
Vital and Health Statistics

Questionnaires From the National Health Interview Survey, 1985–89

Series 1: Programs and Collection Procedures No. 31

This report is the second in a series of reports that describe questionnaires from the National Health Interview Survey. This volume includes the questions used in the National Health Interview Survey from 1985 to 1989. The report contains the basic health and demographic questionnaires and current health topic questionnaires.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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National Center for Health Statistics

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Preface

The National Center for Health Statistics (NCHS) published the first volume of a series of reports focusing on the current health topic questions used in the National Health Interview Survey (NHIS) in 1989. The first report included questions from 1980 through 1984. This report is the second in the series and describes those current health topic questions used in the NHIS from 1985 through 1989. The report also contains the basic health and demographic questionnaire for 1989. The questions in the basic questionnaire have not changed since 1985.

In 1985, however, a new sample design for the NHIS and a different method of presenting sampling errors were introduced. Information about the new sample design features can be found in each of the *Current Estimates* from the NHIS beginning in 1985 and in the *Vital and Health Statistics* series report entitled *Design and Estimation for the National Health Interview Survey, 1985-94*.

The majority of the responses to the NHIS are available on public-use data tapes. As with the first volume, it should be noted that not every question included in a survey instrument appears on an NHIS public-use data tape. The information might have been excluded because

of NCHS' confidentiality provisions, combining of variables as a result of recodes, or factors relating to the data's reliability. Variables may also appear on the public-use data tape that were not in the questionnaire.

Public-use data tapes of NHIS surveys from 1985 through 1989 are available for sale through the National Technical Information Service. These files include household, person condition, hospital episodes, and doctor visit records. A complete listing of NHIS data tapes can be found in NCHS' *Catalog of Electronic Data Products*. Complimentary copies of the catalog are available from NCHS' Data Dissemination Branch, Room 1064, Presidential Building, 6525 Belcrest Road, Hyattsville, Maryland 20782.

Questionnaires on current health topics are organized by year, beginning with 1985. Introductions precede each year's questionnaires and summarize the data collection activity, highlighting the main differences, if any, from previous years.

Public-use data tapes of the current health topics for 1985 through 1989 can be purchased from the Division of Health Interview Statistics at NCHS.

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Symbols

- Data not available
 - . . . Category not applicable
 - Quantity zero
 - 0.0 Quantity more than zero but less than 0.05
 - Z Quantity more than zero but less than 500 where numbers are rounded to thousands
 - * Figure does not meet standard of reliability or precision
 - # Figure suppressed to comply with confidentiality requirements
-

Questionnaires From the National Health Interview Survey, 1985–89

by Michele M. Chyba, Division of Health Interview Statistics, and Linda R. Washington, Division of Data Services

Overview of the National Health Interview Survey

Background

The National Health Interview Survey (NHIS) is the principal source of information on the health of the civilian noninstitutionalized population of the United States. NHIS is one of the major data collection programs of the National Center for Health Statistics. The National Health Survey Act of 1956 provided for a continuing survey and special studies to secure accurate and current statistical information on the amount, distribution, and effects of illness and disability in the United States and the services rendered for or because of such conditions. The survey referred to in the Act, now called the National Health Interview Survey, was initiated in July 1957. Since 1960, the survey has been conducted by the National Center for Health Statistics, which was formed when the National Health Survey and the National Office of Vital Statistics were combined.

Purpose and scope

The objective of the survey is to address major current health issues through the collection and analysis of data on the civilian noninstitutionalized population of the United States. National data on the incidence of acute illness and injuries, the prevalence of chronic conditions and impairments, the extent of disability, the utilization of health care services, and other health-related topics are provided through the survey. A major strength of this survey lies in its ability to display these health factors by many demographic and socioeconomic characteristics.

The NHIS data are obtained through personal interviews with household members. Interviews are conducted each week throughout the year in a probability sample of households. The households selected for interview are a

probability sample representative of the civilian noninstitutionalized population of the United States. Data are collected from approximately 50,000 households, including about 135,000 persons in a calendar year. Participation is voluntary, and confidentiality of responses is guaranteed. The annual response rate of NHIS is over 95 percent of the eligible households in the sample. The nonresponse is divided equally between refusals and households in which no eligible respondents could be found at home after repeated calls.

Interviewing is performed by a permanent staff of interviewers employed by the U.S. Bureau of the Census. Data collected over the period of a year form the basis for the development of annual estimates of the health characteristics of the population and for the analysis of trends in those characteristics. Additional information about data collection procedures can be found in appendix I of *Vital and Health Statistics Series 10, No. 175, "Current Estimates From the National Health Interview Survey, 1989."*

The survey covers the civilian noninstitutionalized population of the United States living at the time of the interview. Because of technical and logistical problems, several segments of the population are not included in the sample or in the estimates from the survey. Persons excluded are patients in long-term care facilities, persons on active duty with the Armed Forces (although their dependents are included), and U.S. nationals living in foreign countries. Appendix II describes the NHIS design and estimation structures.

The questionnaire consists of two parts: a set of basic health and demographic items and one set or more of questions on current health topics. The basic items constitute approximately 50 percent of the questionnaire and are repeated each year. They provide continuous information on basic health variables. Questions on current health topics facilitate a response to changing needs for data and coverage of a wide variety of issues. This combination yields a unique national health data base.

Content of questionnaires

Basic health and demographic questionnaire (formerly core)

The questionnaire includes the following types of basic health and demographic questions.

NOTE: The authors are grateful for the assistance and support received in preparing this report. Support was received from Linda Purvin for typing. We would also like to acknowledge technical assistance provided by Susan S. Jack, NHIS, and response data from Michael Zukauskas, U.S. Bureau of the Census. Technical assistance was also provided by staff of the Systems and Programming Branch, especially Nancy Gagne. The authors are greatly appreciative of the appendix, "NHIS Design and Estimation Structures," prepared by NCHS staff Steve Botman, Van Parsons, Randy Curtin, and John Horn.

- Demographic characteristics of household members, including age, sex, race, education, and family income
- Disability days, including restricted-activity and bed-disability days; work and school-loss days occurring during the 2-week period prior to the week of interview; and bed days during the last 12 months
- Physician visits occurring in the same 2-week period, interval since the last physician visit, and number of visits in the last 12 months
- Acute and chronic conditions responsible for these days and visits
- Long-term limitation of activity resulting from chronic disease or impairment and the chronic conditions associated with the disability
- Short-stay hospitalization data, including the number of hospital episodes during the past year and the number of days for each year

Data tapes, with findings from the NHIS basic health and demographic questionnaire, can be purchased from the National Technical Information Service (703) 487-4650. These files include household, person, condition, hospital episode, and doctor visit records.

Survey instruments

Basic health and demographic questionnaires: 1985–89

The first part of the NHIS questionnaire, the basic health and demographic questionnaire, contains questions on acute conditions, the prevalence of chronic conditions, persons limited in activity due to impairment or health problems, and utilization of health care services involving physician care and short-stay hospitalization. These questions more or less remain the same from year to year.

The 1985 NHIS sample consisted of approximately 34,844 households containing 91,531 persons. The total interview rate was about 4.3 percent.

New sample design features were initiated for the 1985–94 NHIS. One new feature is that the full NHIS sample can be partitioned into four panels. Each individual panel is a representative sample of the U.S. civilian noninstitutionalized population. Each individual panel also has the same sampling properties, and any combination of panels defines a national design.

This feature enables large reductions in the sample size to be made efficiently. Additional information about the 1985–89 NHIS sample survey can be found in *“Current*

Estimates from the National Health Interview Survey” for any year beginning in 1985 (1). The redesign is also discussed by Massey et al in an NCHS *Vital and Health Statistics* series report (2).

Changes in the NHIS basic health and demographic questionnaire: 1985–89

There were minimal changes to the NHIS basic health and demographic questionnaire from 1985 through 1989. Since 1985, questions pertaining to the family members' city and State of birth, social security number, and father's last name, have been included.

In 1989, questions were added that obtained the location (city, county, and State) of any physician contact whether by telephone or in person and for family members born in the United States, how many years have they lived in the State of residence and for family members born in a foreign country, how many years have they lived in the United States. Section L, “Demographic Background Page,” shows the questionnaire changes as they appear in 1989. Only section L6, questions 9a, b, and c are included on the 1989 NHIS public-use data tape.

Characteristics of the current health topics of the National Health Interview Survey, 1985-89

Year and topic	Persons eligible for sample ¹	Number of persons in sample on public-use tape	Respondent rule ²	Response rate ³	Period weeks	Data collection		
						Panels ⁴	Location ⁵	Mode ⁶
1985								
Health promotion and disease prevention:								
Health promotion and disease prevention (HPDP)	One adult per family 18 years and over	33,630	a	90.1H	52	3	S	P
Smoking history during pregnancy	Female family members 18-44 years old	19,700	a	88.1H	52	3	S	P
Child safety and infant feeding	All children under 18 years	25,825	b	88.7H	52	3	S	P
1986								
Longest job worked	Family members 25 years and over	37,917	c	95.6H	52	2	C	P
Dental health	All family members	62,052	c	95.6H	52	2	S	P
Functional limitations	Family members 65 years and over	7,192	f	95.1B	52	2	S	P
Vitamin and mineral intake	One adult 18 years and over and one child 2-6 years old per family	11,500 adults 1,800 children 13,300 total	c,d	93.6H 94.5H 93.7H	52	2	S	P
Health insurance	All family members	62,052	c	96.0H	52	2	C	P
1987								
Cancer risk factors.	Each household was assigned to either the cancer control or cancer epidemiology sample							
Cancer control.	One adult per family 18 years and over	22,043	e	94.2H	52	4	S	P
Cancer epidemiology.	One adult per family 18 years and over	22,080	e	94.0H	52	4	S	P
Child adoption	Female family members 20-54 years old	31,124	g	79.6H	52	4	C	P
Poliomyelitis	Family members 26 years and over	73,574	h	91.6H	52	4	C	P
AIDS knowledge and attitudes	One adult per family 18 years and over	17,696	e	94.8H	August-December	...	S	P,A
1988								
Medical device implants	All family members	122,310	i	93.0H	52	4	S	P
Occupational health	One adult per family 18 years and over	44,233	e	86.5B	52	4	S	P
Alcohol use	One adult per family 18 years and over	43,809	e	85.9B	52	4	S	P
Child health	One child per family under 18 years	17,110	j	88.4B	52	4	S	P
AIDS knowledge and attitudes	One adult per family 18 years and over	29,659	e	84.5H	52	4	S	A

Characteristics of the current health topics of the National Health Interview Survey, 1985–89—Con.

