

A. HOUSEHOLD COMPOSITION PAGE

1

1a. What are the names of all persons living or staying here? Start with the name of the person or one of the persons who owns or rents this home. Enter name in REFERENCE PERSON column.

b. What are the names of all other persons living or staying here? Enter names in columns. If "Yes," enter names in columns

| | |
|--------------------------|--------------------------|
| Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

c. I have listed (read names). Have I missed:

- any babies or small children?
- any lodgers, boarders, or persons you employ who live here?
- anyone who USUALLY lives here but is now away from home traveling or in a hospital?
- anyone else staying here?

d. Do all of the persons you have named usually live here? Yes (2) No (APPLY HOUSEHOLD MEMBERSHIP RULES. Delete nonhousehold members by an "X" from 1-C2 and enter reason.)

Probe if necessary:
Does — usually live somewhere else?

Ask for all persons beginning with column 2:

2. What is — relationship to (reference person)?

3. What is — date of birth? (Enter date and age and mark sex.)

| REFERENCE PERIODS | |
|-------------------|--------------------------|
| A1 | 2-WEEK PERIOD |
| | 12-MONTH DATE |
| | 13-MONTH HOSPITAL DATE |
| A2 | ASK CONDITION LIST _____ |

| | | |
|---------------|------------|---|
| 1. First name | Mid. init. | Age |
| Last name | | Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F |

2. Relationship REFERENCE PERSON

3. Date of birth

| | | |
|-------|------|------|
| Month | Date | Year |
|-------|------|------|

| | | | | | |
|-----------|----------------------------------|-------------------------------|--------------------------------|----------------------------------|--------|
| C1 | HOSP. | WORK | RD | 2-WK. | DV |
| | 00 <input type="checkbox"/> None | 1 <input type="checkbox"/> Wa | 1 <input type="checkbox"/> Yes | 00 <input type="checkbox"/> None | |
| | 2 <input type="checkbox"/> Wb | 2 <input type="checkbox"/> No | | | Number |

| | | | | | | | | |
|-----------|----|----|----|------|------|----|------|-------|
| C2 | LA | TR | DR | TINJ | TCLL | TR | HSTC | COND. |
|-----------|----|----|----|------|------|----|------|-------|

| | | | | | | | | |
|-----------|----|----|----|------|------|----|------|-------|
| C2 | LA | TR | DR | TINJ | TCLL | TR | HSTC | COND. |
|-----------|----|----|----|------|------|----|------|-------|

| | | | | | | | | |
|-----------|----|----|----|------|------|----|------|-------|
| C2 | LA | TR | DR | TINJ | TCLL | TR | HSTC | COND. |
|-----------|----|----|----|------|------|----|------|-------|

| | | | | | | | | |
|-----------|----|----|----|------|------|----|------|-------|
| C2 | LA | TR | DR | TINJ | TCLL | TR | HSTC | COND. |
|-----------|----|----|----|------|------|----|------|-------|

| | | | | | | | | |
|-----------|----|----|----|------|------|----|------|-------|
| C2 | LA | TR | DR | TINJ | TCLL | TR | HSTC | COND. |
|-----------|----|----|----|------|------|----|------|-------|

A3 Refer to ages of all related HH members.

A3 All persons 65 and over (5)
 Other (4)

4a. Are any of the persons in this family now on full-time active duty with the armed forces? Yes No (5)

b. Who is this? Delete column number(s) _____ by an "X" from 1-C2.

c. Anyone else? Yes (Reask 4b and c) No

d. Where does — usually live and sleep, here or somewhere else? Mark box in person's column.

4d. Living at home
 Not living at home

5. We would like to have all adult family members who are at home take part in the interview. Are (names of persons 17 and over) at home now? If "Yes," ask: Could they join us? (Allow time)

Read to respondent(s):
This survey is being conducted to collect information on the nation's health. I will ask about hospitalizations, disability, visits to doctors, illness in the family, and other health related items.

6a. Since (13-month hospital date) a year ago, was — a patient in a hospital OVERNIGHT?

6a. 1 Yes
 2 No (Mark "HOSP." box, THEN NP)

b. How many different times did — stay in any hospital overnight or longer since (13-month hospital date) a year ago?

b. _____ } (Make entry in "HOSP." box THEN NP)
 Number of times

Ask for each child under one:
7a. Was — born in a hospital?

7a. 1 Yes
 2 No (NP)

Ask for mother and child:
b. Have you included this hospitalization in the number you gave me for —?

b. Yes (NP)
 No (Correct 6 and "HOSP." box)

FOOTNOTES

B. LIMITATION OF ACTIVITIES PAGE

| | |
|---|--|
| <p>B1 Refer to age.</p> | <p>B1 1 <input type="checkbox"/> 18-69 (1) 2 <input type="checkbox"/> Other (NP)</p> |
| <p>1. What was -- doing MOST OF THE PAST 12 MONTHS; working at a job or business, keeping house, going to school, or something else? <i>Priority if 2 or more activities reported: (1) Spent the most time doing; (2) Considers the most important.</i></p> | <p>1. 1 <input type="checkbox"/> Working (2) 2 <input type="checkbox"/> Keeping house (3) 3 <input type="checkbox"/> Going to school (5) 4 <input type="checkbox"/> Something else (5)</p> |
| <p>2a. Does any impairment or health problem NOW keep -- from working at a job or business?</p> | <p>2a. 1 <input type="checkbox"/> Yes (7) <input type="checkbox"/> No</p> |
| <p>b. Is -- limited in the kind OR amount of work -- can do because of any impairment or health problem?</p> | <p>b. 2 <input type="checkbox"/> Yes (7) 3 <input type="checkbox"/> No (6)</p> |
| <p>3a. Does any impairment or health problem NOW keep -- from doing any housework at all?</p> | <p>3a. 4 <input type="checkbox"/> Yes (4) <input type="checkbox"/> No</p> |
| <p>b. Is -- limited in the kind OR amount of housework -- can do because of any impairment or health problem?</p> | <p>b. 5 <input type="checkbox"/> Yes (4) 6 <input type="checkbox"/> No (5)</p> |
| <p>4a. What (other) condition causes this? <i>Ask if injury or operation: When did [the (injury) occur?/ -- have the operation?] Ask if operation over 3 months ago: For what condition did -- have the operation? If pregnancy/delivery or 0-3 months injury or operation -- Reask question 3 where limitation reported, saying: Except for -- (condition), . . . ? OR reask 4b/c.</i></p> <p>b. Besides (condition) is there any other condition that causes this limitation?</p> <p>c. Is this limitation caused by any (other) specific condition?</p> <p><i>Mark box if only one condition.</i></p> <p>d. Which of these conditions would you say is the MAIN cause of this limitation?</p> | <p>4a. (Enter condition in C2, THEN 4b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 4c)</p> <p>b. <input type="checkbox"/> Yes (Reask 4a and b) <input type="checkbox"/> No (4d)</p> <p>c. <input type="checkbox"/> Yes (Reask 4a and b) <input type="checkbox"/> No</p> <p>d. <input type="checkbox"/> Only 1 condition</p> <p align="center">Main cause</p> |
| <p>5a. Does any impairment or health problem keep -- from working at a job or business?</p> | <p>5a. 1 <input type="checkbox"/> Yes (7) <input type="checkbox"/> No</p> |
| <p>b. Is -- limited in the kind OR amount of work -- could do because of any impairment or health problem?</p> | <p>b. 2 <input type="checkbox"/> Yes (7) 3 <input type="checkbox"/> No</p> |
| <p>B2 Refer to questions 3a and 3b.</p> | <p>B2 1 <input type="checkbox"/> "Yes" in 3a or 3b (NP) 2 <input type="checkbox"/> Other (6)</p> |
| <p>6a. Is -- limited in ANY WAY in any activities because of an impairment or health problem?</p> | <p>6a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)</p> |
| <p>b. In what way is -- limited? <i>Record limitation, not condition.</i></p> | <p>b. _____ Limitation</p> |
| <p>7a. What (other) condition causes this? <i>Ask if injury or operation: When did [the (injury) occur?/ -- have the operation?] Ask if operation over 3 months ago: For what condition did -- have the operation? If pregnancy/delivery or 0-3 months injury or operation -- Reask question 2, 5, or 6 where limitation reported, saying: Except for -- (condition), . . . ? OR reask 7b/c.</i></p> <p>b. Besides (condition) is there any other condition that causes this limitation?</p> <p>c. Is this limitation caused by any (other) specific condition?</p> <p><i>Mark box if only one condition.</i></p> <p>d. Which of these conditions would you say is the MAIN cause of this limitation?</p> | <p>7a. (Enter condition in C2, THEN 7b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 7c)</p> <p>b. <input type="checkbox"/> Yes (Reask 7a and b) <input type="checkbox"/> No (7d)</p> <p>c. <input type="checkbox"/> Yes (Reask 7a and b) <input type="checkbox"/> No</p> <p>d. <input type="checkbox"/> Only 1 condition</p> <p align="center">Main cause</p> |

