- 4  Noninterview (Inside back cover, then Section R)

5

These next questions are about tobacco use.

- 1  Yes (2)
- 2  No } (22)
- 9  DK }

6

1. Have you smoked at least 100 cigarettes in your entire life?

- 1  Every day
- 2  Some days
- 3  Not at all
- 9  DK

7

2. Around this time LAST YEAR, were you smoking cigarettes every day, some days, or not at all?

- 1  Yes (4)
- 2  No (5)

8

3. Do you smoke cigarettes now?

- 1  Every day (6)
- 2  Some days (13)

9

4. Do you now smoke cigarettes every day or some days?

- 1  Not at all (F2)
- 2  Some days (13)

10

5. Do you now smoke cigarettes "not at all" or "some days"?

- \_\_\_\_\_ Cigarettes a day } (7)  
(Number)
- 99  DK

11-12

6. On the average, how many cigarettes do you now smoke a day?

ITEM F2

Refer to question 2.

- 1  "Every day" in 2 (9)
- 8  All others in 2 (15)

13

7. Have you EVER quit smoking for one day or longer?

- 1  Yes (8)
- 2  No } (19)
- 9  DK }

14

8. During the past 12 months, have you quit smoking for one day or longer?

- 1  Yes (9)
- 2  No } (10)
- 9  DK }

15

9. How many times during the past 12 months have you quit smoking for one day or longer?

- \_\_\_\_\_ Times  
(Number)
- 99  DK

16-17

Hand Card C1. Read answer categories if telephone interview.

10. Thinking about the most recent time you stopped smoking, which of the following describes why you stopped?

Mark all that apply.

- 1  I quit on purpose
- 2  I could not smoke because I was sick
- 3  I could not smoke for some other reason
- 9  DK

18

19

20

21

ITEM F3

Refer to questions 4 and 5.

- 1  "Every day" in 4 (11)
- 2  "Not at all" in 5 (16)

22

11a. How long ago was the START of your MOST RECENT quit attempt that lasted for one day or longer?

- \_\_\_\_\_/19\_\_\_\_ or (12)  
Month Year
- \_\_\_\_\_ } (12)  
(Number) { 1  Days ago  
2  Weeks ago  
3  Months ago } (If 1 year or 12 months ago, go to 11b, otherwise go to 12)
- 4  Years ago }  
999  DK (11b)

23-26

27-29

b. Was it within the past year or a year or more ago?

- 1  Within the past year
- 2  1 year or more
- 9  DK

30

12. How long did you actually stay off cigarettes that time before you started smoking again?

- 000  Still off (19)
- \_\_\_\_\_ } (19)  
(Number) { 1  Days  
2  Weeks  
3  Months  
4  Years
- 999  DK (19)

31-33

13. On how many of the past 30 days did you smoke cigarettes?

- 00  None (F4)
- \_\_\_\_\_ Days } (14)  
(Number)
- 99  DK

34-35

**Section F – TOBACCO – Continued**

<b>14. On the average, when you smoked, how many cigarettes did you smoke a day?</b>	_____ Cigarettes a day (Number) 99 <input type="checkbox"/> DK	<b>36-37</b>				
<b>ITEM F4</b>	<i>Refer to question 2.</i>	1 <input type="checkbox"/> "Every day" in 2 (16) 8 <input type="checkbox"/> All others in 2 (15)	<b>38</b>			
<b>15. Have you EVER smoked cigarettes every day?</b>	1 <input type="checkbox"/> Yes (16) 2 <input type="checkbox"/> No } (F5) 9 <input type="checkbox"/> DK }	<b>39</b>				
<b>16a. About how long has it been since you last smoked cigarettes every day?</b>	_____ { <table style="display: inline-table; vertical-align: middle; border: none;"> <tr><td style="padding: 0 5px;">1 <input type="checkbox"/> Days</td></tr> <tr><td style="padding: 0 5px;">2 <input type="checkbox"/> Weeks</td></tr> <tr><td style="padding: 0 5px;">3 <input type="checkbox"/> Months</td></tr> <tr><td style="padding: 0 5px;">4 <input type="checkbox"/> Years</td></tr> </table> } (17) (Number) } (If 1 year or 12 months ago, go to 16b, otherwise go to 17) 999 <input type="checkbox"/> DK (16b)	1 <input type="checkbox"/> Days	2 <input type="checkbox"/> Weeks	3 <input type="checkbox"/> Months	4 <input type="checkbox"/> Years	<b>40-42</b>
1 <input type="checkbox"/> Days						
2 <input type="checkbox"/> Weeks						
3 <input type="checkbox"/> Months						
4 <input type="checkbox"/> Years						
<b>b. Was it within the past year or a year or more ago?</b>	1 <input type="checkbox"/> Within the past year 2 <input type="checkbox"/> 1 year or more 9 <input type="checkbox"/> DK	<b>43</b>				
<b>17. On the average, how many cigarettes did you smoke a day when you last smoked every day?</b>	_____ Cigarettes a day (Number) 99 <input type="checkbox"/> DK	<b>44-45</b>				
<b>ITEM F5</b>	<i>Refer to questions 2 and 5.</i>	1 <input type="checkbox"/> "Not at all" in 2 and 5 (18) 8 <input type="checkbox"/> All others (19a)	<b>46</b>			
<b>18. Did you smoke cigarettes AT ALL during the past 12 months?</b>	1 <input type="checkbox"/> Yes (19a) 2 <input type="checkbox"/> No } (21) 9 <input type="checkbox"/> DK }	<b>47</b>				
<b>19a. During the past 12 months, how many different times did you stay overnight in a hospital?</b>	00 <input type="checkbox"/> None (20) _____ Times (19b) (Number) 99 <input type="checkbox"/> DK (20)	<b>48-49</b>				
<b>b. On how many of those hospital stays were you advised to quit smoking?</b>	00 <input type="checkbox"/> None _____ Stays (Number) 99 <input type="checkbox"/> DK	<b>50-51</b>				
<b>20a. During the past 12 months, how many times have you visited a doctor or other health professional? (Do not count visits while staying overnight in a hospital).</b>	00 <input type="checkbox"/> None (21) _____ Visits (20b) (Number) 99 <input type="checkbox"/> DK (21)	<b>52-53</b>				
<b>b. On how many of these visits were you advised to quit smoking by a doctor or other health professional?</b>	00 <input type="checkbox"/> None (21) _____ Visits (22) (Number) 99 <input type="checkbox"/> DK (21)	<b>54-55</b>				
<b>21. Has a doctor or other health professional EVER advised you to quit smoking?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	<b>56</b>				
Notes						