Year and topic	Persons eligible for sample ¹	Number of persons in sample on public-use tape	Respondent rule ²	Response rate ³	Period weeks	Data collection		
						Panels ⁴	Location ⁵	Mode ⁶
1989								
Health insurance coverage	All family members	116,929	c	92.2H	52	4	S	P
Adult immunization	Family members 18 years and over	84,572	c	92.1H	52	4	S	P
Mental health	All family members	116,929	c	91.9H	52	4	S	P
Dental health	All family members	116,929	c	92.0H	52	4	S	P
Diabetes:								
Diabetes (initial screening and followup screening questions)	Family members 18 years and over (initial screening)	84,572	k	87.4H	52	4	S	P
	Family members 18 years and over who were ever told by doctor had diabetes (followup screening)		l	91.1H				
Diabetes risk factors	In one-half sample of the families, one adult per family 18 years and over, if nondiabetic	20,847	m	82.1H	52	4	S	P
Orofacial pain	One adult per family 18 years and over	42,370	m	86.4B	52	4	S	P
Digestive disorders	One adult per family 18 years and over	42,392	m	86.4B	52	4	S	P
AIDS: knowledge and attitudes	One adult per family 18 years and over	40,979	e	84.0H	52	4	S	A

¹Sample persons were randomly selected. Unrelated individuals living in households were considered to be one-member families.

²Respondent notes:

- a. The household respondent answered questions 1 and 2 in Section M. The remainder of Section M and the current health topic questions were completed by the sample person. A proxy was not accepted.
- b. The sample person answered the questions on child safety and infant feeding for each child in the family.
- c. Any responsible adult 19 years of age and over or any married person may have answered the questions for all family members. Single persons 17 or 18 years of age may have responded for him/herself.
- d. The household respondent answered questions for the sample child (2–6 years). A proxy was not accepted.
- e. Questions were answered by the sample person. A proxy was not accepted.
- f. The sample person was the preferred respondent. A proxy was acceptable (1) at the time of the interview if the sample person was physically or mentally incapable of responding or (2) after a callback if the sample person was not available. The proxy had to be a household member knowledgeable about the person or a caregiver.
- g. Questions were answered by the female household respondent, the adoptive mother, or whomever adopted the child. A knowledgeable proxy was accepted.
- h. The sample person was the preferred respondent. A proxy was accepted if the sample person was available at the time of interview. A parent or other knowledgeable person could have been the proxy. The parent did not have to be in the household.
- i. Implant questions were answered by the implant recipient unless he/she was absent or physically incapable of responding in which case a household respondent or knowledgeable person was accepted as a proxy.
- j. Questions in the P1 Section were answered by the household respondent. The remainder of the questions were answered by the preferred respondent. The preferred respondent was a related adult, the biological or adoptive mother, the biological father, an adult relative living with the person, legal guardian, or primary caretaker. The sample child could not respond for him/herself. The spouse could not respond for the sample child.
- k. Questions were answered by the household respondent.
- l. Questions 1 through 5 in Section Q2 were answered by the person who was identified as a diabetic by the household respondent. After confirmation that the person was a diabetic, the remaining questions were answered by the diabetic. A proxy was not accepted.
- m. Questions in Section M through Q1 were answered by the household respondent. The current health topic questions were completed by the sample person. A proxy was not accepted.

³Response rate: Response rates take into account both the basic questionnaire and the current health topic questionnaire response rates. The rates are calculated by multiplying the basic questionnaire response rate by the current health topic rate. See text description for additional information. "B" refers to numbers for response rate from the Bureau of the Census; "H" refers to numbers for response rate from the Division of Health Interview Statistics, NCHS.

⁴Number of panels in NHIS sample was reduced in some years due to budget considerations. A panel is a national probability sample consisting of one quarter of the households assigned for the year.

⁵Location of current health topic questions: "C" refers to the core/basic health and demographic questionnaire; "S" refers to the supplement/current health topics.

⁶Mode: All interviews were done in personal face-to-face interview in the home, a telephone callback was permitted. "P" refers to paper and pencil administration. "A" refers to computer-assisted personal interviewing (CAPI).

Source: Additional information about respondent rules and eligible sample persons can be found in the National Health Interview Survey Interviewer's Manual for the years 1985–89.

NOTICE — Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m). Public reporting burden for this collection of information is estimated to vary from 15 to 35 minutes per response, with an average of 25 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer, Room 721-H, Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201; ATTN: PRA, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503.

FORM **HIS-1 (1989)**
(7-15-88)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR THE
U.S. PUBLIC HEALTH SERVICE

NATIONAL HEALTH INTERVIEW SURVEY

1. Book ___ of ___ books	2. R.O. number	3. Sample
4. Segment type <input type="checkbox"/> Area <input type="checkbox"/> Permit <input type="checkbox"/> Block	5. Control number PSU Segment Serial	

6a. What is your exact address? (Include House No., Apt. No., or other identification, county and ZIP Code)

City _____ State _____ County _____ ZIP Code _____

b. Is this your mailing address? (Mark box or specify if different. Include county and ZIP Code.) Same as 6a

City _____ State _____ County _____ ZIP Code _____

c. Special place name _____ **Sample unit number** _____ **Type code** _____

LISTING SHEET

Sheet No. _____

Line No. _____

14. Noninterview reason

TYPE A

01 Refusal — Describe in footnotes
02 No one at home, repeated calls
03 Temporarily absent — Footnote
04 Other (Specify) _____

TYPE B

05 Vacant — nonseasonal
06 Vacant — seasonal
07 Occupied entirely by persons with URE
08 Occupied entirely by Armed Forces members
09 Unfit or to be demolished
10 Under construction, not ready
11 Converted to temporary business or storage
12 Unoccupied site for mobile home, trailer, or tent
13 Permit granted, construction not started
14 Other (Specify) _____

TYPE C

15 Unused line of listing sheet
16 Demolished
17 House or trailer moved
18 Outside segment
19 Converted to permanent business or storage
20 Merged
21 Condemned
22 Built after April 1, 1980
23 Other (Specify) _____

Fill items 1-6a, 7 and 9 as applicable: 10, 12-15

Fill items 1-6a, 7-9 as applicable: 10, 12-15

Fill items 1-6a, 8c if marked: 12-15, send Inter-Comm.

AREA AND BLOCK SEGMENTS

7. YEAR BUILT
 Ask
 Do not ask

When was this structure originally built?
 Before 4-1-80 (Continue interview)
 After 4-1-80 (Complete item 8c when required; end interview)

8. COVERAGE QUESTIONS
 Ask items that are marked
 Do not ask

a. Are there any occupied or vacant living quarters besides your own in this building? Yes (Fill Table X) No

b. Are there any occupied or vacant living quarters besides your own on this floor? Yes (Fill Table X) No

c. Is there any other building on this property for people to live in, either occupied or vacant? Yes (Fill Table X) No

9a. LAND USE
1 URBAN (10)
2 RURAL
— Reg. units and SP, PL. units coded 85-88 in 6c — Ask item 9b
— SP, PL. units not coded 85-88 in 6c — Mark "No" in item 9b without asking

b. During the past 12 months did sales of crops, livestock, and other farm products from this place amount to \$1,000 or more?
1 Yes } (10)
2 No }

15. Record of calls

Month	Date	Beginning time	Ending time	Completed Mark (X)
1		P T	a.m. p.m.	a.m. p.m.
2		P T	a.m. p.m.	a.m. p.m.
3		P T	a.m. p.m.	a.m. p.m.
4		P T	a.m. p.m.	a.m. p.m.
5		P T	a.m. p.m.	a.m. p.m.
6		P T	a.m. p.m.	a.m. p.m.

10. CLASSIFICATION OF LIVING QUARTERS — Mark by observation

a. LOCATION of unit
Unit is:
 In a Special Place — Refer to Table A in Part C of manual; then complete 10c or d
 NOT in a Special Place (10b)

b. Access
 Direct (10c)
 Through another unit — Not a separate HU; combine with unit through which access is gained. (Apply merged unit procedures if additional living quarters space was listed separately.)

c. HOUSING unit (Mark one, THEN page 2)
01 House, apartment, flat
02 HU in nontransient hotel, motel, etc.
03 HU-permanent in transient hotel, motel, etc.
04 HU in rooming house
05 Mobile home or trailer with no permanent room added
06 Mobile home or trailer with one or more permanent rooms added
07 HU not specified above — Describe in footnotes

d. OTHER unit (Mark one)
08 Quarters not HU in rooming or boarding house
09 Unit not permanent in transient hotel, motel, etc.
10 Unoccupied site for mobile home, trailer, or tent
11 Student quarters in college dormitory
12 OTHER unit not specified above — Describe in footnotes

16. List column numbers of persons requiring callbacks, and mark appropriately.

None

Household Resp.	Diabetic	Sample Person
Col. No.	SS No.	Col. No.

GO TO HOUSEHOLD COMPOSITION PAGE

11. What is the telephone number here? None Area code/number _____

12. Interview observed? 1 Yes 2 No

13a. Interviewer's name _____ **Code** _____

b. Language of interview
1 English 3 Both English and Spanish
2 Spanish 8 Other

17. Record of additional contacts

Month	Date	Beginning time	Ending time	Completed Col. No.
1		P T	a.m. p.m.	a.m. p.m.
2		P T	a.m. p.m.	a.m. p.m.
3		P T	a.m. p.m.	a.m. p.m.
4		P T	a.m. p.m.	a.m. p.m.

A. HOUSEHOLD COMPOSITION PAGE

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.