| B. LIMITATION OF ACTIVITIES PAGE, Continued | | |
|---|----------------------|---|
| B3 | <i>Refer to age.</i> | B3 0 <input type="checkbox"/> Under 5 (10) 2 <input type="checkbox"/> 18-69 (NP) 1 <input type="checkbox"/> 5-17 (11) 3 <input type="checkbox"/> 70 and over (B) |
| 8. What was --- doing MOST OF THE PAST 12 MONTHS; working at a job or business, keeping house, going to school, or something else? <i>Priority if 2 or more activities reported: (1) Spent the most time doing; (2) Considers the most important.</i> | | 8. 1 <input type="checkbox"/> Working 2 <input type="checkbox"/> Keeping house 3 <input type="checkbox"/> Going to school 4 <input type="checkbox"/> Something else |
| 9a. Because of any impairment or health problem, does --- need the help of other persons with --- personal care needs, such as eating, bathing, dressing, or getting around this home? b. Because of any impairment or health problem, does --- need the help of other persons in handling --- routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes? | | 9a. 1 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No b. 2 <input type="checkbox"/> Yes (13) 3 <input type="checkbox"/> No (12) |
| 10a. Is --- able to take part AT ALL in the usual kinds of play activities done by most children --- age? b. Is --- limited in the kind OR amount of play activities --- can do because of any impairment or health problem? | | 10a. <input type="checkbox"/> Yes 0 <input type="checkbox"/> No (13) b. 1 <input type="checkbox"/> Yes (13) 2 <input type="checkbox"/> No (12) |
| 11a. Does any impairment or health problem NOW keep --- from attending school? b. Does --- attend a special school or special classes because of any impairment or health problem? c. Does --- need to attend a special school or special classes because of any impairment or health problem? d. Is --- limited in school attendance because of --- health? | | 11a. 1 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No b. 2 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No c. 3 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No d. 4 <input type="checkbox"/> Yes (13) 5 <input type="checkbox"/> No |
| 12a. Is --- limited in ANY WAY in any activities because of an impairment or health problem? b. In what way is --- limited? <i>Record limitation, not condition.</i> | | 12a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP) b. _____ Limitation |
| 13a. What (other) condition causes this? <i>Ask if injury or operation: When did [the (injury) occur?]/--- have the operation?</i> <i>Ask if operation over 3 months ago: For what condition did --- have the operation?</i> <i>If pregnancy/delivery or 0-3 months injury or operation ---</i> <i>Reask question where limitation reported, saying: Except for --- (condition), . . . ?</i> <i>OR reask 13b/c.</i> b. Besides (condition) is there any other condition that causes this limitation? c. Is this limitation caused by any (other) specific condition? <i>Mark box if only one condition.</i> d. Which of these conditions would you say is the MAIN cause of this limitation? | | 13a. <i>(Enter condition in C2, THEN 13b)</i> 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 13c) b. <input type="checkbox"/> Yes (Reask 13a and b) <input type="checkbox"/> No (13d) c. <input type="checkbox"/> Yes (Reask 13a and b) <input type="checkbox"/> No d. <input type="checkbox"/> Only 1 condition _____ Main cause |
| FOOTNOTES | | |

FORM HIS-1 (1991) (8-27-90)

B. LIMITATION OF ACTIVITIES PAGE, Continued

| | | | |
|--|--|-------------|--|
| B4 | Refer to age. | B4 | 0 <input type="checkbox"/> Under 5 (NP) 2 <input type="checkbox"/> 60-69 (14) 1 <input type="checkbox"/> 5-59 (B5) 3 <input type="checkbox"/> 70 and over (NP) |
| B5 | Refer to "Old age" and "LA" boxes. Mark first appropriate box. | B5 | <input type="checkbox"/> "Old age" box marked (14) <input type="checkbox"/> Entry in "LA" box (14) <input type="checkbox"/> Other (NP) |
| 14a. Because of any impairment or health problem, does -- need the help of other persons with -- personal care needs, such as eating, bathing, dressing, or getting around this home? | | 14a. | 1 <input type="checkbox"/> Yes (15) <input type="checkbox"/> No |
| If under 18, skip to next person; otherwise ask: b. Because of any impairment or health problem, does -- need the help of other persons in handling -- routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes? | | b. | 2 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No (NP) |
| 15a. What (other) condition causes this? Ask if injury or operation: When did [the (injury) occur?]/-- have the operation? Ask if operation over 3 months ago: For what condition did -- have the operation? If pregnancy/delivery or 0-3 months injury or operation -- Reask question 14 where limitation reported, saying: Except for -- (condition), ...? OR reask 15b/c. b. Besides (condition) is there any other condition that causes this limitation? <hr/> c. Is this limitation caused by any (other) specific condition? <hr/> Mark box if only one condition. d. Which of these conditions would you say is the MAIN cause of this limitation? | | 15a. | (Enter condition in C2, THEN 15b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 15c) <hr/> b. <input type="checkbox"/> Yes (Reask 15a and b) <input type="checkbox"/> No (15d) <hr/> c. <input type="checkbox"/> Yes (Reask 15a and b) <input type="checkbox"/> No <hr/> d. <input type="checkbox"/> Only 1 condition <hr/> Main cause |
| FOOTNOTES | | | |