**Section F – TOBACCO – Continued**

<p><b>These next questions are about your use of other tobacco products.</b></p> <p><b>22. Have you ever smoked a pipe?</b></p>	<p>1 <input type="checkbox"/> Yes (23)                  2 <input type="checkbox"/> No } (27)                  9 <input type="checkbox"/> DK }</p>	<p><b>57</b></p>
<p><b>23. Have you smoked a pipe at least 50 times in your entire life?</b></p>	<p>1 <input type="checkbox"/> Yes (24)                  2 <input type="checkbox"/> No } (27)                  9 <input type="checkbox"/> DK }</p>	<p><b>58</b></p>
<p><b>24. Do you smoke a pipe now?</b></p>	<p>1 <input type="checkbox"/> Yes (25)                  2 <input type="checkbox"/> No (26)</p>	<p><b>59</b></p>
<p><b>25. Do you now smoke a pipe every day or some days?</b></p>	<p>1 <input type="checkbox"/> Every day } (27)                  2 <input type="checkbox"/> Some days }</p>	<p><b>60</b></p>
<p><b>26. Do you now smoke a pipe "not at all" or "some days"?</b></p>	<p>1 <input type="checkbox"/> Not at all                  2 <input type="checkbox"/> Some days</p>	<p><b>61</b></p>
<p><b>27. Have you ever smoked cigars?</b></p>	<p>1 <input type="checkbox"/> Yes (28)                  2 <input type="checkbox"/> No } (32)                  9 <input type="checkbox"/> DK }</p>	<p><b>62</b></p>
<p><b>28. Have you smoked at least 50 cigars in your entire life?</b></p>	<p>1 <input type="checkbox"/> Yes (29)                  2 <input type="checkbox"/> No } (32)                  9 <input type="checkbox"/> DK }</p>	<p><b>63</b></p>
<p><b>29. Do you smoke cigars now?</b></p>	<p>1 <input type="checkbox"/> Yes (30)                  2 <input type="checkbox"/> No (31)</p>	<p><b>64</b></p>
<p><b>30. Do you now smoke cigars every day or some days?</b></p>	<p>1 <input type="checkbox"/> Every day } (32)                  2 <input type="checkbox"/> Some days }</p>	<p><b>65</b></p>
<p><b>31. Do you now smoke cigars "not at all" or "some days"?</b></p>	<p>1 <input type="checkbox"/> Not at all                  2 <input type="checkbox"/> Some days</p>	<p><b>66</b></p>
<p><b>32. Have you ever used snuff, such as Skoal, Skoal Bandits, or Copenhagen?</b></p>	<p>1 <input type="checkbox"/> Yes (33)                  2 <input type="checkbox"/> No } (37)                  9 <input type="checkbox"/> DK }</p>	<p><b>67</b></p>
<p><b>33. Have you used snuff at least 20 times in your entire life?</b></p>	<p>1 <input type="checkbox"/> Yes (34)                  2 <input type="checkbox"/> No } (37)                  9 <input type="checkbox"/> DK }</p>	<p><b>68</b></p>
<p><b>34. Do you use snuff now?</b></p>	<p>1 <input type="checkbox"/> Yes (35)                  2 <input type="checkbox"/> No (36)</p>	<p><b>69</b></p>
<p><b>35. Do you now use snuff every day or some days?</b></p>	<p>1 <input type="checkbox"/> Every day } (37)                  2 <input type="checkbox"/> Some days }</p>	<p><b>70</b></p>
<p><b>36. Do you now use snuff "not at all" or "some days"?</b></p>	<p>1 <input type="checkbox"/> Not at all                  2 <input type="checkbox"/> Some days</p>	<p><b>71</b></p>
<p><b>37. Have you ever used chewing tobacco, such as Redman, Levi Garrett, or Beechnut?</b></p>	<p>1 <input type="checkbox"/> Yes (38)                  2 <input type="checkbox"/> No } (Section G)                  9 <input type="checkbox"/> DK }</p>	<p><b>72</b></p>
<p><b>38. Have you used chewing tobacco at least 20 times in your entire life?</b></p>	<p>1 <input type="checkbox"/> Yes (39)                  2 <input type="checkbox"/> No } (Section G)                  9 <input type="checkbox"/> DK }</p>	<p><b>73</b></p>
<p><b>39. Do you use chewing tobacco now?</b></p>	<p>1 <input type="checkbox"/> Yes (40)                  2 <input type="checkbox"/> No (41)</p>	<p><b>74</b></p>
<p><b>40. Do you now use chewing tobacco every day or some days?</b></p>	<p>1 <input type="checkbox"/> Every day } (Section G)                  2 <input type="checkbox"/> Some days }</p>	<p><b>75</b></p>
<p><b>41. Do you now use chewing tobacco "not at all" or "some days"?</b></p>	<p>1 <input type="checkbox"/> Not at all                  2 <input type="checkbox"/> Some days</p>	<p><b>76</b></p>

Notes

Section G — NUTRITION

<p>These next questions are about weight control and nutrition.</p>			5
<p>1. Do you consider yourself overweight, underweight, or just about right?</p>	<p>1 <input type="checkbox"/> Overweight 2 <input type="checkbox"/> Underweight 3 <input type="checkbox"/> Just about right</p>		
<p>2. Are you now trying to lose weight, gain weight, stay about the same, or are you not trying to do anything about your weight?</p>	<p>1 <input type="checkbox"/> Lose weight (3) 2 <input type="checkbox"/> Gain weight (4) 3 <input type="checkbox"/> Stay about the same (3) 4 <input type="checkbox"/> Not trying to do anything (4)</p>		6
<p>Hand Card G1. Read each category if telephone interview.</p> <p>3. Are you currently doing any of these things to control your weight?</p> <p>Mark each that applies.</p>	<p>01 <input type="checkbox"/> Joined a weight loss program 02 <input type="checkbox"/> Eating fewer calories 03 <input type="checkbox"/> Eating special products, such as canned or powdered food supplements 04 <input type="checkbox"/> Exercising more 05 <input type="checkbox"/> Fasting for 24 hours or longer 06 <input type="checkbox"/> Skipping meals 07 <input type="checkbox"/> Taking diet pills 08 <input type="checkbox"/> Taking laxatives 09 <input type="checkbox"/> Taking water pills or diuretics 10 <input type="checkbox"/> Vomiting 98 <input type="checkbox"/> Something else — Specify _____ 00 <input type="checkbox"/> Nothing</p>		7-8 9-10 11-12 13-14 15-16 17-18 19-20 21-22 23-24 25-26 27-28 29-30
<p>4a. About how tall are you without shoes?</p> <p>_____ (Feet) _____ (Inches)</p>			31-33
<p>b. About how much do you weigh without shoes?</p> <p>_____ (Pounds)</p>			34-36
<p>5a. How often do you or the person who shops for your food buy items that are labelled "low salt" or "low sodium" — would you say always, often, sometimes, rarely or never?</p>	<p>1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Often 3 <input type="checkbox"/> Sometimes 4 <input type="checkbox"/> Rarely 5 <input type="checkbox"/> Never 9 <input type="checkbox"/> DK</p>		37
<p>b. How often do you add salt to your food at the table — would you say always, often, sometimes, rarely or never? Do not include salt substitutes.</p>	<p>1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Often 3 <input type="checkbox"/> Sometimes 4 <input type="checkbox"/> Rarely 5 <input type="checkbox"/> Never 9 <input type="checkbox"/> DK</p>		38
<p>6a. When you buy a food item for the first time, how often would you say you read the INGREDIENT list on the package — would you say always, often, sometimes, rarely, or never?</p>	<p>0 <input type="checkbox"/> Don't buy food (G1) 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Often 3 <input type="checkbox"/> Sometimes 4 <input type="checkbox"/> Rarely 5 <input type="checkbox"/> Never 9 <input type="checkbox"/> DK</p>		39
<p>b. When you buy a food item for the first time, how often would you say you read the information about calorie, fat and/or cholesterol content sometimes listed on the label — would you say always, often, sometimes, rarely or never?</p>	<p>1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Often 3 <input type="checkbox"/> Sometimes 4 <input type="checkbox"/> Rarely 5 <input type="checkbox"/> Never 9 <input type="checkbox"/> DK</p>		40
<p><b>ITEM G1</b></p> <p>Refer to age.</p>	<p>1 <input type="checkbox"/> 65+ (7) 2 <input type="checkbox"/> Under 65 (Section H)</p>		41
<p>7a. Do you have meals delivered to your home by an agency or organization like Meals on Wheels?</p>	<p>1 <input type="checkbox"/> Yes (Section H) 2 <input type="checkbox"/> No } (7b) 9 <input type="checkbox"/> DK }</p>		42
<p>b. Do you NEED to have meals delivered to your home by an agency or organization like Meals on Wheels?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>		43

**Section H — IMMUNIZATION AND INFECTIOUS DISEASES**

5

The next questions are about foreign travel and the prevention of communicable diseases.

**1 a. During the past 5 years, did you travel outside the U.S. or Canada?**

- 1  Yes (1b)
- 2  No } (Section I)
- 9  DK }

6-7

**b. During the past 5 years, how many trips did you make outside the U.S. or Canada?**

\_\_\_\_ Trips  
(Number)

99  DK

8

**c. In which year(s) did you take the(se) trip(s)?**

Mark all that apply.