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 travelling 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?

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"/>

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 _____.

A3 Refer to ages of all related HH members.

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

Ask for each person in armed forces:
d. Where does --- usually live and sleep, here or somewhere else? Mark box in person's column.

If related persons 17 and over are listed in addition to the respondent and are not present, say:
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.

HOSPITAL PROBE

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

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

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

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

FOOTNOTES

1

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 Number	1 <input type="checkbox"/> Wa 2 <input type="checkbox"/> Wb	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	00 <input type="checkbox"/> None Number			
C2	LA	TRA	DV	TINJ.	TCLL	TR	HSTCOND.
	LA	TRA	DV	TINJ.	TCLL	TR	HSTCOND.
	LA	TRA	DV	TINJ.	TCLL	TR	HSTCOND.
	LA	TRA	DV	TINJ.	TCLL	TR	HSTCOND.
	LA	TRA	DV	TINJ.	TCLL	TR	HSTCOND.
A3	<input type="checkbox"/> All persons 65 and over (5) <input type="checkbox"/> Other (4)						
4d.	<input type="checkbox"/> Living at home <input type="checkbox"/> Not living at home						
6a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Mark "HOSP." box, THEN NP)						
b.	Number of times		(Make entry in "HOSP." box THEN NP)				
7a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)						
b.	<input type="checkbox"/> Yes (NP) <input type="checkbox"/> No (Correct 6 and "HOSP." box)						

B. LIMITATION OF ACTIVITIES PAGE

B1	<i>Refer to age.</i>	B1	1 <input type="checkbox"/> 18-69(1) 2 <input type="checkbox"/> Other (NP)
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>		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)
2a. Does any impairment or health problem NOW keep — from working at a job or business?		2a.	1 <input type="checkbox"/> Yes (7) <input type="checkbox"/> No
b. Is — limited in the kind OR amount of work — can do because of any impairment or health problem?		b.	2 <input type="checkbox"/> Yes (7) 3 <input type="checkbox"/> No (8)
3a. Does any impairment or health problem NOW keep — from doing any housework at all?		3a.	4 <input type="checkbox"/> Yes (4) <input type="checkbox"/> No
b. Is — limited in the kind OR amount of housework — can do because of any impairment or health problem?		b.	5 <input type="checkbox"/> Yes (4) 6 <input type="checkbox"/> No (5)
4a. 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 3 where limitation reported, saying: Except for — (condition), ...?</i> <i>OR reask 4b/c.</i>		4a.	(Enter condition in C2, THEN 4b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 4c)
b. Besides (condition) is there any other condition that causes this limitation?		b.	<input type="checkbox"/> Yes (Reask 4a and b) <input type="checkbox"/> No (4d)
c. Is this limitation caused by any (other) specific condition?		c.	<input type="checkbox"/> Yes (Reask 4a and b) <input type="checkbox"/> No
d. Which of these conditions would you say is the MAIN cause of this limitation? <i>Mark box if only one condition.</i>		d.	<input type="checkbox"/> Only 1 condition _____ Main cause
5a. Does any impairment or health problem keep — from working at a job or business?		5a.	1 <input type="checkbox"/> Yes (7) <input type="checkbox"/> No
b. Is — limited in the kind OR amount of work — could do because of any impairment or health problem?		b.	2 <input type="checkbox"/> Yes (7) 3 <input type="checkbox"/> No
B2	<i>Refer to questions 3a and 3b.</i>	B2	1 <input type="checkbox"/> "Yes" in 3a or 3b (NP) 2 <input type="checkbox"/> Other (6)
6a. Is — limited in ANY WAY in any activities because of an impairment or health problem?		6a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)
b. In what way is — limited? <i>Record limitation, not condition.</i>		b.	_____ Limitation
7a. 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 2, 5, or 6 where limitation reported, saying: Except for — (condition), ...?</i> <i>OR reask 7b/c.</i>		7a.	(Enter condition in C2, THEN 7b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 7c)
b. Besides (condition) is there any other condition that causes this limitation?		b.	<input type="checkbox"/> Yes (Reask 7a and b) <input type="checkbox"/> No (7d)
c. Is this limitation caused by any (other) specific condition?		c.	<input type="checkbox"/> Yes (Reask 7a and b) <input type="checkbox"/> No
d. Which of these conditions would you say is the MAIN cause of this limitation? <i>Mark box if only one condition.</i>		d.	<input type="checkbox"/> Only 1 condition _____ Main cause

B. LIMITATION OF ACTIVITIES PAGE, Continued

B3	Refer to age.	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 (8)
8. What was — doing MOST OF THE PAST 12 MONTHS; working at a job or business, keeping house, going to school, or something else? Priority if 2 or more activities reported: (1) Spent the most time doing; (2) Considers the most important.		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?		9a.	1 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No
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 (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?		10a.	<input type="checkbox"/> Yes 0 <input type="checkbox"/> No (13)
b. Is — limited in the kind OR amount of play activities — can do because of any impairment or health problem?		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?		11a.	1 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No
b. Does — attend a special school or special classes because of any impairment or health problem?		b.	2 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No
c. Does — need to attend a special school or special classes because of any impairment or health problem?		c.	3 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No
d. Is — limited in school attendance because of — health?		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?		12a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)
b. In what way is — limited? <i>Record limitation, not condition.</i>		b.	_____ Limitation
13a. What (other) condition causes this?		13a.	(Enter condition in C2, THEN 13b)
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 where limitation reported, saying: Except for — (condition), . . . ? OR reask 13b/c.			1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 13c)
b. Besides (condition) is there any other condition that causes this limitation?		b.	<input type="checkbox"/> Yes (Reask 13a and b) <input type="checkbox"/> No (13d)
c. Is this limitation caused by any (other) specific condition?		c.	<input type="checkbox"/> Yes (Reask 13a and b) <input type="checkbox"/> No
Mark box if only one condition. d. Which of these conditions would you say is the MAIN cause of this limitation?		d.	<input type="checkbox"/> Only 1 condition _____ Main cause

FOOTNOTES

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? ----- If under 18, skip to next person; otherwise ask:	14a.	1 <input type="checkbox"/> Yes (15) <input type="checkbox"/> No
	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.	15a.	(Enter condition in C2, THEN 15b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 15c)
	b. Besides (condition) is there any other condition that causes this limitation? -----	b.	<input type="checkbox"/> Yes (Reask 15a and b) <input type="checkbox"/> No (15d)
	c. Is this limitation caused by any (other) specific condition? -----	c.	<input type="checkbox"/> Yes (Reask 15a and b) <input type="checkbox"/> No
	Mark box if only one condition. d. Which of these conditions would you say is the MAIN cause of this limitation? -----	d.	<input type="checkbox"/> Only 1 condition _____ 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)

1a. 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)

2a. During those 2 weeks, did -- miss any time from a job or business because of illness or injury?

- Yes 00 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?

- 00 None (4) (4)

3a. During those 2 weeks, did -- miss any time from school because of illness or injury?

- Yes 00 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?

- 00 None

4a. During those 2 weeks, did -- stay in bed because of illness or injury?

- Yes 00 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?

- 00 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?

- 00 None

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

6a. (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 00 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?

- 00 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.

7a. 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

E. 2-WEEK DOCTOR VISITS PROBE PAGE

Read to respondent(s):

These next questions are about health care received during the 2 weeks outlined in red on that calendar.

E1

Refer to age.

E1

- Under 14 (1b)
- 14 and over (1a)

1a. During those 2 weeks, how many times did — see or talk to a medical doctor? {Include all types of doctors, such as dermatologists, psychiatrists, and ophthalmologists, as well as general practitioners and osteopaths.} (Do not count times while an overnight patient in a hospital.)

1a. and b.

- oo None
 -
 - Number of times
- } (NP)

b. During those 2 weeks, how many times did anyone see or talk to a medical doctor about —? (Do not count times while an overnight patient in a hospital.)

2a. (Besides the time(s) you just told me about) During those 2 weeks, did anyone in the family receive health care at home or go to a doctor's office, clinic, hospital or some other place? Include care from a nurse or anyone working with or for a medical doctor. Do not count times while an overnight patient in a hospital.

- Yes
- No (3a)

2b.

- DR Visit

b. Who received this care? Mark "DR Visit" box in person's column.

c. Anyone else?

- Yes (Reask 2b and c)
- No

Ask for each person with "DR Visit" in 2b:

d. How many times did — receive this care during that period?

d.

Number of times

3a. (Besides the time(s) you already told me about) During those 2 weeks, did anyone in the family get any medical advice, prescriptions or test results over the PHONE from a doctor, nurse, or anyone working with or for a medical doctor?

- Yes
- No (E2)

3b.

- Phone call

b. Who was the phone call about? Mark "Phone call" box in person's column.

c. Were there any calls about anyone else?

- Yes (Reask 3b and c)
- No

Ask for each person with "Phone call" in 3b:

d. How many telephone calls were made about —?

d.

Number of calls

E2

Add numbers in 1, 2d, and 3d for each person. Record total number of visits and calls in "2-WK, DV" box in item C1.

FOOTNOTES

F. 2-WEEK DOCTOR VISITS PAGE

DR VISIT 1

Refer to C1, "2-WK. DV" box.

PERSON NUMBER _____

F1 Refer to age.

F1 Under 14 (1b)
 14 and over (1a)

1 a. On what (other) date(s) during those 2 weeks did -- see or talk to a medical doctor, nurse, or doctor's assistant?
b. On what (other) date(s) during those 2 weeks did anyone see or talk to a medical doctor, nurse, or doctor's assistant about --?
Ask after last DR visit column for this person:
c. Were there any other visits or calls for -- during that period? Make necessary correction to 2-Wk. DV box in C1.