D. RESTRICTED ACTIVITY PAGE PERSON 1

Hand calendar.
 {The next questions refer to the 2 weeks outlined in red on that calendar, beginning Monday, (date) and ending this past Sunday (date).}

D1 Refer to age.
 Under 5 (4) 5-17 (3) 18 and over (1)

1 a. DURING THOSE 2 WEEKS, did -- work at any time at a job or business not counting work around the house? (Include unpaid work in the family [farm/business].)
 1 Yes (Mark "Wa" box, THEN 2) 2 No

b. Even though -- did not work during those 2 weeks, did -- have a job or business?
 1 Yes (Mark "Wb" box, THEN 2) 2 No (4)

2 a. During those 2 weeks, did -- miss any time from a job or business because of illness or injury?
 Yes oo No (4)

b. During that 2-week period, how many days did -- miss more than half of the day from -- job or business because of illness or injury?
 oo None (4) (4)

3 a. During those 2 weeks, did -- miss any time from school because of illness or injury?
 Yes oo No (4)

b. During that 2-week period, how many days did -- miss more than half of the day from school because of illness or injury?
 oo None

4 a. During those 2 weeks, did -- stay in bed because of illness or injury?
 Yes oo No (6)

b. During that 2-week period, how many days did -- stay in bed more than half of the day because of illness or injury?
 oo None (6) (D2)

D2 Refer to 2b and 3b.
 No days in 2b or 3b (6)
 1 or more days in 2b or 3b (5)

5. On how many of the (number in 2b or 3b) days missed from [work/school] did -- stay in bed more than half of the day because of illness or injury?
 oo None

Refer to 2b, 3b, and 4b.

6 a. (Not counting the day(s) [missed from work missed from school (and) in bed],
Was there any (OTHER) time during those 2 weeks that -- cut down on the things -- usually does because of illness or injury?
 Yes oo No (D3)

b. (Again, not counting the day(s) [missed from work missed from school (and) in bed],
During that period, how many (OTHER) days did -- cut down for more than half of the day because of illness or injury?
 oo None

D3 Refer to 2-6.
 No days in 2-6 (Mark "No" in RD, THEN NP)
 1 or more days in 2-6 (Mark "Yes" in RD, THEN 7)

Refer to 2b, 3b, 4b, and 6b.

7 a. What (other) condition caused -- to [miss work miss school (or) stay in bed (or) cut down] during those 2 weeks?
 (Enter condition in C2, THEN 7b)

b. Did any other condition cause -- to [miss work miss school (or) stay in bed (or) cut down] during that period?
 1 Yes (Reask 7a and b) 2 No

FOOTNOTES

FORM HIS-1 (11991) (8-27-90)

G. HEALTH INDICATOR PAGE

| | | |
|---|------------|--|
| 1a. During the 2-week period outlined in red on that calendar, has anyone in the family had an injury from an accident or other cause that you have not yet told me about? <input type="checkbox"/> Yes <input type="checkbox"/> No (2) | | |
| b. Who was this? Mark "Injury" box in person's column. | 1b. | <input type="checkbox"/> Injury |
| c. What was -- injury? Enter injury(ies) in person's column. | c. | _____ injury |
| d. Did anyone have any other injuries during that period? <input type="checkbox"/> Yes (Reask 1b, c, and d) <input type="checkbox"/> No | | |
| Ask for each injury in 1c: e. As a result of the (injury in 1c) did [---/anyone] see or talk to a medical doctor or assistant (about ---) or did --- cut down on --- usual activities for more than half of a day? | e. | <input type="checkbox"/> Yes (Enter injury in C2, THEN 1e for next injury) <input type="checkbox"/> No (1e for next injury) |

| | | |
|--|-----------|--|
| 2. During the past 12 months, {that is, since [12-month date] a year ago} ABOUT how many days did illness or injury keep --- in bed more than half of the day? (Include days while an overnight patient in a hospital.) | 2. | 000 <input type="checkbox"/> None _____ No. of days |
|--|-----------|--|

| | | |
|---|------------|---|
| 3a. During the past 12 months, ABOUT how many times did [---/anyone] see or talk to a medical doctor or assistant (about ---)? (Do not count doctors seen while an overnight patient in a hospital.) (Include the (number in 2-WK DV box) visit(s) you already told me about.) | 3a. | 000 <input type="checkbox"/> None (3b) 000 <input type="checkbox"/> Only when overnight patient in hospital } (NP) _____ No. of visits |
| b. About how long has it been since [---/anyone] last saw or talked to a medical doctor or assistant (about ---)? Include doctors seen while a patient in a hospital. | b. | 1 <input type="checkbox"/> Interview week (Reask 3b) 2 <input type="checkbox"/> Less than 1 yr. (Reask 3a) 3 <input type="checkbox"/> 1 yr., less than 2 yrs. 4 <input type="checkbox"/> 2 yrs., less than 5 yrs. 5 <input type="checkbox"/> 5 yrs. or more 0 <input type="checkbox"/> Never |

| | | |
|--|-----------|---|
| 4. Would you say -- health in general is excellent, very good, good, fair, or poor? | 4. | 1 <input type="checkbox"/> Excellent 4 <input type="checkbox"/> Fair 2 <input type="checkbox"/> Very good 5 <input type="checkbox"/> Poor 3 <input type="checkbox"/> Good |
|--|-----------|---|

| | | |
|---|------------|--|
| Mark box if under 18. 5a. About how tall is -- without shoes? | 5a. | <input type="checkbox"/> Under 18 (NP) _____ Feet _____ Inches |
| b. About how much does -- weigh without shoes? | b. | _____ Pounds |