- 1  1991
- 2  1990
- 3  1989
- 4  1988
- 5  1987
- 6  1986
- 9  DK

- 9
- 10
- 11
- 12
- 13
- 14

Hand Card H1. Read each category if telephone interview.

**d. Where did you travel during the past 5 years?**

Mark each that applies.

If Africa, ask: "Was that East Africa, West Africa, Central Africa, Northern Africa, or Southern Africa?"

- 01  Europe
- 02  Middle East
- 03  East Africa
- 04  West Africa
- 05  Central Africa
- 06  Northern Africa
- 07  Southern Africa
- 08  Asia or Pacific Islands
- 09  Australia or New Zealand
- 10  Mexico
- 11  Central America
- 12  Caribbean
- 13  South America
- 98  Other — Specify \_\_\_\_\_
- 99  DK

- 15-16
- 17-18
- 19-20
- 21-22
- 23-24
- 25-26
- 27-28
- 29-30
- 31-32
- 33-34
- 35-36
- 37-38
- 39-40
- 41-42
- 43-44

**ITEM H1**

Refer to question 1d.

- 1  Only Box 01 "Europe" marked (Section I)
- 8  Other (2)

45

**2a. Before you left on (any of) your trip(s), did you get any shots to PREVENT infectious diseases?**

- 1  Yes (2b)
- 2  No } (3)
- 9  DK }

46

Hand Card H2. Read each category if telephone interview.

**b. Which shots did you receive? Any others?**

Mark each that applies.

- 0  Cholera
- 1  Gamma globulin or immune globulin
- 2  Hepatitis B
- 3  Meningococcal meningitis
- 4  Rabies
- 5  Typhoid fever
- 6  Yellow fever
- 8  Other — Specify \_\_\_\_\_
- 9  DK

- 47
- 48
- 49
- 50
- 51
- 52
- 53
- 54
- 55

**3a. Before or during (any of) your trip(s), did you take any prescription medicine to PREVENT malaria ?**

- 1  Yes (3b)
- 2  No } (Section I)
- 9  DK }

56

Hand Card H3. Read each category if telephone interview.

**b. Which medications did you take? Any others?**

Mark each that applies.

- 1  Aralen (AIR-uh-len)  
Chloroquine phosphate (Klo-roh-KWIN fos-FATE)
- 2  Doxycycline (dox-i-SIGH--kleen)
- 3  Fansidar (Fan-see-DAR; last syllable rhymes with car)  
Pyrimethamine Sulfadoxine (Pie-rih-METH-uh-mean sulfa-DOX-een)
- 4  Lariam (LAIR-e-am)  
Mefloquine (meh-flow-KWIN); e in first syllable has short vowel sound.
- 5  Paludrine (Pal-you-DRUN)  
Proguanil (Pro-GWAN-nil)
- 6  Plaquenil (Plah-GWAN-nil)  
Hydroxy-chloroquine sulfate (hi-DROCKS-e kloro-KWIN sul-FATE)
- 8  Other — Specify \_\_\_\_\_
- 9  DK

- 57
- 58
- 59
- 60
- 61
- 62
- 63
- 64

Section I — OCCUPATIONAL SAFETY AND HEALTH

<p><b>ITEM 11</b></p>	<p>Refer to "Wa/Wb" boxes in C1 on HIS-1.</p>	<p>1 <input type="checkbox"/> Wa or Wb box marked (Item 12) 8 <input type="checkbox"/> Other (Section J)</p>	<p>5</p>
<p><b>ITEM 12</b></p>	<p>Refer to 6g on page 44 or 45 on HIS-1.</p>	<p>1 <input type="checkbox"/> Entry of P, F, S or L (1) 8 <input type="checkbox"/> Other (Section J)</p>	<p>6</p>
<p><b>These next questions are about health and safety in the work place.</b></p> <p>1. [You told me/I was told] that you were employed during the past two weeks. How long have you worked at your main job?</p>		<p>000 <input type="checkbox"/> Less than one month          _____ } 1 <input type="checkbox"/> Months          (Number) } 2 <input type="checkbox"/> Years          996 <input type="checkbox"/> Not employed in past 2 weeks (Section J)          999 <input type="checkbox"/> DK</p>	<p>7-9</p>
<p>2a. Altogether, does your employer have 50 or more employees?</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (3) 9 <input type="checkbox"/> DK</p>	<p>10</p>
<p>b. Does your employer have 50 or more employees at the building or location where you work?</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p>11</p>
<p>3. How many hours did you work at your main job during the past two weeks?</p>		<p>_____ Hours (Number) 00 <input type="checkbox"/> Did not work in past 2 weeks (7) 99 <input type="checkbox"/> DK</p>	<p>12-13</p>
<p>4a. During the past 2 weeks, did you drive or travel in a motor vehicle AS PART OF YOUR JOB? Do not count air travel or time spent traveling to and from work.</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (5) 9 <input type="checkbox"/> DK</p>	<p>14</p>
<p>b. During the past 2 weeks, what kind of vehicle did you spend the most time traveling in AS PART OF YOUR WORK.  Mark only one.</p>		<p>1 <input type="checkbox"/> Car 2 <input type="checkbox"/> Light truck/van 3 <input type="checkbox"/> Heavy truck 4 <input type="checkbox"/> Motorcycle 5 <input type="checkbox"/> Motorized bicycle/moped 6 <input type="checkbox"/> Taxi 7 <input type="checkbox"/> Bus/trolley 8 <input type="checkbox"/> Other vehicle — Specify ↴ _____ 9 <input type="checkbox"/> DK</p>	<p>15</p>
<p>c. During the past 2 weeks, about how many hours did you drive or travel in a (vehicle in 4b) AS PART OF YOUR JOB? Do not count time spent traveling to and from your job.</p>		<p>00 <input type="checkbox"/> None          _____ Hours          (Number)          99 <input type="checkbox"/> DK</p>	<p>16-17</p>
<p>d. Does your employer require you to use vehicle safety devices, such as seat belts, helmets, or other types of protection? Do not count use when traveling to and from your job.</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p>18</p>
<p>Hand card I1. Read all categories if telephone interview.</p> <p><b>The next few questions are about smoking at work.</b></p> <p>5. Which of these best describes the area in which you work most of the time?  Mark only one.</p>		<p>01 <input type="checkbox"/> Private enclosed office with door 02 <input type="checkbox"/> Enclosed office with door shared with one or more other persons 03 <input type="checkbox"/> Cubicle with floor to ceiling bookcases or partitions and no door 04 <input type="checkbox"/> Cubicle surrounded by mid-height bookcases or partitions 05 <input type="checkbox"/> Open office areas 06 <input type="checkbox"/> In one building, but no regular work area } (7) 07 <input type="checkbox"/> Mainly work outdoors 08 <input type="checkbox"/> Travel to different buildings or sites 09 <input type="checkbox"/> In a motor vehicle 98 <input type="checkbox"/> Other — Specify ↴ _____ 99 <input type="checkbox"/> DK</p>	<p>19-20</p>