1 a. and b. _____
Month Date OR { 7777 Last week
8888 Week before
c. 1 Yes (Reask 1a or b and c).
2 No (Ask 2-6 for each visit)

2. Where did -- receive health care on (date in 1), at a doctor's office, clinic, hospital, some other place, or was this a telephone call?
If doctor's office: Was this office in a hospital?
If hospital: Was it the outpatient clinic or the emergency room?
If clinic: Was it a hospital outpatient clinic, a company clinic, a public health clinic, or some other kind of clinic?
If lab: Was this lab in a hospital?
What was done during this visit? (Footnote)

2. 01 Telephone
Not in hospital: 02 Home
03 Doctor's office
04 Co. or Ind. clinic
05 Other clinic
06 Lab
07 Other (Specify) ↓
Hospital: 08 O.P. clinic
09 Emergency room
10 Doctor's office
11 Lab
12 Overnight patient(6)
88 Other (Specify) ↓

Ask 3b if under 14.
3 a. Did -- actually talk to a medical doctor?
b. Did anyone actually talk to a medical doctor about --?
c. What type of medical person or assistant was talked to?
d. Does the (entry in 3c) work with or for ONE doctor or MORE than one doctor?
e. For this [visit/call] what kind of doctor was the (entry in 3c) working with or for -- a general practitioner or a specialist?
f. Is that doctor a general practitioner or a specialist?
g. What kind of specialist?

3 a. and b. 1 Yes (3f) 8 DK if M.D. (3c)
2 No (3c) 9 DK who was seen (3f)
c. _____ Type 99 DK
d. 1 One (3f) 2 More 3 None (4) 9 DK
e. and f. 1 GP (4) 2 Specialist (3g) 9 DK (4)
g. _____ Kind of specialist

Ask 4b if under 14.
4 a. For what condition did -- see or talk to the [doctor/(entry in 3c)] on (date in 1)? Mark first appropriate box.
b. For what condition did anyone see or talk to the [doctor/(entry in 3c)] about -- on (date in 1)? Mark first appropriate box.
c. Was a condition found as a result of the [test(s)/examination]?
d. Was this [test/examination] because of a specific condition -- had?
e. During the past 2 weeks was -- sick because of her pregnancy?
f. What was the matter?
g. During this [visit/call] was the [doctor/(entry in 3c)] talked to about any (other) condition?
h. What was the condition?

4 a. and b. 1 Condition (Item C2, THEN 4g)
2 Pregnancy (4e)
3 Test(s) or examination (4c)
8 Other (Specify) ↓ (4g)
c. Yes (4h) No
d. Yes (4h) No (4g)
e. Yes No (4g)
f. _____ Condition (Item C2, THEN 4g)
g. Yes No (5)
h. Pregnancy (4e)
_____ Condition (Item C2, THEN 4g)

Mark box if "Telephone" in 2.
5 a. Did -- have any kind of surgery or operation during this visit, including bone settings and stitches?
b. What was the name of the surgery or operation? If name of operation not known, describe what was done.
c. Was there any other surgery or operation during this visit?

5 a. 0 Telephone in 2 (Next Dr. visit) 1 Yes 2 No (6)
b. (1) _____
(2) _____
c. Yes (Reask 5b and c) No

6. In what city (town), county, and State is the (place in 2) located?

6. City/County _____
State/ZIP Code _____

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.

1	2
<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>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.</p> <p style="text-align: center;">A—L are conditions affecting { Hearing. Vision Speech }</p> <p style="text-align: center;">Conditions M—AA are impairments.</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> <hr/> <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>	<p>A. Deafness in one or both ears?</p> <hr/> <p>B. Any other trouble hearing with one or both ears?</p> <hr/> <p>C. Tinnitus or ringing in the ears?</p> <hr/> <p>D. Blindness in one or both eyes?</p> <hr/> <p>E. Cataracts?</p> <hr/> <p>F. Glaucoma?</p> <hr/> <p>G. Color blindness?</p> <hr/> <p>H. A detached retina or any other condition of the retina?</p> <hr/> <p>I. Any other trouble seeing with one or both eyes EVEN when wearing glasses?</p> <hr/> <p>J. A Cleft palate or harelip?</p> <hr/> <p>K. Stammering or stuttering?</p> <hr/> <p>L. Any other speech defect?</p> <hr/> <p>M. Loss of taste or smell which has lasted 3 months or more?</p> <hr/> <p>N. A missing finger, hand, or arm; toe, foot, or leg?</p>
<p>C. Arthritis of any kind or rheumatism?</p> <hr/> <p>D. Gout?</p> <hr/> <p>E. Lumbago?</p> <hr/> <p>F. Sciatica?</p> <hr/> <p>G. A bone cyst or bone spur?</p> <hr/> <p>H. Any other disease of the bone or cartilage?</p> <hr/> <p>I. A slipped or ruptured disc?</p> <hr/> <p>J. REPEATED trouble with neck, back, or spine?</p> <hr/> <p>K. Bursitis?</p> <hr/> <p>L. Any disease of the muscles or tendons?</p>	<p style="text-align: center;"><i>Reask 1d</i></p> <p>M. A tumor, cyst, or growth of the skin?</p> <hr/> <p>N. Skin cancer?</p> <hr/> <p>O. Eczema or Psoriasis? (ek'sa-ma) or (so-rye'uh-sis)</p> <hr/> <p>P. TROUBLE with dry or itching skin?</p> <hr/> <p>Q. TROUBLE with acne?</p> <hr/> <p>R. A skin ulcer?</p> <hr/> <p>S. Any kind of skin allergy?</p> <hr/> <p>T. Dermatitis or any other skin trouble?</p> <hr/> <p>U. TROUBLE with ingrown toenails or fingernails?</p> <hr/> <p>V. TROUBLE with bunions, corns, or calluses?</p> <hr/> <p>W. Any disease of the hair or scalp?</p>
	<p style="text-align: center;"><i>Reask 2a</i></p> <p>O. A missing joint?</p> <hr/> <p>P. A missing breast, kidney, or lung?</p> <hr/> <p>Q. Palsy or cerebral palsy? (ser'a-bral)</p> <hr/> <p>R. Paralysis of any kind?</p> <hr/> <p>S. Curvature of the spine?</p> <hr/> <p>T. REPEATED trouble with neck, back, or spine?</p> <hr/> <p>U. Any TROUBLE with fallen arches or flatfeet?</p> <hr/> <p>V. A clubfoot?</p> <hr/> <p>W. A trick knee?</p> <hr/> <p>X. PERMANENT stiffness or any deformity of the foot, leg, or back? (Permanent stiffness — joints will not move at all.)</p> <hr/> <p>Y. PERMANENT stiffness or any deformity of the fingers, hand, or arm?</p> <hr/> <p>Z. Mental retardation?</p> <hr/> <p>AA. Any condition caused by an accident or injury which happened more than 3 months ago? If "Yes," ask: What is the condition?</p>

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

3a. DURING THE PAST 12 MONTHS, did anyone in the family {read names} have —
If "Yes," ask 3b and c.

b. Who was this?

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.

	<i>Reask 3a</i>
A. Gallstones?	N. Enteritis?
B. Any other gallbladder trouble?	O. Diverticulitis? (Dye-ver-tic-yoo-lye'tis)
C. Cirrhosis of the liver?	P. Colitis?
D. Fatty liver?	Q. A spastic colon?
E. Hepatitis?	R. FREQUENT constipation?
F. Yellow jaundice?	S. Any other bowel trouble?
G. Any other liver trouble?	T. Any other intestinal trouble?
H. An ulcer?	U. Cancer of the stomach, intestines, colon, or rectum?
I. A hernia or rupture?	V. During the past 12 months, did anyone (else) in the family have any other condition of the digestive system? <i>If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask V.</i>
J. Any disease of the esophagus?	
K. Gastritis?	
L. FREQUENT indigestion?	
M. Any other stomach trouble?	

4

4a. DURING THE PAST 12 MONTHS, did anyone in the family {read names} have —
If "Yes," ask 4b and c.

b. Who was this?

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.

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?

*Ask only if males in family.
**Ask only if females in family.

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>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: 10px;"> <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. 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Any other condition affecting blood circulation?	<p>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: 10px;"> <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. 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A tumor or growth of the bronchial tube or lung?</td> <td></td> </tr> </table> <p><i>*If reported in this list only, ask:</i></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.</p> <p>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? 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J. HOSPITAL PAGE		HOSPITAL STAY 1		
1. Refer to C1, "HOSP." box.		1. PERSON NUMBER _____		
2. You said earlier that — was a patient in the hospital since (13-month hospital date) a year ago. On what date did — enter the hospital ([the last time/the time before that])? Record each entry date in a separate Hospital Stay column.		Month	Date	Year 19 _____
3. How many nights was — in the hospital?		3. 0000 <input type="checkbox"/> None (Next HS) _____ Nights		
4. For what condition did — enter the hospital? <ul style="list-style-type: none"> • For delivery ask: Was this a normal delivery? If "No," ask: What was the matter? • For newborn ask: Was the baby normal at birth? If "No," ask: What was the matter? • For initial "No condition" ask: Why did — enter the hospital? • For tests, ask: What were the results of the tests? If no results, ask: Why were the tests performed? 		4. 1 <input type="checkbox"/> Normal delivery } (5) 2 <input type="checkbox"/> Normal at birth } 3 <input type="checkbox"/> No condition } <input type="checkbox"/> Condition \nearrow		
J1	Refer to questions 2, 3, and 2-week reference period.	J1 <input type="checkbox"/> At least one night in 2-week reference period (Enter condition in C2, THEN 5) <input type="checkbox"/> No nights in 2-week reference period (5)		
5a. Did — have any kind of surgery or operation during this stay in the hospital, including bone settings and stitches?		5a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)		
b. What was the name of the surgery or operation? If name of operation not known, describe what was done.		b. (1) _____ (2) _____ (3) _____		
c. Was there any other surgery or operation during this stay?		c. <input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No		
6. What is the name and address of this hospital?		6. Name _____ Number and street _____ City or County _____ State _____		
FOOTNOTES				

CONDITION 1

PERSON NO. _____

1. Name of condition

Mark "2-wk. ref. pd." box without asking if "DV" or "HS" in C2 as source.