FOOTNOTES

H. CONDITION LISTS 1 AND 2

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

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

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|-----------------|-----------------|---|--------------------|------------------------|---------------------|--|-------------------------------------|---|---|------------------------------|---------------------------------------|-------------------------|---|-------------------------------------|---------------------|---|--|---|--|---|--|---|--|---|-----------------------------|---|-----------------|--|----------------------------|--|--|--|---|----------------------|----------------------------------|---------------------|-----------------------------------|----------------------------|---|---|---|---|-----------------------|--------------------------------------|-------------------------|-------------------------------------|--|------------------------------------|--|---|-------------------------------|--|---|
| <p>1</p> <p>1a. Does anyone in the family {read names} NOW HAVE — If "Yes," ask 1b and c.</p> <p>b. Who is this?</p> <p>c. Does anyone else NOW have — Enter condition and letter in appropriate person's column.</p> <p>A. PERMANENT stiffness or any deformity of the foot, leg, fingers, arm, or back? (Permanent stiffness — joints will not move at all.)</p> <hr/> <p>B. Paralysis of any kind?</p> <p>1d. DURING THE PAST 12 MONTHS, did anyone in the family have — If "Yes," ask 1e and f.</p> <p>e. Who was this?</p> <p>f. DURING THE PAST 12 MONTHS, did anyone else have — Enter condition and letter in appropriate person's column. C—L are conditions affecting the bone and muscle. M—W are conditions affecting the skin.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;">C. Arthritis of any kind or rheumatism?</td> <td style="width: 50%; padding: 2px; text-align: center;"><i>Reask 1d</i></td> </tr> <tr> <td style="padding: 2px;">D. Gout?</td> <td style="padding: 2px;">M. A tumor, cyst, or growth of the skin?</td> </tr> <tr> <td style="padding: 2px;">E. Lumbago?</td> <td style="padding: 2px;">N. Skin cancer?</td> </tr> <tr> <td style="padding: 2px;">F. Sciatica?</td> <td style="padding: 2px;">O. Eczema or Psoriasis? (ek'sa-ma) or (so-rye'uh-sis)</td> </tr> <tr> <td style="padding: 2px;">G. A bone cyst or bone spur?</td> <td style="padding: 2px;">P. TROUBLE with dry or itching skin?</td> </tr> <tr> <td style="padding: 2px;">H. Any other disease of the bone or cartilage?</td> <td style="padding: 2px;">Q. TROUBLE with acne?</td> </tr> <tr> <td style="padding: 2px;">I. A slipped or ruptured disc?</td> <td style="padding: 2px;">R. A skin ulcer?</td> </tr> <tr> <td style="padding: 2px;">J. REPEATED trouble with neck, back, or spine?</td> <td style="padding: 2px;">S. Any kind of skin allergy?</td> </tr> <tr> <td style="padding: 2px;">K. Bursitis?</td> <td style="padding: 2px;">T. Dermatitis or any other skin trouble?</td> </tr> <tr> <td style="padding: 2px;">L. Any disease of the muscles or tendons?</td> <td style="padding: 2px;">U. TROUBLE with ingrown toenails or fingernails?</td> </tr> <tr> <td style="padding: 2px;"></td> <td style="padding: 2px;">V. TROUBLE with bunions, corns, or calluses?</td> </tr> <tr> <td style="padding: 2px;"></td> <td style="padding: 2px;">W. Any disease of the hair or scalp?</td> </tr> </table> | C. Arthritis of any kind or rheumatism? | <i>Reask 1d</i> | D. Gout? | M. A tumor, cyst, or growth of the skin? | E. Lumbago? | N. Skin cancer? | F. Sciatica? | O. Eczema or Psoriasis? (ek'sa-ma) or (so-rye'uh-sis) | G. A bone cyst or bone spur? | P. TROUBLE with dry or itching skin? | H. Any other disease of the bone or cartilage? | Q. TROUBLE with acne? | I. A slipped or ruptured disc? | R. A skin ulcer? | J. REPEATED trouble with neck, back, or spine? | S. Any kind of skin allergy? | K. Bursitis? | T. Dermatitis or any other skin trouble? | L. Any disease of the muscles or tendons? | U. TROUBLE with ingrown toenails or fingernails? | | V. TROUBLE with bunions, corns, or calluses? | | W. Any disease of the hair or scalp? | <p>2</p> <p>2a. Does anyone in the family {read names} NOW HAVE — If "Yes," ask 2b and c.</p> <p>b. Who is this?</p> <p>c. Does anyone else NOW have — Enter condition and letter in appropriate person's column. A—L are conditions affecting <table style="display: inline-table; vertical-align: middle;"><tr><td style="font-size: 2em;">}</td><td style="padding: 0 5px;">Hearing Vision Speech</td></tr></table> Conditions M—AA are impairments.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;">A. Deafness in one or both ears?</td> <td style="width: 50%; padding: 2px; text-align: center;"><i>Reask 2a</i></td> </tr> <tr> <td style="padding: 2px;">B. Any other trouble hearing with one or both ears?</td> <td style="padding: 2px;">O. A missing joint?</td> </tr> <tr> <td style="padding: 2px;">C. Tinnitus or ringing in the ears?</td> <td style="padding: 2px;">P. A missing breast, kidney, or lung?</td> </tr> <tr> <td style="padding: 2px;">D. Blindness in one or both eyes?</td> <td style="padding: 2px;">Q. Palsy or cerebral palsy? (ser'a-bral)</td> </tr> <tr> <td style="padding: 2px;">E. Cataracts?</td> <td style="padding: 2px;">R. Paralysis of any kind?</td> </tr> <tr> <td style="padding: 2px;">F. Glaucoma?</td> <td style="padding: 2px;">S. Curvature of the spine?</td> </tr> <tr> <td style="padding: 2px;">G. Color blindness?</td> <td style="padding: 2px;">T. REPEATED trouble with neck, back, or spine?</td> </tr> <tr> <td style="padding: 2px;">H. A detached retina or any other condition of the retina?</td> <td style="padding: 2px;">U. Any TROUBLE with fallen arches or flatfeet?