**Section I – OCCUPATIONAL SAFETY AND HEALTH – Continued**

<p><b>6a. During the past 2 weeks, has anyone smoked in your IMMEDIATE work area?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No                  9 <input type="checkbox"/> DK</p>	<p>21</p>
<p><b>b. In general, would you say that your IMMEDIATE work area is very smoky, somewhat smoky, a little smoky, or not smoky at all?</b></p>	<p>1 <input type="checkbox"/> Very smoky                  2 <input type="checkbox"/> Somewhat smoky                  3 <input type="checkbox"/> A little smoky                  4 <input type="checkbox"/> Not smoky at all                  9 <input type="checkbox"/> DK</p>	<p>22</p>
<p><b>c. Is smoking allowed in your IMMEDIATE work area?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No                  9 <input type="checkbox"/> DK</p>	<p>23</p>
<p><b>7a. Does your employer have an official policy that restricts smoking in any way?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No } (8)                  9 <input type="checkbox"/> DK }</p>	<p>24</p>
<p><i>Hand card 12. Read all categories if telephone interview.</i></p> <p><b>b. Which of these best describes your employer's smoking policy for indoor public or common areas, such as lobbies, rest rooms, and lunch rooms?</b>  <i>Mark only one.</i></p>	<p>1 <input type="checkbox"/> Not allowed in ANY indoor or common public areas                  2 <input type="checkbox"/> Allowed in SOME public areas, including designated smoking areas                  3 <input type="checkbox"/> Allowed in ALL indoor or common public areas                  9 <input type="checkbox"/> DK</p>	<p>25</p>
<p><i>Hand card 13. Read all categories if telephone interview.</i></p> <p><b>c. Which of these best describes your employer's smoking policy for work areas?</b>  <i>Mark only one.</i></p>	<p>1 <input type="checkbox"/> Not allowed in ANY work areas                  2 <input type="checkbox"/> Allowed in SOME work areas                  3 <input type="checkbox"/> Allowed in ALL work areas                  9 <input type="checkbox"/> DK</p>	<p>26</p>
<p><b>8. Does your employer offer a quit smoking program or any other help to employees who want to quit smoking?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No                  9 <input type="checkbox"/> DK</p>	<p>27</p>
<p><b>9a. Not counting Medicare or Medicaid, are you now covered by a health insurance plan which pays any part of hospital or doctor bills?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No } (10)                  9 <input type="checkbox"/> DK }</p>	<p>28</p>
<p><b>b. Does your health insurance cover any part of the cost of quit smoking programs or other treatment for quitting smoking?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No                  9 <input type="checkbox"/> DK</p>	<p>29</p>
<p><i>Hand Card 14. Read each category if telephone interview.</i></p> <p><b>10a. Which of these exercise programs are made available to you by your employer?</b>  <i>Mark each that applies.</i></p>	<p>01 <input type="checkbox"/> Walking group                  02 <input type="checkbox"/> Jogging/Running group                  03 <input type="checkbox"/> Biking/Cycling group                  04 <input type="checkbox"/> Aerobics classes                  05 <input type="checkbox"/> Swimming classes                  06 <input type="checkbox"/> Non-aerobic exercise classes                  07 <input type="checkbox"/> Weight lifting classes                  08 <input type="checkbox"/> Fully paid membership in health/fitness club                  09 <input type="checkbox"/> Partially paid membership in health/fitness club                  10 <input type="checkbox"/> Physical activity or exercise competitions                  98 <input type="checkbox"/> Other – <i>Specify</i> ↴</p> <hr/> <p>00 <input type="checkbox"/> No programs                  99 <input type="checkbox"/> DK</p>	<p>30-31 32-33 34-35 36-37 38-39 40-41 42-43 44-45 46-47 48-49 50-51</p> <hr/> <p>52-53 54-55</p>
<p><i>Hand Card 15. Read each category if telephone interview.</i></p> <p><b>b. Which of these exercise facilities are made available to you by your employer, on the premises?</b>  <i>Mark each that applies.</i></p>	<p>01 <input type="checkbox"/> Gymnasium/Exercise room                  02 <input type="checkbox"/> Weight lifting equipment                  03 <input type="checkbox"/> Exercise equipment                  04 <input type="checkbox"/> Walking/Jogging path                  05 <input type="checkbox"/> Parcours/Fitness trails                  06 <input type="checkbox"/> Bike path                  07 <input type="checkbox"/> Bike racks                  08 <input type="checkbox"/> Swimming pool                  09 <input type="checkbox"/> Showers                  10 <input type="checkbox"/> Lockers                  98 <input type="checkbox"/> Other – <i>Specify</i> ↴</p> <hr/> <p>00 <input type="checkbox"/> No facilities                  99 <input type="checkbox"/> DK</p>	<p>56-57 58-59 60-61 62-63 64-65 66-67 68-69 70-71 72-73 74-75 76-77</p> <hr/> <p>78-79 80-81</p>

Section J — HEART DISEASE AND STROKE

<p>These next questions are about health conditions.</p> <p>1. Have you EVER been told by a doctor or other health professional that you had hypertension, sometimes called high blood pressure?</p>	<p>0 <input type="checkbox"/> Borderline (2)          1 <input type="checkbox"/> Yes (2)          2 <input type="checkbox"/> No (6)          3 <input type="checkbox"/> Only during pregnancy (6)          9 <input type="checkbox"/> DK (3)</p>	<p>5</p>
<p>2. Were you told two or more DIFFERENT times that you had high blood pressure?</p>	<p>1 <input type="checkbox"/> Yes          2 <input type="checkbox"/> No          3 <input type="checkbox"/> Only during pregnancy (6)          9 <input type="checkbox"/> DK</p>	<p>6</p>
<p>3a. Has a doctor or other health professional EVER advised you to go on a diet or change your eating habits to help lower your high blood pressure?</p>	<p>1 <input type="checkbox"/> Yes (3b)          2 <input type="checkbox"/> No } (4)          9 <input type="checkbox"/> DK }</p>	<p>7</p>
<p>b. Did you EVER follow this advice?</p>	<p>1 <input type="checkbox"/> Yes (3c)          2 <input type="checkbox"/> No } (4)          9 <input type="checkbox"/> DK }</p>	<p>8</p>
<p>c. Are you NOW following this advice?</p>	<p>1 <input type="checkbox"/> Yes          2 <input type="checkbox"/> No          9 <input type="checkbox"/> DK</p>	<p>9</p>
<p>4a. Was any medication EVER prescribed by a doctor to help you lower your high blood pressure?</p>	<p>1 <input type="checkbox"/> Yes (4b)          2 <input type="checkbox"/> No } (5)          9 <input type="checkbox"/> DK }</p>	<p>10</p>
<p>b. Did you EVER take this medication?</p>	<p>1 <input type="checkbox"/> Yes (4c)          2 <input type="checkbox"/> No } (5)          9 <input type="checkbox"/> DK }</p>	<p>11</p>
<p>c. Are you NOW taking this medication?</p>	<p>1 <input type="checkbox"/> Yes          2 <input type="checkbox"/> No          9 <input type="checkbox"/> DK</p>	<p>12</p>
<p>5a. Do you still have high blood pressure?</p>	<p>1 <input type="checkbox"/> Yes (6)          2 <input type="checkbox"/> No } (5b)          9 <input type="checkbox"/> DK }</p>	<p>13</p>
<p>b. Is this condition completely cured or is it under control?</p>	<p>1 <input type="checkbox"/> Cured          2 <input type="checkbox"/> Under control          9 <input type="checkbox"/> DK</p>	<p>14</p>
<p>6. About how long has it been since you had your blood pressure checked by a doctor or other health professional?</p>	<p>000 <input type="checkbox"/> Never (8)          _____ } 1 <input type="checkbox"/> Days          (Number) } 2 <input type="checkbox"/> Weeks          } 3 <input type="checkbox"/> Months          } 4 <input type="checkbox"/> Years          999 <input type="checkbox"/> DK</p>	<p>15-17</p>
<p>7. At that time, did the doctor or other health professional say your blood pressure was high, low, or normal?</p>	<p>1 <input type="checkbox"/> Not told          2 <input type="checkbox"/> High          3 <input type="checkbox"/> Low          4 <input type="checkbox"/> Normal          5 <input type="checkbox"/> Borderline          8 <input type="checkbox"/> Other — Specify ↴          _____          9 <input type="checkbox"/> DK</p>	<p>18</p>