2. When did [---/anyone] last see or talk to a doctor or assistant about --- (condition)?

- | | |
|---|---|
| 0 <input type="checkbox"/> Interview week (Reask 2) | 5 <input type="checkbox"/> 2 yrs., less than 5 yrs. |
| 1 <input type="checkbox"/> 2-wk. ref. pd. | 6 <input type="checkbox"/> 5 yrs. or more |
| 2 <input type="checkbox"/> Over 2 weeks, less than 6 mos. | 7 <input type="checkbox"/> Dr. seen, DK when |
| 3 <input type="checkbox"/> 6 mos., less than 1 yr. | 8 <input type="checkbox"/> DK if Dr. seen |
| 4 <input type="checkbox"/> 1 yr., less than 2 yrs. | 9 <input type="checkbox"/> Dr. never seen } (3b) |

3a. (Earlier you told me about --- (condition) Did the doctor or assistant call the (condition) by a more technical or specific name?

- 1 Yes 2 No 9 DK

Ask 3b if "Yes" in 3a, otherwise transcribe condition name from item 1 without asking:

b. What did he or she call it? _____

(Specify)

- | | |
|---|---|
| 1 <input type="checkbox"/> Color Blindness (NC) | 2 <input type="checkbox"/> Cancer (3e) |
| 3 <input type="checkbox"/> Normal pregnancy, normal delivery, vasectomy } (5) | 4 <input type="checkbox"/> Old age (NC) |
| | 8 <input type="checkbox"/> Other (3c) |

c. What was the cause of --- (condition in 3b)? (Specify) 7

Mark box if accident or injury. 0 Accident/injury (5)

d. Did the (condition in 3b) result from an accident or injury?

- 1 Yes (5) 2 No

Ask 3e if the condition name in 3b includes any of the following words:

Allment	Cancer	Disease	Problem
Anemia	Condition	Disorder	Rupture
Asthma	Cyst	Growth	Trouble
Attack	Defect	Measles	Tumor
Bad			Ulcer

e. What kind of (condition in 3b) is it? _____

(Specify)

Ask 3f only if allergy or stroke in 3b-e:

f. How does the [allergy/stroke] NOW affect ---? (Specify) 7

For Stroke, fill remainder of this condition page for the first present effect. Enter in item C2 and complete a separate condition page for each additional present effect.

Ask 3g if there is an impairment (refer to Card CP2) or any of the following entries in 3b-f:

Abscess	Damage	Palsy
Ache (except head or ear)	Growth	Paralysis
Bleeding (except menstrual)	Hemorrhage	Rupture
Blood clot	Infection	Sore(ness)
Boil	Inflammation	Stiff(ness)
Cancer	Neuralgia	Tumor
Cramps (except menstrual)	Neuritis	Ulcer
Cyst	Pain	Varicose veins
		Weak(ness)

g. What part of the body is affected? _____

(Specify)

Show the following detail:

- Head skull, scalp, face
 Back/spine/vertebrae upper, middle, lower
 Side left or right
 Ear Inner or outer; left, right, or both
 Eye left, right, or both
 Arm shoulder, upper, elbow, lower or wrist; left, right, or both
 Hand entire hand or fingers only; left, right, or both
 Leg hip, upper, knee, lower, or ankle; left, right, or both
 Foot entire foot, arch, or toes only; left, right, or both

Except for eyes, ears, or internal organs, ask 3h if there are any of the following entries in 3b-f:

- Infection Sore Soreness

h. What part of the (part of body in 3b-g) is affected by the [infection/sore/soreness] - the skin, muscle, bone, or some other part?

(Specify) _____

Ask if there are any of the following entries in 3b-f:

- Tumor Cyst Growth

4. Is this [tumor/cyst/growth] malignant or benign?

- 1 Malignant 2 Benign 9 DK

5

a. When was --- (condition in 3b/3f) first noticed?

- 1 2-wk. ref. pd.
 2 Over 2 weeks to 3 months
 3 Over 3 months to 1 year
 4 Over 1 year to 5 years
 5 Over 5 years

b. When did --- (name of injury in 3b)?

Ask probes as necessary:

(Was it on or since (first date of 2-week ref. period) or was it before that date?)

(Was it less than 3 months or more than 3 months ago?)

(Was it less than 1 year or more than 1 year ago?)

(Was it less than 5 years or more than 5 years ago?)

K1 Refer to RD and C2.
 1 "Yes" in "RD" box AND more than 1 condition in C2 (6)
 8 Other (K2)

6a. During the 2 weeks outlined in red on that calendar, did -- (condition) cause -- to cut down on the things -- usually does?
 Yes No (K2)

b. During that period, how many days did -- cut down for more than half of the day?
 00 None (K2) _____ Days

7. During those 2 weeks, how many days did -- stay in bed for more than half of the day because of this condition?
 00 None _____ Days

Ask if "Wa/Wb" box marked in C1:
8. During those 2 weeks, how many days did -- miss more than half of the day from -- job or business because of this condition?
 00 None _____ Days

Ask if age 5-17:
9. During those 2 weeks, how many days did -- miss more than half of the day from school because of this condition?
 00 None _____ Days

K2 Condition has "CL LTR" in C2 as source (10)
 Condition does not have "CL LTR" in C2 as source (K4)

10. About how many days since (12-month date) a year ago, has this condition kept -- in bed more than half of the day? (Include days while an overnight patient in a hospital.)
 000 None _____ Days

11. Was -- ever hospitalized for -- (condition in 3b)?
 1 Yes 2 No

K3 Missing extremity or organ (K4)
 Other (12)

12a. Does -- still have this condition?
 1 Yes (K4) No

b. Is this condition completely cured or is it under control?
 2 Cured 8 Other (Specify) (K4)
 3 Under control (K4)

c. About how long did -- have this condition before it was cured?
 000 Less than 1 month OR _____ Number { 1 Months
 2 Years

d. Was this condition present at any time during the past 12 months?
 1 Yes 2 No

K4 0 Not an accident/injury (NC)
 1 First accident/injury for this person (14)
 8 Other (13)

13. Is this (condition in 3b) the result of the same accident you already told me about?
 Yes (Record condition page number where accident questions first completed.) → _____ (NC) Page No.
 No

14. Where did the accident happen?
 1 At home (inside house)
 2 At home (adjacent premises)
 3 Street and highway (includes roadway and public sidewalk)
 4 Farm
 5 Industrial place (includes premises)
 6 School (includes premises)
 7 Place of recreation and sports, except at school
 8 Other (Specify)

Mark box if under 18. Under 18 (16)

15a. Was -- under 18 when the accident happened?
 1 Yes (16) No

b. Was -- in the Armed Forces when the accident happened?
 2 Yes (16) No

c. Was -- at work at -- job or business when the accident happened?
 3 Yes 4 No

16a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way?
 1 Yes 2 No (17)

b. Was more than one vehicle involved?
 1 Yes 2 No

c. Was [it/either one] moving at the time?
 1 Yes 2 No

17a. At the time of the accident what part of the body was hurt? What kind of injury was it? Anything else?

Part(s) of body *	Kind of injury

Ask if box 3, 4, or 5 marked in Q. 5:
b. What part of the body is affected now? How is -- (part of body) affected? Is -- affected in any other way?

Part(s) of body *	Present effects **

* Enter part of body in same detail as for 3g.
 ** If multiple present effects, enter in C2 each one that is not the same as 3b or C2 and complete a separate condition page for it.

L. DEMOGRAPHIC BACKGROUND PAGE

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

L.DEMOGRAPHIC BACKGROUND PAGE, Continued

Mark box if under 14. If "Married" refer to household composition and mark accordingly.
7. Is — now married, widowed, divorced, separated, or has — never been married?

- 7.**
- 0 Under 14
 - 1 Married — spouse in HH
 - 2 Married — spouse not in HH
 - 3 Widowed
 - 4 Divorced
 - 5 Separated
 - 6 Never married

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.
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.

- 8a.**
- 1 \$20,000 or more (Hand Card I)
 - 2 Less than \$20,000 (Hand Card J)

Read parenthetical phrase if Armed Forces member living at home or if necessary.

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.

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.

- b.**
- 00 A 10 K 20 U
 - 01 B 11 L 21 V
 - 02 C 12 M 22 W
 - 03 D 13 N 23 X
 - 04 E 14 O 24 Y
 - 05 F 15 P 25 Z
 - 06 G 16 Q 26 ZZ
 - 07 H 17 R
 - 08 I 18 S
 - 09 J 19 T

R

a. Mark first appropriate box.

- Ra.**
- 0 Under 17
 - 1 Present for all questions
 - 2 Present for some questions
 - 3 Not present

b. Enter person number of respondent.

b.

 Person number(s) of respondent(s)

L3

Enter person number of first parent listed or mark box.

L3

 Person number of parent
 00 None in household

L4

Enter person number of spouse or mark box.