</td> </tr> <tr> <td style="padding: 2px;">I. Any other trouble seeing with one or both eyes EVEN when wearing glasses?</td> <td style="padding: 2px;">V. A clubfoot?</td> </tr> <tr> <td style="padding: 2px;">J. A cleft palate or harelip?</td> <td style="padding: 2px;">W. A trick knee?</td> </tr> <tr> <td style="padding: 2px;">K. Stammering or stuttering?</td> <td style="padding: 2px;">X. PERMANENT stiffness or any deformity of the foot, leg, or back? (Permanent stiffness — joints will not move at all.)</td> </tr> <tr> <td style="padding: 2px;">L. Any other speech defect?</td> <td style="padding: 2px;">Y. PERMANENT stiffness or any deformity of the fingers, hand, or arm?</td> </tr> <tr> <td style="padding: 2px;">M. Loss of taste or smell which has lasted 3 months or more?</td> <td style="padding: 2px;">Z. Mental retardation?</td> </tr> <tr> <td style="padding: 2px;">N. A missing finger, hand, or arm; toe, foot, or leg?</td> <td style="padding: 2px;">AA. Any condition caused by an accident or injury which happened more than 3 months ago? If "Yes," ask: What is the condition?</td> </tr> </table> | } | Hearing Vision Speech | A. Deafness in one or both ears? | <i>Reask 2a</i> | B. Any other trouble hearing with one or both ears? | O. A missing joint? | C. Tinnitus or ringing in the ears? | P. A missing breast, kidney, or lung? | D. Blindness in one or both eyes? | Q. Palsy or cerebral palsy? (ser'a-bral) | E. Cataracts? | R. Paralysis of any kind? | F. Glaucoma? | S. Curvature of the spine? | G. Color blindness? | T. REPEATED trouble with neck, back, or spine? | H. A detached retina or any other condition of the retina? | U. Any TROUBLE with fallen arches or flatfeet? | I. Any other trouble seeing with one or both eyes EVEN when wearing glasses? | V. A clubfoot? | J. A cleft palate or harelip? | W. A trick knee? | K. Stammering or stuttering? | X. PERMANENT stiffness or any deformity of the foot, leg, or back? (Permanent stiffness — joints will not move at all.) | L. Any other speech defect? | Y. PERMANENT stiffness or any deformity of the fingers, hand, or arm? | M. Loss of taste or smell which has lasted 3 months or more? | Z. Mental retardation? | N. A missing finger, hand, or arm; toe, foot, or leg? | AA. Any condition caused by an accident or injury which happened more than 3 months ago? If "Yes," ask: What is the condition? |
| C. Arthritis of any kind or rheumatism? | <i>Reask 1d</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D. Gout? | M. A tumor, cyst, or growth of the skin? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E. Lumbago? | N. Skin cancer? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F. Sciatica? | O. Eczema or Psoriasis? (ek'sa-ma) or (so-rye'uh-sis) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| G. A bone cyst or bone spur? | P. TROUBLE with dry or itching skin? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| H. Any other disease of the bone or cartilage? | Q. TROUBLE with acne? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I. A slipped or ruptured disc? | R. A skin ulcer? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| J. REPEATED trouble with neck, back, or spine? | S. Any kind of skin allergy? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| K. Bursitis? | T. Dermatitis or any other skin trouble? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L. Any disease of the muscles or tendons? | U. TROUBLE with ingrown toenails or fingernails? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | V. TROUBLE with bunions, corns, or calluses? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | W. Any disease of the hair or scalp? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| } | Hearing Vision Speech | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| A. Deafness in one or both ears? | <i>Reask 2a</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B. Any other trouble hearing with one or both ears? | O. A missing joint? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. Tinnitus or ringing in the ears? | P. A missing breast, kidney, or lung? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D. Blindness in one or both eyes? | Q. Palsy or cerebral palsy? (ser'a-bral) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E. Cataracts? | R. Paralysis of any kind? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F. Glaucoma? | S. Curvature of the spine? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| G. Color blindness? | T. REPEATED trouble with neck, back, or spine? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| H. A detached retina or any other condition of the retina? | U. Any TROUBLE with fallen arches or flatfeet? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I. Any other trouble seeing with one or both eyes EVEN when wearing glasses? | V. A clubfoot? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| J. A cleft palate or harelip? | W. A trick knee? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| K. Stammering or stuttering? | X. PERMANENT stiffness or any deformity of the foot, leg, or back? (Permanent stiffness — joints will not move at all.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L. Any other speech defect? | Y. PERMANENT stiffness or any deformity of the fingers, hand, or arm? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| M. Loss of taste or smell which has lasted 3 months or more? | Z. Mental retardation? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| N. A missing finger, hand, or arm; toe, foot, or leg? | AA. Any condition caused by an accident or injury which happened more than 3 months ago? If "Yes," ask: What is the condition? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