## Section K — OTHER CHRONIC AND DISABLING CONDITIONS

These next questions are about health conditions.		5
1. Have you EVER been told by a doctor that you had diabetes? Do not include pre, potential, or borderline diabetes.	1 <input type="checkbox"/> Yes (2) 2 <input type="checkbox"/> No } (11) 9 <input type="checkbox"/> DK }	
Ask if female, otherwise go to 4:		6
2. Were you pregnant when you were first told that you had diabetes?	1 <input type="checkbox"/> Yes (3) 2 <input type="checkbox"/> No } (4) 9 <input type="checkbox"/> DK }	
3. Other than during pregnancy, did a doctor EVER tell you that you had diabetes? Do not include pre, potential, or borderline diabetes.	1 <input type="checkbox"/> Yes (4) 2 <input type="checkbox"/> No } (11) 9 <input type="checkbox"/> DK }	7
4. How old were you when your diabetes was diagnosed?	_____ Years old 99 <input type="checkbox"/> DK	8-9
5. Are you now taking insulin?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	10
6a. In the past 6 months, on your own, about how often did you check your blood for glucose or sugar? Include times when checked by a family member or friend.	000 <input type="checkbox"/> Never _____ Times per { 1 <input type="checkbox"/> Day 2 <input type="checkbox"/> Week 3 <input type="checkbox"/> Month 4 <input type="checkbox"/> Year 999 <input type="checkbox"/> DK	11-13
b. In the past 6 months, about how many times has a health professional checked your blood for glucose or sugar? Do not count times when an overnight patient in a hospital.	00 <input type="checkbox"/> None _____ Times (Number) 99 <input type="checkbox"/> DK	14-15
If "Never" in 6a AND "None" in 6b, mark Box 0; otherwise, ask:		16
7. Based on ALL your blood sugar tests during the past 6 months, how often would you say your blood sugar level has been too high? Would you say always, most of the time, some of the time, rarely, or never?	0 <input type="checkbox"/> No test in past 6 months 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> Rarely 5 <input type="checkbox"/> Never 9 <input type="checkbox"/> DK	
8a. Have you EVER been told that diabetes has affected the back of your eyes, that is, the retina?	1 <input type="checkbox"/> Yes (8b) 2 <input type="checkbox"/> No } (10) 9 <input type="checkbox"/> DK }	17
b. How old were you when the doctor first told you this?	_____ Years old 99 <input type="checkbox"/> DK	18-19
9a. Have you ever had laser or photocoagulation treatment for this problem? Do not include treatments for cataracts.	1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No } (10) 9 <input type="checkbox"/> DK }	20
b. Did you receive this treatment within the past 12 months?	1 <input type="checkbox"/> Yes (9c) 2 <input type="checkbox"/> No } (10) 9 <input type="checkbox"/> DK }	21
c. Was this the first time you had this treatment?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	22
10a. Have you ever taken a course or class in how to manage your diabetes yourself?	1 <input type="checkbox"/> Yes (11) 2 <input type="checkbox"/> No } (10b) 9 <input type="checkbox"/> DK }	23
b. Would you like to take a course or class in how to manage your diabetes yourself?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	24

**Section K -- OTHER CHRONIC AND DISABLING CONDITIONS -- Continued**

<b>11. Do you have trouble seeing with one or both eyes EVEN when wearing glasses or contact lenses?</b>	1 <input type="checkbox"/> Yes (12) 2 <input type="checkbox"/> No } (13) 9 <input type="checkbox"/> DK	25
<b>12. Are you blind in one or both eyes?</b> <i>If "Yes," ask: In one or both?</i>	Yes <input checked="" type="checkbox"/> 2 <input type="checkbox"/> No 0 <input type="checkbox"/> One 1 <input type="checkbox"/> Both	26
<b>13. IN THE PAST TWO YEARS, have you had ANY kind of eye exam by a MEDICAL DOCTOR? Do not include visits to an optometrist or optician.</b>	1 <input type="checkbox"/> Yes (14) 2 <input type="checkbox"/> No } (16) 9 <input type="checkbox"/> DK	27
<b>14. IN THE PAST 12 MONTHS, have you seen a ophthalmologist, that is, a medical doctor who specializes in eye care?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	28
<b>15. In the past 12 months, have you had ANY kind of eye exam by any (other) kind of medical doctor?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	29
<b>16a. Have you EVER had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light.</b>	1 <input type="checkbox"/> Yes (16b) 2 <input type="checkbox"/> No } (18) 9 <input type="checkbox"/> DK	30
<b>b. When was the last time you had this exam?</b>	1 <input type="checkbox"/> Less than 1 month 2 <input type="checkbox"/> 1 month, less than 1 year 3 <input type="checkbox"/> 1 year, less than 2 years 4 <input type="checkbox"/> 2 years or more 9 <input type="checkbox"/> DK	31
<b>17. Have you EVER had photographs taken of the retina or inside of your eyes?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	32
<b>18a. Has a doctor EVER told you that you had glaucoma?</b>	1 <input type="checkbox"/> Yes (18b) 2 <input type="checkbox"/> No } (18c) 9 <input type="checkbox"/> DK	33
<b>b. Are you NOW using medication for glaucoma?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	34
<b>c. Is there a history of glaucoma in your family?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	35
<b>19. Has a doctor EVER told you that you had cataracts?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	36
<b>20a. During the past 12 months, have you had asthma?</b>	1 <input type="checkbox"/> Yes (20b) 2 <input type="checkbox"/> No } (21) 9 <input type="checkbox"/> DK	37
<b>b. Have you ever taken a course or class in how to manage your asthma yourself?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	38

Notes

**Section K — OTHER CHRONIC AND DISABLING CONDITIONS — Continued**

Ask all of 21a BEFORE GOING TO 21b.

The next questions are about how well you are able to do certain activities.

If "Doesn't do," ask before marking a box: Is this because of a **PHYSICAL OR MENTAL HEALTH** condition?  
If "Yes," mark "Yes."  
If "No," mark "Doesn't do."

Ask 21b for each activity marked "Yes" in 21a.

**21a. Because of any physical or mental condition, do you have difficulty —**

**b. Do you need help from another person (activity in 21a)?**

	YES	NO	DOESN'T DO		YES	NO	
(1) Lifting and carrying something as heavy as 10 lbs., such as a full bag of groceries?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	39	1 <input type="checkbox"/>	2 <input type="checkbox"/>	40
(2) Climbing a flight of stairs without resting?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	41	1 <input type="checkbox"/>	2 <input type="checkbox"/>	42
(3) Walking a quarter of a mile — about 3 city blocks?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	43	1 <input type="checkbox"/>	2 <input type="checkbox"/>	44
(4) Doing heavy work around the house, such as scrubbing floors or washing windows?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	45	1 <input type="checkbox"/>	2 <input type="checkbox"/>	46
(5) Shopping for personal items, such as food or medication?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	47	1 <input type="checkbox"/>	2 <input type="checkbox"/>	48
(6) Going OUTSIDE the home ALONE, such as to shop or visit a doctor's office?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	49	1 <input type="checkbox"/>	2 <input type="checkbox"/>	50
(7) Doing light work around the house, such as washing dishes or doing light yard work?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	51	1 <input type="checkbox"/>	2 <input type="checkbox"/>	52
(8) Preparing your meals?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	53	1 <input type="checkbox"/>	2 <input type="checkbox"/>	54
<b>Because of any physical or mental condition, do you have difficulty —</b>							
(9) Managing your money, such as keeping track of expenses or paying bills?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	55	1 <input type="checkbox"/>	2 <input type="checkbox"/>	56
(10) Using a telephone?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	57	1 <input type="checkbox"/>	2 <input type="checkbox"/>	58
(11) Getting around INSIDE the home?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	59	1 <input type="checkbox"/>	2 <input type="checkbox"/>	60
(12) Walking?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	61	1 <input type="checkbox"/>	2 <input type="checkbox"/>	62
(13) Getting in and out of bed or chairs?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	63	1 <input type="checkbox"/>	2 <input type="checkbox"/>	64
(14) Eating?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	65	1 <input type="checkbox"/>	2 <input type="checkbox"/>	66
(15) Using the toilet, including getting to and from the toilet?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	67	1 <input type="checkbox"/>	2 <input type="checkbox"/>	68
(16) Bathing or showering?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	69	1 <input type="checkbox"/>	2 <input type="checkbox"/>	70
(17) Dressing?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	71	1 <input type="checkbox"/>	2 <input type="checkbox"/>	72