L4

 Person number of spouse
 00 None in household

FOOTNOTES

L. DEMOGRAPHIC BACKGROUND PAGE, Continued

RT61
3-4

L5	Refer to age. Complete a separate column for each nondeleted person aged 18 and over.	L5	PERSON NUMBER _____																				
<p>Read to respondent(s): In order to determine how health practices and conditions are related to how long people live, we would like to refer to statistical records maintained by the National Center for Health Statistics.</p>																							
L6	Enter date of birth from question 3 on Household Composition page.	L6	Date of birth 5-11 <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">Month</td> <td style="width:25%;">Date</td> <td style="width:25%;">Year</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> </tr> </table>	Month	Date	Year																	
Month	Date	Year																					
<p>9a. In what State or country was — born?</p> <p><i>Print the full name of the State or mark the appropriate box if the person was not born in the United States.</i></p> <p>-----</p> <p><i>If born in U.S., ask 9b; if born in foreign country, ask 9c.</i></p> <p>b. Altogether, how many years has — lived in (State of present residence)?</p> <p>-----</p> <p>c. Altogether, how many years has — lived in the United States?</p>		<p>9a. 99 <input type="checkbox"/> DK 12-13</p> <p>_____ State</p> <table style="width:100%;"> <tr> <td>01 <input type="checkbox"/> Puerto Rico</td> <td>05 <input type="checkbox"/> Cuba</td> </tr> <tr> <td>02 <input type="checkbox"/> Virgin Islands</td> <td>06 <input type="checkbox"/> Mexico</td> </tr> <tr> <td>03 <input type="checkbox"/> Guam</td> <td>98 <input type="checkbox"/> All other countries</td> </tr> <tr> <td>04 <input type="checkbox"/> Canada</td> <td></td> </tr> </table> <p>b. 14</p> <table style="width:100%;"> <tr> <td>1 <input type="checkbox"/> Less than 1 yr.</td> <td>4 <input type="checkbox"/> 10 yrs., less than 15</td> </tr> <tr> <td>2 <input type="checkbox"/> 1 yr., less than 5</td> <td>5 <input type="checkbox"/> 15 yrs. or more</td> </tr> <tr> <td>3 <input type="checkbox"/> 5 yrs., less than 10</td> <td>9 <input type="checkbox"/> DK</td> </tr> </table> <p>c. 15</p> <table style="width:100%;"> <tr> <td>1 <input type="checkbox"/> Less than 1 yr.</td> <td>4 <input type="checkbox"/> 10 yrs., less than 15</td> </tr> <tr> <td>2 <input type="checkbox"/> 1 yr., less than 5</td> <td>5 <input type="checkbox"/> 15 yrs. or more</td> </tr> <tr> <td>3 <input type="checkbox"/> 5 yrs., less than 10</td> <td>9 <input type="checkbox"/> DK</td> </tr> </table>		01 <input type="checkbox"/> Puerto Rico	05 <input type="checkbox"/> Cuba	02 <input type="checkbox"/> Virgin Islands	06 <input type="checkbox"/> Mexico	03 <input type="checkbox"/> Guam	98 <input type="checkbox"/> All other countries	04 <input type="checkbox"/> Canada		1 <input type="checkbox"/> Less than 1 yr.	4 <input type="checkbox"/> 10 yrs., less than 15	2 <input type="checkbox"/> 1 yr., less than 5	5 <input type="checkbox"/> 15 yrs. or more	3 <input type="checkbox"/> 5 yrs., less than 10	9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Less than 1 yr.	4 <input type="checkbox"/> 10 yrs., less than 15	2 <input type="checkbox"/> 1 yr., less than 5	5 <input type="checkbox"/> 15 yrs. or more	3 <input type="checkbox"/> 5 yrs., less than 10	9 <input type="checkbox"/> DK
01 <input type="checkbox"/> Puerto Rico	05 <input type="checkbox"/> Cuba																						
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1 <input type="checkbox"/> Less than 1 yr.	4 <input type="checkbox"/> 10 yrs., less than 15																						
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2 <input type="checkbox"/> 1 yr., less than 5	5 <input type="checkbox"/> 15 yrs. or more																						
3 <input type="checkbox"/> 5 yrs., less than 10	9 <input type="checkbox"/> DK																						
L7	Print full name, including middle initial, from question 1 on Household Composition page.	L7	Last 16-35 _____ First 36-60 _____ Middle initial 51 _____																				
<p><i>Verify for males; ask for females.</i></p> <p>10. What is — father's LAST name?</p> <p><i>Verify spelling. DO NOT write "Same."</i></p>		<p>10. Father's LAST name 52-71</p> <p>_____</p>																					
<p>Read to respondent(s): We also need — Social Security Number. This information is voluntary and collected under the authority of the Public Health Service Act. There will be no effect on — benefits and no information will be given to any other government or nongovernment agency.</p> <p>Read if necessary: The Public Health Service Act is title 42, United States Code, section 242k.</p> <p>11. What is — Social Security Number?</p>		<p>11. 99999999 <input type="checkbox"/> DK 72-80</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%; border: 1px solid black; height: 20px;"></td> <td style="width:25%; border: 1px solid black; height: 20px;"></td> <td style="width:25%; border: 1px solid black; height: 20px;"></td> <td style="width:25%; border: 1px solid black; height: 20px;"></td> </tr> </table> <p>Social Security Number</p> <p>Mark if number obtained from → 1 <input type="checkbox"/> Memory 81 2 <input type="checkbox"/> Records</p>																					
L8	Mark box to indicate how Social Security number was or was not obtained.	L8	<table style="width:100%;"> <tr> <td>1 <input type="checkbox"/> Self-personal</td> </tr> <tr> <td>2 <input type="checkbox"/> Self-telephone</td> </tr> <tr> <td>3 <input type="checkbox"/> Proxy-personal</td> </tr> <tr> <td>4 <input type="checkbox"/> Proxy-telephone</td> </tr> </table> 82	1 <input type="checkbox"/> Self-personal	2 <input type="checkbox"/> Self-telephone	3 <input type="checkbox"/> Proxy-personal	4 <input type="checkbox"/> Proxy-telephone																
1 <input type="checkbox"/> Self-personal																							
2 <input type="checkbox"/> Self-telephone																							
3 <input type="checkbox"/> Proxy-personal																							
4 <input type="checkbox"/> Proxy-telephone																							

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		3-4 5-24	25-39	40	14. Area code/telephone number	RT62 97-106
Last	First	Middle initial				
13a. Address (Number and street)					41-65	
b. City	State	ZIP Code	86-87	88-98	15. Relationship to household respondent	
						107 108-109

FOOTNOTES

SP Old age AF

SP Old age AF

SP Old age AF

SP Old age AF

2				3				4				5					
1. First name		Mid. init.	Age	1. First name		Mid. init.	Age	1. First name		Mid. init.	Age	1. First name		Mid. init.	Age		
Last name			Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	Last name			Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	Last name			Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	Last name			Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F		
2. Relationship				2. Relationship				2. Relationship				2. Relationship					
3. Date of birth				3. Date of birth				3. Date of birth				3. Date of birth					
HOSP.		WORK	RD	2-WK. DV		HOSP.		WORK	RD	2-WK. DV		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		00 <input type="checkbox"/> None		1 <input type="checkbox"/> Wa	1 <input type="checkbox"/> Yes	00 <input type="checkbox"/> None		00 <input type="checkbox"/> None		1 <input type="checkbox"/> Wa	1 <input type="checkbox"/> Yes	00 <input type="checkbox"/> None	
Number		2 <input type="checkbox"/> Wb	2 <input type="checkbox"/> No	Number		Number		2 <input type="checkbox"/> Wb	2 <input type="checkbox"/> No	Number		Number		2 <input type="checkbox"/> Wb	2 <input type="checkbox"/> No	Number	
C1				C1				C1				C1					
C2				C2				C2				C2					
LA RA DV INJ. CLT R HS COND.				LA RA DV INJ. CLT R HS COND.				LA RA DV INJ. CLT R HS COND.				LA RA DV INJ. CLT R HS COND.					
LA RA DV INJ. CLT R HS COND.				LA RA DV INJ. CLT R HS COND.				LA RA DV INJ. CLT R HS COND.				LA RA DV INJ. CLT R HS COND.					
LA RA DV INJ. CLT R HS COND.				LA RA DV INJ. CLT R HS COND.				LA RA DV INJ. CLT R HS COND.				LA RA DV INJ. CLT R HS COND.					
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FOOTNOTES

E

If this questionnaire is for an EXTRA unit, enter Control Number of original sample unit → _____

If in AREA OR BLOCK SEGMENT, also enter for FIRST unit listed on property → _____

LISTING SHEET

Sheet number _____ Line number _____

TABLE X – LIVING QUARTERS DETERMINATIONS AT LISTED ADDRESS

ADDRESS OF ADDITIONAL LIVING QUARTERS	LOCATION OF UNIT	SEPARATENESS AND FACILITIES		CLASSIFICATION	AREA AND BLOCK SEGMENTS	PERMIT SEGMENTS
<p>If already listed, fill sheet and line number below and stop Table X. Otherwise, enter basic address and unit address, if any, OR description of location.</p> <p style="text-align: center;">(1)</p>	<p>Is this a unit in a special place?</p> <p style="text-align: center;">(2)</p>	<p>Do the occupants (or intended occupants) of (address in col. (1)) live and eat separately from all other persons on the property?</p> <p style="text-align: center;">(3)</p>	<p>Does (address in col. (1)) have direct access from the outside or through a common hall?</p> <p style="text-align: center;">(4)</p>	<p>N – Not a separate unit Include on this questionnaire.</p> <p>HU OT</p> <p>Separate unit – Do not include on this questionnaire. Complete the appropriate segment type column for interviewing instructions.</p> <p style="text-align: center;">(5)</p>	<p>Is this unit within the segment boundaries?</p> <p style="text-align: center;">(6)</p>	<p>Is this unit within the same structure as the original sample unit?</p> <p style="text-align: center;">(7)</p>
<p>Sheet _____ Line _____</p>	<p><input type="checkbox"/> Yes – Skip to col. (5) and mark according to Table A in Part C of manual</p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No – Skip to col. (5) and mark N</p>	<p><input type="checkbox"/> Yes – Mark HU in col. (5)</p> <p><input type="checkbox"/> No – Mark N in col. (5)</p>	<p><input type="checkbox"/> N – Stop Table X for this line</p> <p><input type="checkbox"/> HU – Fill col. (6) or (7), as appropriate</p> <p><input type="checkbox"/> OT – Fill col. (6) or (7), as appropriate</p>	<p><input type="checkbox"/> Yes – Interview as an EXTRA unit</p> <p><input type="checkbox"/> No – Do not interview</p>	<p><input type="checkbox"/> Yes – List on first available line of listing sheet. Interview if in sample.</p> <p><input type="checkbox"/> No – Do not interview</p>
<p>Sheet _____ Line _____</p>	<p><input type="checkbox"/> Yes – Skip to col. (5) and mark according to Table A in Part C of manual</p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No – Skip to col. (5) and mark N</p>	<p><input type="checkbox"/> Yes – Mark HU in col. (5)</p> <p><input type="checkbox"/> No – Mark N in col. (5)</p>	<p><input type="checkbox"/> N – Stop Table X for this line</p> <p><input type="checkbox"/> HU – Fill col. (6) or (7), as appropriate</p> <p><input type="checkbox"/> OT – Fill col. (6) or (7), as appropriate</p>	<p><input type="checkbox"/> Yes – Interview as an EXTRA unit</p> <p><input type="checkbox"/> No – Do not interview</p>	<p><input type="checkbox"/> Yes – List on first available line of listing sheet. Interview if in sample.</p> <p><input type="checkbox"/> No – Do not interview</p>
<p>Sheet _____ Line _____</p>	<p><input type="checkbox"/> Yes – Skip to col. (5) and mark according to Table A in Part C of manual</p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No – Skip to col. (5) and mark N</p>	<p><input type="checkbox"/> Yes – Mark HU in col. (5)</p> <p><input type="checkbox"/> No – Mark N in col. (5)</p>	<p><input type="checkbox"/> N – Stop Table X for this line</p> <p><input type="checkbox"/> HU – Fill col. (6) or (7), as appropriate</p> <p><input type="checkbox"/> OT – Fill col. (6) or (7), as appropriate</p>	<p><input type="checkbox"/> Yes – Interview as an EXTRA unit</p> <p><input type="checkbox"/> No – Do not interview</p>	<p><input type="checkbox"/> Yes – List on first available line of listing sheet. Interview if in sample.</p> <p><input type="checkbox"/> No – Do not interview</p>

NOTE: Be sure to continue interview for original unit after completing Table X for all lines.

