

**Section B – UNINTENTIONAL INJURIES**

**PERSON 1**

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These questions are about injuries.

**1 a. During the past 12 months, did anyone in the family have a head injury where he or she lost consciousness or completely blacked out?**

**1 a.** 1  Yes (1b)  
2  No } (B1)  
9  DK }

**b. Who was this?**  
Mark "Head injury" box in appropriate person's column.

**b.** 1  Head injury

**c. Did anyone else have such a head injury in the past 12 months?**

**c.** 1  Yes (Reask 1b and c)  
2  No } (B1)  
9  DK }

**ITEM B1**

Refer to 1b

**B1.** 1  Head injury in 1b (2)  
8  Other (B2)

**2 a. How many head injuries did --- have in the past 12 months where --- lost consciousness or completely blacked out?**

**2 a.** \_\_\_\_\_ Head injuries  
(Number)

**b. Did --- receive medical care for --- most recent head injury?**

**b.** 1  Yes (2c)  
2  No } (2e)  
9  DK }

**c. Where did --- FIRST get medical care for this head injury, at a doctor's office, clinic, hospital, or some other place? (Do not count care in an ambulance).**

**If doctor's office: Was this office in a hospital?**

**If hospital: Was it the emergency room or an outpatient clinic?**

**If clinic: Was it a hospital outpatient clinic, a company clinic, or some other kind of clinic?**

**c.** Non-hospital:  
01  Doctor's office  
02  Company clinic  
03  Urgent care center  
04  Other clinic  
05  Other non-hospital - Specify  $\nabla$

Hospital:  
06  Outpatient clinic  
07  Emergency room  
08  Doctor's office  
98  Other hospital - Specify  $\nabla$

99  DK

**d. Did --- stay in a hospital overnight or longer because of this head injury?**

**d.** 1  Yes (2f)  
2  No } (2e)  
9  DK }

**e. Did this head injury cause --- to cut down for more than half of the day on the things --- usually does?**

**e.** 1  Yes } (3a)  
2  No }  
9  DK }

**f. Altogether, how many nights did --- stay in the hospital because of this head injury?**

**f.** \_\_\_\_\_ Nights  
(Number)  
999  DK

**g. When --- was discharged from the hospital, was --- transferred to a rehabilitation center or extended care facility because of this head injury?**

**g.** 1  Yes } (3a)  
2  No }  
9  DK }

Notes

Section B -- UNINTENTIONAL INJURIES -- Continued		PERSON 1
3a. Where did -- head injury happen?		19 3a. 1 <input type="checkbox"/> At home (inside house or adjacent premises) 2 <input type="checkbox"/> Street or highway (includes roadway and public sidewalks) 3 <input type="checkbox"/> Industrial place (includes premises) 4 <input type="checkbox"/> School (includes premises) 5 <input type="checkbox"/> Place of recreation and sports, except at school 8 <input type="checkbox"/> Other 9 <input type="checkbox"/> DK
b. Was -- at work at -- job or business when this head injury occurred?		20 b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
c. What was the cause of this head injury?		21 c. 1 <input type="checkbox"/> Motor vehicle accident 2 <input type="checkbox"/> Other accident - Specify ↓ _____ 3 <input type="checkbox"/> Assault (Item B2) 4 <input type="checkbox"/> Other non-accident - Specify ↓ _____ 9 <input type="checkbox"/> DK
d. At the time of the head injury, was -- playing sports or engaged in some other physical activity or exercise? <i>Mark box or ask.</i>		22 d. 1 <input type="checkbox"/> Playing sports 2 <input type="checkbox"/> Other physical activity - Specify ↓ _____ 3 <input type="checkbox"/> Not playing sports or other physical activity 9 <input type="checkbox"/> DK
<b>ITEM B2</b>	<i>Refer to age</i>	23 B2. 1 <input type="checkbox"/> Under 65 (Item B1 for NP) 2 <input type="checkbox"/> 65 and over (4)
4a. During the past 12 months, has -- fallen?		24 4a. 1 <input type="checkbox"/> Yes (4b) 2 <input type="checkbox"/> No } (Item B1 for NP) 9 <input type="checkbox"/> DK }
b. How many times?		25 b. _____ Times (Number) 9 <input type="checkbox"/> DK
c. Did -- break -- hip as a result of [this/any of these] fall(s)?		26 c. 1 <input type="checkbox"/> Yes (Item B1 for NP) 2 <input type="checkbox"/> No } (4d) 9 <input type="checkbox"/> DK }
d. [Did this fall result/how many of these falls resulted] in an injury where -- had to cut down for more than half of the day on the things -- usually does?		27 d. 0 <input type="checkbox"/> No/None _____ (Number) Fall(s) 9 <input type="checkbox"/> DK
e. (For how many of these falls) Did -- receive medical care?		28 e. 0 <input type="checkbox"/> No/None } _____ (Number) Fall(s) } (Item B1 for NP) 9 <input type="checkbox"/> DK }