<b>ITEM K1</b>	Refer to age.	1 <input type="checkbox"/> 65 and over (22) 8 <input type="checkbox"/> Other (Section L)	73
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<b>22a. Do you have trouble controlling your urination?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	74
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<b>b. Do you have a urinary catheter or a device to help control urination?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	75
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<b>ITEM K2</b>	Refer to 22a and b. Mark first appropriate box.	1 <input type="checkbox"/> "Yes" in 22b (Section L) 2 <input type="checkbox"/> "Yes" in 22a (23) 8 <input type="checkbox"/> Other (Section L)	76
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<b>23. Have YOU told your doctor or other health professional about the trouble you have controlling your urination?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	77
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Notes

**Section L — CLINICAL AND PREVENTIVE SERVICES**

<p>The next questions are about prevention of injury and illness.</p> <p><b>1a. When driving or riding in the front seat of a car, do you wear a seat belt all or most of the time, some of the time, once in awhile, or never?</b></p>	<p>1 <input type="checkbox"/> All or most of the time                  2 <input type="checkbox"/> Some of the time                  3 <input type="checkbox"/> Once in awhile                  4 <input type="checkbox"/> Never                  5 <input type="checkbox"/> Don't ride in front seat                  6 <input type="checkbox"/> Don't ride in a car (2)                  9 <input type="checkbox"/> DK</p> <p style="text-align: right;"><b>5</b></p>																																			
<p><b>b. When riding in the back seat of a car, do you wear a seat belt all or most of the time, some of the time, once in awhile, or never?</b></p>	<p>1 <input type="checkbox"/> All or most of the time                  2 <input type="checkbox"/> Some of the time                  3 <input type="checkbox"/> Once in awhile                  4 <input type="checkbox"/> Never                  5 <input type="checkbox"/> Don't ride in back seat                  6 <input type="checkbox"/> Don't ride in a car                  9 <input type="checkbox"/> DK</p> <p style="text-align: right;"><b>6</b></p>																																			
<p><b>2a. Is there a particular clinic, health center, doctor's office, or other place that you usually go to if you are sick or need advice about your health?</b></p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No (3)</p> <p style="text-align: right;"><b>7</b></p>																																			
<p><b>b. What kind of place is it — a clinic, a health center, a hospital, a doctor's office, or some other place?</b></p> <p><i>IF HOSPITAL: Is this an outpatient clinic or the emergency room?</i></p> <p><i>IF CLINIC: Is this a hospital outpatient clinic, a company clinic, or some other kind of clinic?</i></p>	<p>1 <input type="checkbox"/> Doctor's office (group practice, doctor's clinic or HMO)                  2 <input type="checkbox"/> Hospital outpatient clinic                  3 <input type="checkbox"/> Sample person's home                  4 <input type="checkbox"/> Hospital emergency room                  5 <input type="checkbox"/> Company or industry clinic                  6 <input type="checkbox"/> Health center                  8 <input type="checkbox"/> Other</p> <p style="text-align: right;"><b>8</b></p>																																			
<p><b>3. About how long has it been since your last routine check-up by a medical doctor or other health professional?</b></p>	<p>1 <input type="checkbox"/> Less than 1 year                  2 <input type="checkbox"/> 1 year, less than 2 years                  3 <input type="checkbox"/> 2 years, less than 3 years                  4 <input type="checkbox"/> 3 years, less than 4 years                  5 <input type="checkbox"/> 4+ years                  6 <input type="checkbox"/> Never (8)                  9 <input type="checkbox"/> DK</p> <p style="text-align: right;"><b>9</b></p>																																			
<p><b>4. During this last check-up, were you asked about —</b></p> <p><b>a. Your diet and eating habits? . . . . .</b></p> <p><b>b. The amount of physical activity or exercise you get? . . . . .</b></p> <p><b>c. Whether you smoke cigarettes or use other forms of tobacco? . . . . .</b></p> <p><b>d. How much and how often you drink alcohol? . . . . .</b></p> <p><b>e. Whether you use marijuana, cocaine, or other drugs? . . . . .</b></p> <p><b>f. Sexually transmitted diseases? . . . . .</b></p>	<table border="0"> <tr> <td></td> <td>Yes</td> <td>No</td> <td>DK</td> <td></td> </tr> <tr> <td>a.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="border: 1px solid black; text-align: center;"><b>10</b></td> </tr> <tr> <td>b.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="border: 1px solid black; text-align: center;"><b>11</b></td> </tr> <tr> <td>c.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="border: 1px solid black; text-align: center;"><b>12</b></td> </tr> <tr> <td>d.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="border: 1px solid black; text-align: center;"><b>13</b></td> </tr> <tr> <td>e.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="border: 1px solid black; text-align: center;"><b>14</b></td> </tr> <tr> <td>f.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="border: 1px solid black; text-align: center;"><b>15</b></td> </tr> </table>		Yes	No	DK		a.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>10</b>	b.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>11</b>	c.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>12</b>	d.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>13</b>	e.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>14</b>	f.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>15</b>
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b.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>11</b>																																
c.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>12</b>																																
d.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>13</b>																																
e.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>14</b>																																
f.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>15</b>																																
<p><i>Ask ONLY IF SP is less than 50 otherwise, skip to 5.</i></p> <p><b>g. The use of contraceptives? . . . . .</b></p>	<table border="0"> <tr> <td></td> <td>Yes</td> <td>No</td> <td>DK</td> <td></td> </tr> <tr> <td>g.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="border: 1px solid black; text-align: center;"><b>16</b></td> </tr> </table>		Yes	No	DK		g.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>16</b>																									
	Yes	No	DK																																	
g.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>16</b>																																
<p><b>5. During this last check-up, did you have any of the following things checked —</b></p> <p><b>a. Your blood pressure? . . . . .</b></p> <p><b>b. Your cholesterol level? . . . . .</b></p> <p><b>c. Your height? . . . . .</b></p> <p><b>d. Your weight? . . . . .</b></p>	<table border="0"> <tr> <td></td> <td>Yes</td> <td>No</td> <td>DK</td> <td></td> </tr> <tr> <td>a.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="border: 1px solid black; text-align: center;"><b>17</b></td> </tr> <tr> <td>b.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="border: 1px solid black; text-align: center;"><b>18</b></td> </tr> <tr> <td>c.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="border: 1px solid black; text-align: center;"><b>19</b></td> </tr> <tr> <td>d.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="border: 1px solid black; text-align: center;"><b>20</b></td> </tr> </table>		Yes	No	DK		a.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>17</b>	b.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>18</b>	c.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>19</b>	d.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>20</b>										
	Yes	No	DK																																	
a.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>17</b>																																
b.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>18</b>																																
c.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>19</b>																																
d.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>20</b>																																

**Section L – CLINICAL AND PREVENTIVE SERVICES – Continued**

<b>ITEM L1</b>	<i>Refer to age.</i>	1 <input type="checkbox"/> SP is 65+ (6) 8 <input type="checkbox"/> Other (8)	21
<b>6a. During this last check-up, were you asked about the symptoms of a transient ischemic attack(TIA)?</b> <i>Read if necessary:</i> <b>This is an episode of weakness or paralysis in the arms and legs, loss of vision, speech, or memory, and facial droop that lasted for less than 24 hours?</b>		1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    9 <input type="checkbox"/> DK	22
<b>b. During this last check-up, were you asked about whether you have difficulty taking care of yourself, including dressing, using the toilet, bathing, eating, or getting around inside your home without help?</b>		1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    9 <input type="checkbox"/> DK	23
<b>c. During this last check-up, were you asked about whether you have difficulty doing every day activities and chores, including preparing your meals, managing your money, using the telephone, doing light housework, and shopping?</b>		1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    9 <input type="checkbox"/> DK	24
<b>7. During this last check-up, did you have –</b>		Yes                  No                  DK	
<b>a. A vision test to see how well you see? . . . . .</b>		1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	25
<b>b. A hearing test? . . . . .</b>		1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	26
<b>c. A urine test? . . . . .</b>		1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	27
<b>d. A blood test to check your thyroid function? . . . . .</b>		1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	28
<b>e. A stool test to check for blood in the stool? . . . . .</b>		1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	29
<b>8. During the past 12 months, have you had a flu shot?</b> <i>Read if necessary:</i> <b>This vaccination is usually given in the fall and protects against influenza for the flu season.</b>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	30
<b>9. Have you EVER had a pneumonia vaccination? This shot is given only once in a person's lifetime.</b>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	31
<b>10. During the past TEN years, have you had a tetanus shot?</b>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	32
<b>ITEM L2</b>	<i>Refer to sex.</i>	1 <input type="checkbox"/> Male (Section M) 2 <input type="checkbox"/> Female (11)	33
<b>11. During the past 12 months, did you have a pap smear or pap test to check for cancer of the cervix?</b>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	34
<b>12. Have you had a hysterectomy?</b>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	35
<b>ITEM L3</b>	<i>Refer to age.</i>	1 <input type="checkbox"/> Under 40 (Section M) 2 <input type="checkbox"/> 40+ (13)	36
<b>13a. During the past 12 months, have you had a breast physical exam in which a medical doctor or health professional checked your breasts for lumps?</b>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	37
<b>b. During the past two years have you had a mammogram?</b> <i>Read if necessary:</i> <b>That is, an x-ray taken only of the breasts by a machine that presses against the breast while the picture is taken.</b>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	38