FORM HIS-1 (1991) (8-27-90)

H. CONDITION LISTS 3 AND 4

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

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

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|----------------|--|-----------------------------------|---------------|----------------------------|---|-----------------|-------------|---------------|---------------------|---------------------|---------------------------|-----------------------------|-----------------------------|--------------|----------------------------------|-------------------------|---|----------------------------------|---|---------------|---|--------------------------|--|-------------------------------|--|--|--|---------------------------------------|-----------------|--------------|------------------------------|------------------------|---------------------|--------------|---------------------------------------|--|----------------------|------------------------|-------------------|--------------|-----------------------------|------------------------|---------------------------------|---------------------------|---------------------------------|---------------|---|-------------------|---|--------------------------------|--|----------------------|--------------------------------|
| 3 | <p>3a. DURING THE PAST 12 MONTHS, did anyone in the family {read names} have — If "Yes," ask 3b and c.</p> <p>b. Who was this?</p> <p>c. DURING THE PAST 12 MONTHS, did anyone else have — Enter condition and letter in appropriate person's column. Make no entry in item C2 for cold; flu; red, sore, or strep throat; or "virus" even if reported in this list. Conditions affecting the digestive system.</p> | 4 | <p>4a. DURING THE PAST 12 MONTHS, did anyone in the family {read names} have — If "Yes," ask 4b and c.</p> <p>b. Who was this?</p> <p>c. DURING THE PAST 12 MONTHS, did anyone else have — Enter condition and letter in appropriate person's column. A—B are conditions affecting the glandular system. C is a blood condition. D—I are conditions affecting the nervous system. J—Y are conditions affecting the genito-urinary system.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;">A. Gallstones?</td> <td style="width: 50%; padding: 2px; text-align: center;"><i>Reask 3a</i></td> </tr> <tr> <td style="padding: 2px;">B. Any other gallbladder trouble?</td> <td style="padding: 2px;">N. Enteritis?</td> </tr> <tr> <td style="padding: 2px;">C. Cirrhosis of the liver?</td> <td style="padding: 2px;">O. Diverticulitis? (Dye-ver-tic-yoo-lye'tis)</td> </tr> <tr> <td style="padding: 2px;">D. Fatty liver?</td> <td style="padding: 2px;">P. Colitis?</td> </tr> <tr> <td style="padding: 2px;">E. Hepatitis?</td> <td style="padding: 2px;">Q. A spastic colon?</td> </tr> <tr> <td style="padding: 2px;">F. Yellow jaundice?</td> <td style="padding: 2px;">R. FREQUENT constipation?</td> </tr> <tr> <td style="padding: 2px;">G. Any other liver trouble?</td> <td style="padding: 2px;">S. Any other bowel trouble?</td> </tr> <tr> <td style="padding: 2px;">H. An ulcer?</td> <td style="padding: 2px;">T. Any other intestinal trouble?</td> </tr> <tr> <td style="padding: 2px;">I. A hernia or rupture?</td> <td style="padding: 2px;">U. Cancer of the stomach, intestines, colon, or rectum?</td> </tr> <tr> <td style="padding: 2px;">J. Any disease of the esophagus?</td> <td style="padding: 2px;">V. During the past 12 months, did anyone (else) in the family have any other condition of the digestive system?</td> </tr> <tr> <td style="padding: 2px;">K. Gastritis?</td> <td style="padding: 2px;"><i>If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask V.</i></td> </tr> <tr> <td style="padding: 2px;">L. FREQUENT indigestion?</td> <td></td> </tr> <tr> <td style="padding: 2px;">M. Any other stomach trouble?</td> <td></td> </tr> </table> | A. Gallstones? | <i>Reask 3a</i> | B. Any other gallbladder trouble? | N. Enteritis? | C. Cirrhosis of the liver? | O. Diverticulitis? (Dye-ver-tic-yoo-lye'tis) | D. Fatty liver? | P. Colitis? | E. Hepatitis? | Q. A spastic colon? | F. Yellow jaundice? | R. FREQUENT constipation? | G. Any other liver trouble? | S. Any other bowel trouble? | H. An ulcer? | T. Any other intestinal trouble? | I. A hernia or rupture? | U. Cancer of the stomach, intestines, colon, or rectum? | J. Any disease of the esophagus? | V. During the past 12 months, did anyone (else) in the family have any other condition of the digestive system? | K. Gastritis? | <i>If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask V.</i> | L. FREQUENT indigestion? | | M. Any other stomach trouble? | | | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;">A. A goiter or other thyroid trouble?</td> <td style="width: 50%; padding: 2px; text-align: center;"><i>Reask 4a</i></td> </tr> <tr> <td style="padding: 2px;">B. Diabetes?</td> <td style="padding: 2px;">N. Any other kidney trouble?</td> </tr> <tr> <td style="padding: 2px;">C. Anemia of any kind?</td> <td style="padding: 2px;">O. Bladder trouble?</td> </tr> <tr> <td style="padding: 2px;">D. Epilepsy?</td> <td style="padding: 2px;">P. Any disease of the genital organs?</td> </tr> <tr> <td style="padding: 2px;">E. REPEATED seizures, convulsions, or blackouts?</td> <td style="padding: 2px;">Q. A missing breast?</td> </tr> <tr> <td style="padding: 2px;">F. Multiple sclerosis?</td> <td style="padding: 2px;">R. Breast cancer?</td> </tr> <tr> <td style="padding: 2px;">G. Migraine?</td> <td style="padding: 2px;">S. *Cancer of the prostate?</td> </tr> <tr> <td style="padding: 2px;">H. FREQUENT headaches?</td> <td style="padding: 2px;">T. *Any other prostate trouble?</td> </tr> <tr> <td style="padding: 2px;">I. Neuralgia or neuritis?</td> <td style="padding: 2px;">U. **Trouble with menstruation?</td> </tr> <tr> <td style="padding: 2px;">J. Nephritis?</td> <td style="padding: 2px;">V. **A hysterectomy? If "Yes," ask: For what condition did — have a hysterectomy?</td> </tr> <tr> <td style="padding: 2px;">K. Kidney stones?</td> <td style="padding: 2px;">W. **A tumor, cyst, or growth of the uterus or ovaries?</td> </tr> <tr> <td style="padding: 2px;">L. REPEATED kidney infections?</td> <td style="padding: 2px;">X. **Any other disease of the uterus or ovaries?</td> </tr> <tr> <td style="padding: 2px;">M. A missing kidney?</td> <td style="padding: 2px;">Y. **Any other female trouble?</td> </tr> </table> <p style="font-size: small; margin-top: 5px;">*Ask only if males in family. **Ask only if females in family.</p> | A. A goiter or other thyroid trouble? | <i>Reask 4a</i> | B. Diabetes? | N. Any other kidney trouble? | C. Anemia of any kind? | O. Bladder trouble? | D. Epilepsy? | P. Any disease of the genital organs? | E. REPEATED seizures, convulsions, or blackouts? | Q. A missing breast? | F. Multiple sclerosis? | R. Breast cancer? | G. Migraine? | S. *Cancer of the prostate? | H. FREQUENT headaches? | T. *Any other prostate trouble? | I. Neuralgia or neuritis? | U. **Trouble with menstruation? | J. Nephritis? | V. **A hysterectomy? If "Yes," ask: For what condition did — have a hysterectomy? | K. Kidney stones? | W. **A tumor, cyst, or growth of the uterus or ovaries? | L. REPEATED kidney infections? | X. **Any other disease of the uterus or ovaries? | M. A missing kidney? | Y. **Any other female trouble? |
| A. Gallstones? | <i>Reask 3a</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B. Any other gallbladder trouble? | N. Enteritis? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. Cirrhosis of the liver? | O. Diverticulitis? (Dye-ver-tic-yoo-lye'tis) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D. Fatty liver? | P. Colitis? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E. Hepatitis? | Q. A spastic colon? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F. Yellow jaundice? | R. FREQUENT constipation? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| G. Any other liver trouble? | S. Any other bowel trouble? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| H. An ulcer? | T. Any other intestinal trouble? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I. A hernia or rupture? | U. Cancer of the stomach, intestines, colon, or rectum? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| J. Any disease of the esophagus? | V. During the past 12 months, did anyone (else) in the family have any other condition of the digestive system? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| K. Gastritis? | <i>If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask V.</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L. FREQUENT indigestion? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| M. Any other stomach trouble? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| A. A goiter or other thyroid trouble? | <i>Reask 4a</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B. Diabetes? | N. Any other kidney trouble? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. Anemia of any kind? | O. Bladder trouble? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D. Epilepsy? | P. Any disease of the genital organs? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E. REPEATED seizures, convulsions, or blackouts? | Q. A missing breast? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F. Multiple sclerosis? | R. Breast cancer? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| G. Migraine? | S. *Cancer of the prostate? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| H. FREQUENT headaches? | T. *Any other prostate trouble? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I. Neuralgia or neuritis? | U. **Trouble with menstruation? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| J. Nephritis? | V. **A hysterectomy? If "Yes," ask: For what condition did — have a hysterectomy? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| K. Kidney stones? | W. **A tumor, cyst, or growth of the uterus or ovaries? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L. REPEATED kidney infections? | X. **Any other disease of the uterus or ovaries? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| M. A missing kidney? | Y. **Any other female trouble? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

FORM HIS-1 (1991) (8-27-90)