**Section M – PHYSICAL ACTIVITY AND FITNESS**

These next questions are about physical exercise.

**ITEM  
M1**

Mark from observation or previous information.

- 1  SP is physically handicapped (Describe in footnotes, THEN 1)  
 8  Other (2)

5

Hand calendar.

**1 a. In the past 2 weeks (outlined on that calendar), beginning Monday (date) and ending this past Sunday (date), have you done any exercises, sports, or physically active hobbies?**

- 1  Yes (1b)  
 2  No } (3 on page 40)  
 9  DK }

6

**b. What were they?**

Record on next page, THEN 1c.

**c. Anything else?**

- Yes (Reask 1b and c)  
 No (2b)

Notes

**Section M – PHYSICAL ACTIVITY AND FITNESS – Continued**

**NOTE: ASK ALL OF 2a BEFORE GOING TO 2b–d.**

**NOTE: ASK 2b–d FOR EACH ACTIVITY MARKED "YES" IN 2a.**

*Hand calendar.*

**2a. In the past 2 weeks (outlined on that calendar), beginning Monday, (date), and ending this past Sunday, (date), have you done any of the following exercises, sports, or physically active hobbies –**

**b. How many times in the past 2 weeks did you [go/do] (activity in 2a)?**

**c. On the average, about how many minutes did you actually spend (doing) (activity in 2a) each time?**

**d. {What usually happened to your heart rate or breathing when you [did/went] (activity in 2a)? Did you have a small, moderate, or large increase, or no increase at all in your heart rate or breathing?**

Activity	YES	NO	7	8-9	10-12	13
(1) Walking for exercise?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7	(1) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK
(2) Gardening or yard work?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	14	(2) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK
(3) Stretching exercises?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	21	(3) _____ Times	_____ Minutes (Next activity)	
(4) Weightlifting or other exercises to increase muscle strength?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	27	(4) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK
(5) Jogging or running?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	34	(5) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK
(6) Aerobics or aerobic dancing?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	41	(6) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK
(7) Riding a bicycle or exercise bike?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	48	(7) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK
(8) Stair climbing?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	55	(8) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK
(9) Swimming for exercise?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	62	(9) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK
(10) Playing tennis?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	69	(10) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK
(11) Bowling?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	76	(11) _____ Times (Next activity)		
(12) Playing golf?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	79	(12) _____ Times (Next activity)		
(13) Playing baseball or softball?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	82	(13) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK
(14) Playing handball, racquetball, or squash?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	89	(14) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK
(15) Skiing? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (16)			96	(a) _____ Times (Next activity)		
(a) Downhill?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	99	(b) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK
(b) Cross-country?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	106	(c) _____ Times (Next activity)		
(c) Water?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	RT 84			
(16) Playing basketball?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3-4 5	(16) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK
(17) Playing volleyball?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	12	(17) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK
(18) Playing soccer?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	19	(18) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK
(19) Playing football?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	26	(19) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK
(20) Have you done any (other) exercises, sports, or physically active hobbies in the past 2 weeks?			33			
1 <input type="checkbox"/> Yes – What were they? 2 <input type="checkbox"/> No Anything else?			34-35	(20) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK
If listed activity, mark "Yes" for that activity, otherwise, specify <input checked="" type="checkbox"/>			42			
Anything else? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			43-44	(20) _____ Times	_____ Minutes	1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 0 <input type="checkbox"/> No inc. 9 <input type="checkbox"/> DK

**Section M – PHYSICAL ACTIVITY AND FITNESS – Continued**

**ITEM  
M2**

Refer to Section L, question 3 on page 36 about last routine check-up.

- 1  Less than 1 year (3)  
8  Other (Section N)

51

**3. During your last routine check-up, did the doctor or other health professional recommend that you BEGIN or CONTINUE to do any type of exercise or physical activity?**

If "Yes," ask if this was to begin or continue.

- 1  Yes, to BEGIN  
2  Yes, to CONTINUE } (4a)  
3  Yes, Both  
4  No  
9  DK } (Section N)

52

**4a. What type of exercise or physical activity did the doctor or other health professional recommend that you [BEGIN (or) CONTINUE] to do?**

Read all categories.

YES NO

RT 94  
3-4

Ask 4b, c, and d for each activity marked "Yes" in 4a.

**b. How many times per week did the doctor or other health professional tell you to [play/go/do] (activity in 4a)?**

**c. How many minutes did the doctor or other health professional tell you to spend [playing/going/doing] (activity in 4a) each time that you do it?**

**d. Which of these ways, if any, did the doctor or other health professional recommend to check how hard you should exercise?**

(1) Aerobics or aerobic dancing? 1  2

(1) \_\_\_\_\_ Times  
97  No rec.

\_\_\_\_\_ Minutes  
997  No rec.

0  No rec. 4  Distance/Speed  
1  Heart 5  Talk  
2  Breath 8  Other  
3  Sweat

(2) Riding a bicycle or exercise bike? 1  2

(2) \_\_\_\_\_ Times  
97  No rec.

\_\_\_\_\_ Minutes  
997  No rec.

0  No rec. 4  Distance/Speed  
1  Heart 5  Talk  
2  Breath 8  Other  
3  Sweat

(3) Jogging or running? 1  2

(3) \_\_\_\_\_ Times  
97  No rec.

\_\_\_\_\_ Minutes  
997  No rec.

0  No rec. 4  Distance/Speed  
1  Heart 5  Talk  
2  Breath 8  Other  
3  Sweat

(4) Swimming laps or water exercises? 1  2

(4) \_\_\_\_\_ Times  
97  No rec.

\_\_\_\_\_ Minutes  
997  No rec.

0  No rec. 4  Distance/Speed  
1  Heart 5  Talk  
2  Breath 8  Other  
3  Sweat

(5) Walking? 1  2

(5) \_\_\_\_\_ Times  
97  No rec.

\_\_\_\_\_ Minutes  
997  No rec.

0  No rec. 4  Distance/Speed  
1  Heart 5  Talk  
2  Breath 8  Other  
3  Sweat

(6) Other aerobic type exercise? 1  2

(6) \_\_\_\_\_ Times  
97  No rec.

\_\_\_\_\_ Minutes  
997  No rec.

0  No rec. 4  Distance/Speed  
1  Heart 5  Talk  
2  Breath 8  Other  
3  Sweat

(7) Exercises to increase muscle strength? 1  2

(7) \_\_\_\_\_ Times  
97  No rec.

\_\_\_\_\_ Minutes (Next activity)  
997  No rec.

(8) Stretching exercises? 1  2

(8) \_\_\_\_\_ Times  
97  No rec.

\_\_\_\_\_ Minutes (Next activity)  
997  No rec.

(9) Other – Specify  \_\_\_\_\_ 1  2

(9) \_\_\_\_\_ Times  
97  No rec.

\_\_\_\_\_ Minutes  
997  No rec.

0  No rec. 4  Distance/Speed  
1  Heart 5  Talk  
2  Breath 8  Other  
3  Sweat

Notes

Section N — ALCOHOL

5

These next questions are about drinking alcoholic beverages. Included are liquor, such as whiskey or gin, beer, wine, and any other type of alcoholic beverage.

1. Have you had at least one drink of beer, wine, or liquor during the PAST YEAR?

- 1  Yes (2)
- 2  No } (Section O)
- 9  DK }

6-7

Hand calendar.

2. During the past 2 WEEKS (outlined on that calendar), beginning Monday (date) and ending this past Sunday (date), on how many days did you drink any alcoholic beverages, such as beer, wine, or liquor?

- 00  None/never (4)
- \_\_\_\_\_ Days (3)  
(Number)
- 14  Everyday } (3)
- 99  DK }

8-9

3. On the (number in 2) day(s) that you drank alcoholic beverages, how many drinks did you have (per day on the average)?

- \_\_\_\_\_ Drinks/day  
(Number)
- 99  DK

10

4a. Was the amount of your drinking during that 2-WEEK period typical of your drinking during the past 12 months?

- 1  Yes (Section O)
- 2  No } (4b)
- 9  DK }

11

b. During that 2-week period, did you drink MORE or LESS than usual?

- 1  More
- 2  Less
- 9  DK

Notes

Section O – MENTAL HEALTH

These questions are about how you have been feeling emotionally.

Hand Card O1. Read categories, if telephone interview.

1. During the past 2 weeks, how often have you felt bored?

- 0  Never
- 1  Rarely
- 2  Sometimes
- 3  Often
- 4  Very often
- 9  DK

5

2. (During the past 2 weeks,) How often have you felt so restless that you could hardly sit still?

- 0  Never
- 1  Rarely
- 2  Sometimes
- 3  Often
- 4  Very often
- 9  DK

6

3. (During the past 2 weeks,) How often have you felt depressed or very low about something?

- 0  Never
- 1  Rarely
- 2  Sometimes
- 3  Often
- 4  Very often
- 9  DK

7

4. (During the past 2 weeks,) How often have you felt upset because of something someone said about you?

- 0  Never
- 1  Rarely
- 2  Sometimes
- 3  Often
- 4  Very often
- 9  DK

8

5. (During the past 2 weeks,) How often have you felt very lonely or abandoned?

- 0  Never
- 1  Rarely
- 2  Sometimes
- 3  Often
- 4  Very often
- 9  DK

9

Notes

Notes section with a large empty space for handwritten text.

**Section P – ORAL HEALTH**

These next questions are about oral health.

1. During the past 12 months, that is, since *(12-month date)* a year ago, about how many visits did you make to a dentist?

00  None

\_\_\_\_\_ Dental visits  
(Number)

99  DK

2. Have you lost ALL of your UPPER natural teeth?

1  Yes

2  No

3. Have you lost ALL of your LOWER natural teeth?

1  Yes

2  No

Notes

**CARD H1**

1. Europe
2. Middle East
3. East Africa
4. West Africa
5. Cental Africa
6. Northern Africa
7. Southern Africa
8. Asia or Pacific Islands
9. Australia or New Zealand
10. Mexico
11. Cental America
12. Caribbean
13. South America
98. Other — *Specify*

**CARD H2**

0. Cholera vaccine
1. Gamma globulin or immune globulin
2. Hepatitis B vaccine
3. Meningococcal vaccine
4. Rabbies vaccine
5. Typhoid fever vaccine
6. Yellow fever vaccine
8. Other — *Specify*

H1

H2

(Cut along broken line)

**CARD H3**

1. Aralen (Chloroquine phosphate)
2. Doxycycline
3. Fansidar (Pyrimethamine Sulfadoxine)
4. Lariam (Mefloquine)
5. Paludrine (Proguanil)
6. Plaquenil (Hydroxy-chloroquine sulfate)
8. Other — *Specify*

**CARD I1**

1. Private enclosed office with door
2. Enclosed office with door shared with one or more other persons
3. Cubicle with floor to ceiling bookcases or partitions and no door
4. Cubicle surrounded by mid-height bookcases or partitions
5. Open office areas
6. In one building, but no regular work area
7. Mainly work outdoors
8. Travel to different buildings or sites
9. In a motor vehicle
98. Other — *Specify*

H3

I1

(Cut along broken line)

**CARD I2**

- 1. Not allowed in ANY indoor or common public areas**
- 2. Allowed in SOME public areas, including designated smoking areas**
- 3. Allowed in ALL indoor or common public areas**

**CARD I3**

- 1. Not allowed in ANY work areas**
- 2. Allowed in SOME work areas**
- 3. Allowed in ALL work areas**

12

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**CARD I4**

- 1. Walking group**
- 2. Jogging/Running group**
- 3. Biking/Cycling group**
- 4. Aerobics classes**
- 5. Swimming classes**
- 6. Non-aerobic exercise classes**
- 7. Weight lifting classes**
- 8. Fully paid membership in health/fitness club**
- 9. Partially paid membership in health/fitness club**
- 10. Physical activity or exercise competitions**
- 98. Other — Specify**
- 00. No programs**

**CARD I5**

- 1. Gymnasium/Exercise room**
- 2. Weight lifting equipment**
- 3. Exercise equipment**
- 4. Walking/Jogging path**
- 5. Parcours/Fitness trails**
- 6. Bike path**
- 7. Bike racks**
- 8. Swimming pool**
- 9. Showers**
- 10. Lockers**
- 98. Other — Specify**
- 00. No facilities**

14

15

**CARD M1**

- 0. No recommendation was made
- 1. Measure heart rate or pulse
- 2. Pay attention to rate or depth of breathing
- 3. Told to work up a sweat
- 4. Measure the distance or speed of walking/cycling/swimming, etc.
- 5. The talk test — exercising to the level that talking is difficult
- 8. Other

**CARD O1**

- 0. Never
- 1. Rarely
- 2. Sometimes
- 3. Often
- 4. Very often

M1

O1

(Cut along broken line)

**CARD Q1**

- Television programs
- Radio programs
- Magazine articles
- Newspaper articles
- Street signs/billboards
- Store displays/store distributed brochures
- Bus/street car/subway displays
- Health Department brochures
- Workplace distributed brochures
- School distributed brochures
- Church distributed brochures
- Community organization
- Friend/acquaintance
- AIDS hotline
- Other source — *Specify*
- Received no AIDS information in the past month

**CARD Q2**

- 1. Very likely
- 2. Somewhat likely
- 3. Somewhat unlikely
- 4. Very unlikely
- 5. Definitely not possible

Q1

Q2

(Cut along broken line)

**CARD Q3**

- a. AZT can delay or slow down the symptoms of AIDS virus infection
- b. AZT cures people with AIDS
- c. AZT has no known side effects
- d. AZT is appropriate for a person with the AIDS virus infection ONLY at certain times during the illness
- e. There are other drugs available to treat AIDS related illnesses

**CARD Q4**

- a. You have hemophilia or another blood clotting disorder and have received clotting factor concentrations since 1977
- b. You are a man who has had sex with another man at some time since 1977, even one time
- c. You have taken illegal drugs by needle at any time since 1977
- d. You have had sex for money or drugs at any time since 1977
- e. Since 1977, you are or have been the sex partner of any person who could answer "Yes" to any of the items above on this card

Q3

Q4

(Cut along broken line)

**MEDICARE**

<b>Health Insurance</b>	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY John Q. Public	
CLAIM NUMBER 000-00-0000-A	SEX MALE
IS ENTITLED TO Hospital Insurance	EFFECTIVE DATE 7-1-66
Medical Insurance	7-1-66
SIGN HERE <i>John Q. Public</i>	

**STATE NAMES FOR MEDICAID**

**MEDI - CAL**

California

**MEDI - KAN**

Kansas

**HEALTH CARE COST CONTAINMENT SYSTEM (HCCCS)**

Arizona

**MEDICAL ASSISTANCE**

All other States

Medicare

State name for Medicare

(Cut along broken line)