H. CONDITION LISTS 5 AND 6

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

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

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--|-----------------------------|-------------------------------|---|-------------------------------------|------------------------------|-----------------------------|----------------------------|----------------------------|--|--|--------------------------|---------------------|--------------------------------|--------------------|--------------------|--------------------------|-----------------------------|-----------------------------------|----------------------------------|---|--|----------------|---------------------------------|------------|-----------------|---------------|---------------|-------------------|--------------|-------------------|------------------|--|--|--|---|-----------------|--|---|--|---|--|
| <p style="font-size: 24pt; font-weight: bold; text-align: center;">5</p> <p>5a. Has anyone in the family {read names} EVER had — If "Yes," ask 5b and c.</p> <p>b. Who was this?</p> <p>c. Has anyone else EVER had — Enter condition and letter in appropriate person's column. Conditions affecting the heart and circulatory system.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width: 50%; padding: 2px;">A. Rheumatic fever?</td> <td style="width: 50%; padding: 2px;">G. A stroke or a cerebrovascular accident? (ser'a-bro vas ku-lar)</td> </tr> <tr> <td style="padding: 2px;">B. Rheumatic heart disease?</td> <td style="padding: 2px;">H. A hemorrhage of the brain?</td> </tr> <tr> <td style="padding: 2px;">C. Hardening of the arteries or arteriosclerosis?</td> <td style="padding: 2px;">I. Angina pectoris? (pek'to-ris)</td> </tr> <tr> <td style="padding: 2px;">D. Congenital heart disease?</td> <td style="padding: 2px;">J. A myocardial infarction?</td> </tr> <tr> <td style="padding: 2px;">E. Coronary heart disease?</td> <td style="padding: 2px;">K. Any other heart attack?</td> </tr> <tr> <td style="padding: 2px;">F. Hypertension, sometimes called high blood pressure?</td> <td></td> </tr> </table> <p>5d. DURING THE PAST 12 MONTHS, did anyone in the family have — If "Yes," ask 5e and f.</p> <p>e. Who was this?</p> <p>f. DURING THE PAST 12 MONTHS, did anyone else have — Enter condition and letter in appropriate person's column. Conditions affecting the heart and circulatory system.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width: 50%; padding: 2px;">L. Damaged heart valves?</td> <td style="width: 50%; padding: 2px;">Q. Any blood clots?</td> </tr> <tr> <td style="padding: 2px;">M. Tachycardia or rapid heart?</td> <td style="padding: 2px;">R. Varicose veins?</td> </tr> <tr> <td style="padding: 2px;">N. A heart murmur?</td> <td style="padding: 2px;">S. Hemorrhoids or piles?</td> </tr> <tr> <td style="padding: 2px;">O. Any other heart trouble?</td> <td style="padding: 2px;">T. Phlebitis or thrombophlebitis?</td> </tr> <tr> <td style="padding: 2px;">P. An aneurysm? (an yoo-rizm)</td> <td style="padding: 2px;">U. Any other condition affecting blood circulation?</td> </tr> </table> | A. Rheumatic fever? | G. A stroke or a cerebrovascular accident? (ser'a-bro vas ku-lar) | B. Rheumatic heart disease? | H. A hemorrhage of the brain? | C. Hardening of the arteries or arteriosclerosis? | I. Angina pectoris? (pek'to-ris) | D. Congenital heart disease? | J. A myocardial infarction? | E. Coronary heart disease? | K. Any other heart attack? | F. Hypertension, sometimes called high blood pressure? | | L. Damaged heart valves? | Q. Any blood clots? | M. Tachycardia or rapid heart? | R. Varicose veins? | N. A heart murmur? | S. Hemorrhoids or piles? | O. Any other heart trouble? | T. Phlebitis or thrombophlebitis? | P. An aneurysm? (an yoo-rizm) | U. Any other condition affecting blood circulation? | <p style="font-size: 24pt; font-weight: bold; text-align: center;">6</p> <p>6a. DURING THE PAST 12 MONTHS, did anyone in the family {read names} have — If "Yes," ask 6b and c.</p> <p>b. Who was this?</p> <p>c. DURING THE PAST 12 MONTHS, did anyone else have — Enter condition and letter in appropriate person's column. Make no entry in item C2 for cold; flu; red, sore, or strep throat; or "virus" even if reported in this list. Conditions affecting the respiratory system.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width: 50%; padding: 2px;">A. Bronchitis?</td> <td style="width: 50%; padding: 2px;">Reask 6a. K. A missing lung?</td> </tr> <tr> <td style="padding: 2px;">B. Asthma?</td> <td style="padding: 2px;">L. Lung cancer?</td> </tr> <tr> <td style="padding: 2px;">C. Hay fever?</td> <td style="padding: 2px;">M. Emphysema?</td> </tr> <tr> <td style="padding: 2px;">D. Sinus trouble?</td> <td style="padding: 2px;">N. Pleurisy?</td> </tr> <tr> <td style="padding: 2px;">E. A nasal polyp?</td> <td style="padding: 2px;">O. Tuberculosis?</td> </tr> <tr> <td style="padding: 2px;">F. A deflected or deviated nasal septum?</td> <td style="padding: 2px;">P. Any other work-related respiratory condition, such as dust on the lungs, silicosis, asbestosis, or pneu-mo-co-ni-o-sis?</td> </tr> <tr> <td style="padding: 2px;">G. *Tonsillitis or enlargement of the tonsils or adenoids?</td> <td style="padding: 2px;">Q. During the past 12 months did anyone (else) in the family have any other respiratory, lung, or pulmonary condition? If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask Q.</td> </tr> <tr> <td style="padding: 2px;">H. *Laryngitis?</td> <td></td> </tr> <tr> <td style="padding: 2px;">I. A tumor or growth of the throat, larynx, or trachea?</td> <td></td> </tr> <tr> <td style="padding: 2px;">J. A tumor or growth of the bronchial tube or lung?</td> <td></td> </tr> </table> <p style="font-size: 10pt; margin-top: 5px;">*If reported in this list only, ask:</p> <p>1. How many times did — have (condition) in the past 12 months? If 2 or more times, enter condition in item C2. If only 1 time, ask:</p> <p>2. How long did it last? If 1 month or longer, enter in item C2. If less than 1 month, do not record. If tonsils or adenoids were removed during past 12 months, enter the condition causing removal in item C2.</p> | A. Bronchitis? | Reask 6a. K. A missing lung? | B. Asthma? | L. Lung cancer? | C. Hay fever? | M. Emphysema? | D. Sinus trouble? | N. Pleurisy? | E. A nasal polyp? | O. Tuberculosis? | F. A deflected or deviated nasal septum? | P. Any other work-related respiratory condition, such as dust on the lungs, silicosis, asbestosis, or pneu-mo-co-ni-o-sis? | G. *Tonsillitis or enlargement of the tonsils or adenoids? | Q. During the past 12 months did anyone (else) in the family have any other respiratory, lung, or pulmonary condition? If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask Q. | H. *Laryngitis? | | I. A tumor or growth of the throat, larynx, or trachea? | | J. A tumor or growth of the bronchial tube or lung? | |
| A. Rheumatic fever? | G. A stroke or a cerebrovascular accident? (ser'a-bro vas ku-lar) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B. Rheumatic heart disease? | H. A hemorrhage of the brain? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. Hardening of the arteries or arteriosclerosis? | I. Angina pectoris? (pek'to-ris) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D. Congenital heart disease? | J. A myocardial infarction? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E. Coronary heart disease? | K. Any other heart attack? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F. Hypertension, sometimes called high blood pressure? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L. Damaged heart valves? | Q. Any blood clots? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| M. Tachycardia or rapid heart? | R. Varicose veins? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| N. A heart murmur? | S. Hemorrhoids or piles? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| O. Any other heart trouble? | T. Phlebitis or thrombophlebitis? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| P. An aneurysm? (an yoo-rizm) | U. Any other condition affecting blood circulation? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| A. Bronchitis? | Reask 6a. K. A missing lung? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B. Asthma? | L. Lung cancer? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. Hay fever? | M. Emphysema? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D. Sinus trouble? | N. Pleurisy? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E. A nasal polyp? | O. Tuberculosis? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F. A deflected or deviated nasal septum? | P. Any other work-related respiratory condition, such as dust on the lungs, silicosis, asbestosis, or pneu-mo-co-ni-o-sis? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| G. *Tonsillitis or enlargement of the tonsils or adenoids? | Q. During the past 12 months did anyone (else) in the family have any other respiratory, lung, or pulmonary condition? If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask Q. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| H. *Laryngitis? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I. A tumor or growth of the throat, larynx, or trachea? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| J. A tumor or growth of the bronchial tube or lung? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

FORM HIS-1 (1991) (8-27-90)

L. DEMOGRAPHIC BACKGROUND PAGE

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

FORM HIS-1 (11991) (8-27-90)

L. DEMOGRAPHIC BACKGROUND PAGE, Continued

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

L.DEMOGRAPHIC BACKGROUND PAGE, Continued

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|-----------------------------|----------------------------|----------------------------|--|----------------------------|----------------------------|--|----------------------------|----------------------------|--|
| <p>Mark box if under 14. If "Married" refer to household composition and mark accordingly.</p> <p>7. Is — now married, widowed, divorced, separated, or has — never been married?</p> | | <p>7.</p> <p><input type="checkbox"/> Under 14</p> <p><input type="checkbox"/> Married — spouse in HH</p> <p><input type="checkbox"/> Married — spouse not in HH</p> <p><input type="checkbox"/> Widowed</p> <p><input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Separated</p> <p><input type="checkbox"/> Never married</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>8a. Was the total combined FAMILY income during the past 12 months — that is, yours, (read names, including Armed Forces members living at home) more or less than \$20,000? Include money from jobs, social security, retirement income, unemployment payments, public assistance, and so forth. Also include income from interest, dividends, net income from business, farm, or rent, and any other money income received.</p> <p><i>Read if necessary: Income is important in analyzing the health information we collect. For example, this information helps us to learn whether persons in one income group use certain types of medical care services or have certain conditions more or less often than those in another group.</i></p> <p><i>Read parenthetical phrase if Armed Forces member living at home or if necessary.</i></p> <p>b. Of those income groups, which letter best represents the total combined FAMILY income during the past 12 months (that is, yours, (read names, including Armed Forces members living at home))? Include wages, salaries, and other items we just talked about.</p> <p><i>Read if necessary: Income is important in analyzing the health information we collect. For example, this information helps us to learn whether persons in one income group use certain types of medical care services or have certain conditions more or less often than those in another group.</i></p> | | <p>8a.</p> <p><input type="checkbox"/> \$20,000 or more (Hand Card I)</p> <p><input type="checkbox"/> Less than \$20,000 (Hand Card J)</p> <p>b.</p> <table border="0"> <tr> <td><input type="checkbox"/> A</td> <td><input type="checkbox"/> K</td> <td><input type="checkbox"/> U</td> </tr> <tr> <td><input type="checkbox"/> B</td> <td><input type="checkbox"/> L</td> <td><input type="checkbox"/> V</td> </tr> <tr> <td><input type="checkbox"/> C</td> <td><input type="checkbox"/> M</td> <td><input type="checkbox"/> W</td> </tr> <tr> <td><input type="checkbox"/> D</td> <td><input type="checkbox"/> N</td> <td><input type="checkbox"/> X</td> </tr> <tr> <td><input type="checkbox"/> E</td> <td><input type="checkbox"/> O</td> <td><input type="checkbox"/> Y</td> </tr> <tr> <td><input type="checkbox"/> F</td> <td><input type="checkbox"/> P</td> <td><input type="checkbox"/> Z</td> </tr> <tr> <td><input type="checkbox"/> G</td> <td><input type="checkbox"/> Q</td> <td><input type="checkbox"/> ZZ</td> </tr> <tr> <td><input type="checkbox"/> H</td> <td><input type="checkbox"/> R</td> <td></td> </tr> <tr> <td><input type="checkbox"/> I</td> <td><input type="checkbox"/> S</td> <td></td> </tr> <tr> <td><input type="checkbox"/> J</td> <td><input type="checkbox"/> T</td> <td></td> </tr> </table> | <input type="checkbox"/> A | <input type="checkbox"/> K | <input type="checkbox"/> U | <input type="checkbox"/> B | <input type="checkbox"/> L | <input type="checkbox"/> V | <input type="checkbox"/> C | <input type="checkbox"/> M | <input type="checkbox"/> W | <input type="checkbox"/> D | <input type="checkbox"/> N | <input type="checkbox"/> X | <input type="checkbox"/> E | <input type="checkbox"/> O | <input type="checkbox"/> Y | <input type="checkbox"/> F | <input type="checkbox"/> P | <input type="checkbox"/> Z | <input type="checkbox"/> G | <input type="checkbox"/> Q | <input type="checkbox"/> ZZ | <input type="checkbox"/> H | <input type="checkbox"/> R | | <input type="checkbox"/> I | <input type="checkbox"/> S | | <input type="checkbox"/> J | <input type="checkbox"/> T | |
| <input type="checkbox"/> A | <input type="checkbox"/> K | <input type="checkbox"/> U | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> B | <input type="checkbox"/> L | <input type="checkbox"/> V | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> C | <input type="checkbox"/> M | <input type="checkbox"/> W | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> D | <input type="checkbox"/> N | <input type="checkbox"/> X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> E | <input type="checkbox"/> O | <input type="checkbox"/> Y | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> F | <input type="checkbox"/> P | <input type="checkbox"/> Z | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> G | <input type="checkbox"/> Q | <input type="checkbox"/> ZZ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> H | <input type="checkbox"/> R | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> I | <input type="checkbox"/> S | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> J | <input type="checkbox"/> T | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| R | a. Mark first appropriate box. | <p>Ra.</p> <p><input type="checkbox"/> Present for all questions</p> <p><input type="checkbox"/> Present for some questions</p> <p><input type="checkbox"/> Not present</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. Enter person number of respondent. | <p>b.</p> <p>_____</p> <p>Person number(s) of respondent(s)</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L3 | Enter person number of first parent listed or mark box. | <p>L3</p> <p>_____</p> <p>Person number of parent</p> <p><input type="checkbox"/> None in household</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L4 | Enter person number of spouse or mark box. | <p>L4</p> <p>_____</p> <p>Person number of spouse</p> <p><input type="checkbox"/> None in household</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

FOOTNOTES

L. DEMOGRAPHIC BACKGROUND PAGE, Continued

Read to Hhld. respondent: **The National Center for Health Statistics may wish to contact you again to obtain additional health related information. Please give me the name, address, and telephone number of a relative or friend who would know where you could be reached in case we have trouble reaching you. (Please give me the name of someone who is not currently living in the household.) Please print items 12-15.**

| | |
|---|---|
| 12. Contact Person name Last 3-4 5-24 First 25-39 40 Middle initial | 14. Area code/telephone number <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div> |
| 13a. Address (Number and street) b. City 66-85 State 86-87 ZIP Code 88-96 | 1 <input type="checkbox"/> None 2 <input type="checkbox"/> Refused 9 <input type="checkbox"/> DK |
| 15. Relationship to household respondent | |

FOOTNOTES

CARD R

RACE

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

CARD O

ORIGIN

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

R
O

(Cut along broken line)

CARD I

INCOME

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

CARD J

INCOME

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

I
J

(Cut along broken line)