FOOTNOTES

Current health topics: 1985–89

1985

The 1985 NHIS included 34,844 households that yielded interviews with 91,531 persons. Because of budgetary limitations, the NHIS sample was reduced by 25 percent in the 1985 data collection year.

Health promotion and disease prevention was the special health topic of interest in 1985. One adult family member, 18 years of age and over, was selected to participate in the questions on health promotion and disease prevention. Female family members were asked questions concerning their smoking history during pregnancy. Children under 18 years of age were the subject of questions about child safety and infant feeding.

The 1985 basic health and demographic questionnaire included questions that were in the survey in prior years: acute conditions, chronic conditions, restriction in activity, use of medical services, and short-stay hospitalization. However, the 1985 NHIS marked the initiation of several new design features.

The NHIS sample design implemented with the 1985 data collection year reflected a complete redesign from

the previous years (1,2). The major changes covered four areas (1). The formation of panels of primary sampling units (PSU's) was one of the changes. The total NHIS sample of PSU's was subdivided into four separate panels such that each panel was a representative sample of the United States population. This design feature had a number of advantages, including flexibility for the total sample size. The 1985 NHIS sample included three of the four panels. The second change was the reduction of the number of primary sampling locations from 376 to 198 to improve sampling efficiency. The third design change implemented in 1985 was the oversampling of the black population to improve the precision of estimates. The oversampling resulted in an increase in the number of black persons in the NHIS sample by approximately 75 percent and an increase in the precision of most related statistics by more than 20 percent. The fourth change facilitated followup studies of respondents and linkage with other national health-related data sets such as the National Death Index by using an all-area frame not based on the decennial census.

FORM HIS-1(SB) (1985)
(4-25-85)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR THE
U.S. PUBLIC HEALTH SERVICE

**NATIONAL HEALTH INTERVIEW
SURVEY**

**HEALTH PROMOTION AND DISEASE PREVENTION
SUPPLEMENT BOOKLET**

NOTICE — Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

RT70

1. 3-7 8 **2. R.O. Number** 9-10 **3. Sample** 11-13

Book _____ of _____ books

4. Control number 14-16 17-20 21-22

PSU _____ Segment _____ Serial _____

5. Person number 23-24 **6. Sex** 25
1 Male
2 Female

7. Sample Person 26-45 46-60
Last name _____ First name _____

8. FINAL STATUS OF SUPPLEMENTS 61
 No person 18+ in this family (*Household page*)
a. Section M (Household Respondent Section)
 Interview
 1 Complete interview (all appropriate items completed)
 2 Partial interview (some but not all appropriate items completed) (*Explain in notes*)
 Noninterview
 3 Refusal } (*Explain in notes*)
 4 Other }
b. Sections N through V (Sample Person Section)
 Interview 62
 1 Complete interview (all appropriate sections completed)
 2 Partial interview (some but not all appropriate sections completed) (*Explain in notes*)
 Noninterview
 3 Refusal (*Explain in notes*)
 4 SP temporarily absent
 5 SP mentally or physically incapable
 6 Other (*Explain in notes*)

9. Beginning time 63-66 67 68-71 72
 1 a.m. _____ 1 a.m. _____
 2 p.m. _____ 2 p.m. _____

10. Interviewer identification 73-74
 Name _____ Code _____

11. FAMILY ROSTER
 List all nondeleted family members 18+ by age (oldest to youngest). Refer to sample selection label and circle as appropriate. THEN circle Person No. in item 11 and mark "SP" box on HIS-1 for the selected sample person.

Line No.	Person No.	Name	Age
75	76-77		78-79
1			
2			
3			
4			
5			
6			
7			
8			
9			

12. Telephone in household (*Household page, question 11, THEN 16*) 80
 1 Yes 9 DK
 2 No

13. Education of SP (*page 42, question 2a*) 81-82
 00 Never attended or kindergarten
 Elem: 1 2 3 4 5 6 7 8
 High: 9 10 11 12
 College: 1 2 3 4 5 6+
 Finish grade/year (*Question 2b*) 83
 1 Yes
 2 No

14. Main Race of SP (*page 42, question 3a/b*) 84
 1 2 3 4 5 — Specify

15. Family Income (*page 46, question 8b*) 85-86
 00 A 10 K 20 U
 01 B 11 L 21 V
 02 C 12 M 22 W
 03 D 13 N 23 X
 04 E 14 O 24 Y
 05 F 15 P 25 Z
 06 G 16 Q 26 ZZ
 07 H 17 R (*Transcribe from 8a if 8b blank*)
 08 I 18 S 27 \$20,000 or more
 09 J 19 T 28 Less than \$20,000

16. TELEPHONE NUMBER 87-96
 None
 Area code _____ Number _____

FOOTNOTES

Refer to HIS-1(SB) page 4, questions 4a and b. Transcribe from HIS-1 for the sample person, if required (*page 20, questions 5a and b*).

Section M. PREGNANCY AND SMOKING		Person Number _____	First name _____
M1	Refer to age and sex on Household Composition Page. <input type="checkbox"/> Females 18-44 in family (Enter person number and name of all females 18-44; THEN 1) <input type="checkbox"/> No females 18-44 in family (Section N)		
Read to respondent: These next few questions refer to smoking and pregnancy and are asked of women aged 18-44. In this family the questions refer to (read names).			
1a. Are any of these women now pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No (2) <input type="checkbox"/> DK (2)			
b. Who is this? Mark box in person's column.		1b.	1 <input type="checkbox"/> Yes, pregnant now 9 <input type="checkbox"/> DK 7
c. Anyone else? <input type="checkbox"/> Yes (Reask 1b and c) <input type="checkbox"/> No			
2a. Have any of these women given birth to a live born infant in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No (M2) <input type="checkbox"/> DK (M2)			
b. Who is this? Mark box in person's column.		2b.	1 <input type="checkbox"/> Yes, child past 5 years 9 <input type="checkbox"/> DK 8
c. Anyone else? <input type="checkbox"/> Yes (Reask 2b and c) <input type="checkbox"/> No			
M2	Mark first appropriate box. <input type="checkbox"/> 1b and 2b blank for all persons (Section N)	M2	1 <input type="checkbox"/> Available, "Yes" in 2b (3) 2 <input type="checkbox"/> Available, "Yes" in 1b (4) 3 <input type="checkbox"/> Callback required (NP) 4 <input type="checkbox"/> Noninterview (Cover page, THEN NP) 8 <input type="checkbox"/> Other (NP) 9
3. In what month and year was your last child born?		3.	_____/19_____ Month Year 10-13
4. Have you smoked at least 100 cigarettes in your entire life?		4.	1 <input type="checkbox"/> Yes (Mark "Smoking asked" box, THEN 5) 14 2 <input type="checkbox"/> No (Mark "Smoking asked" box, THEN NP)
5a. Do you smoke cigarettes now?		5a.	1 <input type="checkbox"/> Yes (6) 15 2 <input type="checkbox"/> No
b. About how long has it been since you last smoked cigarettes fairly regularly?		b.	1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years (M3) 16-18 Number 998 <input type="checkbox"/> Never smoked regularly (M3)
6. On the average, about how many cigarettes a day do you now smoke?		6.	_____ Number 00 <input type="checkbox"/> Less than 1 per day 19-20
M3	Mark appropriate box.	M3	1 <input type="checkbox"/> "Yes" in 1b and "Yes" in 5a (8) 21 2 <input type="checkbox"/> "Yes" in 1b and "No" in 5a (7) 8 <input type="checkbox"/> Other (M4)
7. Have you smoked cigarettes at any time during this pregnancy?		7.	1 <input type="checkbox"/> Yes 22 2 <input type="checkbox"/> No (M4)
8. On the average, about how many cigarettes a day did you smoke BEFORE you found out you were pregnant this time?		8.	_____ Number 98 <input type="checkbox"/> Did not smoke regularly 23-24
9. On the average, about how many cigarettes a day did you smoke AFTER you found out you were pregnant this time?		9.	_____ Number 98 <input type="checkbox"/> Did not smoke regularly 25-26
M4	Mark appropriate box.	M4	1 <input type="checkbox"/> "Yes" in 2b (10) 27 8 <input type="checkbox"/> Other (14)
10. Did you smoke cigarettes at all during the 12 months before your last child was born in (month and year in 3)?		10.	1 <input type="checkbox"/> Yes 28 2 <input type="checkbox"/> No (14)
11. On the average, about how many cigarettes a day did you smoke BEFORE you found out you were pregnant?		11.	_____ Number 98 <input type="checkbox"/> Did not smoke regularly 29-30
12. On the average, about how many cigarettes a day did you smoke AFTER you found out you were pregnant?		12.	_____ Number 98 <input type="checkbox"/> Did not smoke regularly 00 <input type="checkbox"/> None (14) 31-32
13. In general, would you say that you smoked cigarettes during MOST of that pregnancy?		13.	1 <input type="checkbox"/> Yes 33 2 <input type="checkbox"/> No 8 <input type="checkbox"/> Other (Specify) _____
14. Did a doctor EVER advise you to quit or cut down on smoking?		14.	1 <input type="checkbox"/> Yes 34 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK

Section N. GENERAL HEALTH HABITS

		Sample Person Number _____	3-4
N1		1 <input type="checkbox"/> Callback required (Hhld. page) 2 <input type="checkbox"/> Noninterview (Cover page) 3 <input type="checkbox"/> Available (1)	5
Read to respondent: These questions are about general health practices.			6
	1. How often do you eat breakfast — almost every day, sometimes, rarely or never?	1 <input type="checkbox"/> Almost every day 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely or never	6
	2. Including evening snacks, how often do you eat between meals — almost every day, sometimes, rarely or never?	1 <input type="checkbox"/> Almost every day 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely or never	7
	3. When you visit a doctor or other health professional for routine care, is eating proper foods discussed often, sometimes, rarely or never?	1 <input type="checkbox"/> Often 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely or never 4 <input type="checkbox"/> Don't visit for routine care	8
N2	Refer to page 46 or 47, item R, of HIS-1.	1 <input type="checkbox"/> SP is Hhld. resp. (5) 8 <input type="checkbox"/> Other (4)	9
	4a. About how tall are you without shoes? _____ Feet _____ Inches		10-12
	b. About how much do you weigh without shoes? _____ Pounds		13-15
Hand Card N1 or read responses for telephone interview.			16
	5. In your opinion which of these are the TWO best ways to lose weight?	1 <input type="checkbox"/> Don't eat at bedtime 2 <input type="checkbox"/> Eat fewer calories 3 <input type="checkbox"/> Take diet pills 4 <input type="checkbox"/> Increase physical activity 5 <input type="checkbox"/> Eat NO fat 6 <input type="checkbox"/> Eat grapefruit with each meal	17
	6. Are you now trying to lose weight?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (9)	18
	7. Are you eating fewer calories to lose weight?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	19
	8. Have you increased your physical activity to lose weight?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	20
	9a. Do you consider yourself overweight, underweight, or just about right?	1 <input type="checkbox"/> Overweight 2 <input type="checkbox"/> Underweight 3 <input type="checkbox"/> About right } (10)	21
	b. Would you say you are very overweight, somewhat overweight, or only a little overweight?	1 <input type="checkbox"/> Very overweight 2 <input type="checkbox"/> Somewhat overweight 3 <input type="checkbox"/> Only a little overweight	22
	10. On the average, how many hours of sleep do you get in a 24-hour period? _____ Hours		23-24

FOOTNOTES

Section N. GENERAL HEALTH HABITS – Continued

11. 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?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (14)	25
12. What kind of place is it — a clinic, a health center, a hospital, a doctor's office, or some other place? IF HOSPITAL: Is this an outpatient clinic or the emergency room? IF CLINIC: Is this a hospital outpatient clinic, a company clinic, or some other kind of clinic?	1 <input type="checkbox"/> Doctor's office (group practice or doctor's clinic) 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 (Specify) _____	26
13. Is there ONE particular doctor you usually see at (place in 12)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (N3)	27
<i>Hand Card N2 or read reasons for telephone interview.</i> 14. Which of these is the MAIN reason you don't have a particular place you usually go?	1 <input type="checkbox"/> Have two or more usual doctors or places depending on what is wrong 2 <input type="checkbox"/> Haven't needed a doctor 3 <input type="checkbox"/> Previous doctor no longer available 4 <input type="checkbox"/> Haven't been able to find the right doctor 5 <input type="checkbox"/> Recently moved to area 6 <input type="checkbox"/> Can't afford medical care 8 <input type="checkbox"/> Other reason (Specify) _____	28
N3 <i>Refer to sex.</i>	1 <input type="checkbox"/> Male (Section O) 2 <input type="checkbox"/> Female (15)	29
15. About how long has it been since you had a Pap smear test?	_____ Years 98 <input type="checkbox"/> Never 00 <input type="checkbox"/> Less than 1 year	30-31
16a. About how long has it been since you had a breast examination by a doctor or other health professional?	_____ Years 98 <input type="checkbox"/> Never 00 <input type="checkbox"/> Less than 1 year	32-33
b. Do you know how to examine your own breasts for lumps?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Section O)	34
c. About how many times a year do you examine your own breasts for lumps?	_____ Times per year 88 <input type="checkbox"/> Other (Specify) _____ 98 <input type="checkbox"/> Never	35-36

FOOTNOTES

Section O. INJURY CONTROL AND CHILD SAFETY AND HEALTH

01	<i>Refer to household composition.</i>	1 <input type="checkbox"/> Children under 10 in family (1) 2 <input type="checkbox"/> No children under 10 in family (03)	37
Read to respondent: These questions are about preventing injuries to children.			38
1a. Have you ever heard about POISON CONTROL CENTERS?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2)	
b. Do you have the telephone number for a Poison Control Center in your area?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	39
2. There is a medication called IPECAC (ip' i kak) SYRUP which is sometimes taken to cause vomiting after something poisonous is swallowed. Do you now have any Ipecac Syrup in this household?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	40
02	<i>Refer to household composition.</i>	1 <input type="checkbox"/> Children under 5 in family (3) 2 <input type="checkbox"/> No children under 5 in family (03)	41
3. Have you heard about child safety seats, sometimes called car safety carriers, which are designed to carry children while they are riding in a car?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (03)	42
4. Did a doctor or other health professional EVER tell you about the importance of using car safety seats for (your) children?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	43
03	<i>Refer to household composition.</i>	1 <input type="checkbox"/> Children under 18 in family (04) 2 <input type="checkbox"/> No children under 18 in family (10)	44
		RT73	3-4
04	<i>Enter person number and name of all children under 18; THEN mark box.</i>	Person Number _____ First name _____ 1 <input type="checkbox"/> Under 5 (5) 2 <input type="checkbox"/> 5-17 (7)	5-6 7
5. When -- was brought home from the hospital following birth, was -- buckled in a car safety seat?		5. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Not born in hospital 4 <input type="checkbox"/> Didn't ride home in "car" 9 <input type="checkbox"/> DK	8
6a. Does -- now have a car safety seat?		6a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (7)	9
b. When riding in a car, is -- buckled in a car safety seat all or most of the time, some of the time, once in awhile, or never?		b. 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 9 <input type="checkbox"/> DK } (7) (NP)	10
7. When riding in a car, does -- wear a seat belt all or most of the time, some of the time, once in awhile, or never?		7. 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"/> Uses child safety seat 9 <input type="checkbox"/> DK	11
05	<i>Refer to age.</i>	05 1 <input type="checkbox"/> Under 5 (8) 8 <input type="checkbox"/> Other (06)	12
Read to respondent: {These next questions are about breastfeeding.}			13
8. Was -- ever breastfed?		8. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (06)	13
9. How old was -- when -- COMPLETELY stopped breastfeeding?		9. 000 <input type="checkbox"/> Still breastfed { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years Age _____	14-16
06	<i>Respondent</i>	06 1 <input type="checkbox"/> Child's parent 8 <input type="checkbox"/> Other	17

Section O. INJURY CONTROL AND CHILD SAFETY AND HEALTH – Continued		RT74
		3-4
10. When driving or riding in a car, do you wear a seat belt all or most of the time, some of the time, once in awhile, or never?	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 car	5
<i>Read to respondent:</i> The next questions are about this home.		6-7
11a. How many smoke detectors are installed in this home?	01 <input type="checkbox"/> Only 1 (11c) _____ Number (11b) 00 <input type="checkbox"/> None } (12) 99 <input type="checkbox"/> DK }	
b. How many of them are now working?	_____ Number (11d) 00 <input type="checkbox"/> None (11f)	8-9
c. Is it now working?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (11f) 9 <input type="checkbox"/> DK }	10
d. How do you know [it is/they are] working?	1 <input type="checkbox"/> Tested it/them 1 <input type="checkbox"/> It/they went off because of smoke 1 <input type="checkbox"/> It/they went off while cooking 1 <input type="checkbox"/> Changed the batteries 1 <input type="checkbox"/> The light is on 1 <input type="checkbox"/> Beeps when battery is low 1 <input type="checkbox"/> Other (Specify) _____	11 12 13 14 15 16 17
e. Any other way?	<input type="checkbox"/> Yes (Reask 11d and e) <input type="checkbox"/> No	
f. [Is it/Are any of the smoke detectors] next to a sleeping area?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	18
12a. Do you know about what the hot water temperature is in this home?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (13)	19
b. About what temperature is the hot water?	_____ Temperature OR 1 <input type="checkbox"/> High 2 <input type="checkbox"/> Low 3 <input type="checkbox"/> Medium	20-22 23
c. How did you estimate the hot water temperature?	1 <input type="checkbox"/> The setting on hot water heater 2 <input type="checkbox"/> Tested with thermometer 3 <input type="checkbox"/> Guessed 8 <input type="checkbox"/> Other (Specify) _____	24
13. In the past 12 months, have you (or has anyone in your household) used a thermometer to test the temperature of the hot water here?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	25
14. ABOVE what temperature will hot water cause scald injuries?	_____ Temperature 999 <input type="checkbox"/> DK	26-28
FOOTNOTES		

Section P. HIGH BLOOD PRESSURE

1. I am going to read a list of things which may or may not affect a person's chances of getting HEART DISEASE.

Hand Card P

After I read each one, tell me if you think it definitely increases, probably increases, probably does not, or definitely does not increase a person's chances of getting heart disease. First —

DEFINITELY INCREASES PROBABLY INCREASES PROBABLY DOES NOT INCREASE DEFINITELY DOES NOT INCREASE DK/NO OPINION

a. Cigarette smoking? (Give me a number from the card.)

1 2 3 4 9 **5**

b. Worry or anxiety?

1 2 3 4 9 **6**

c. High blood pressure?

1 2 3 4 9 **7**

d. Diabetes?

1 2 3 4 9 **8**

e. Being VERY overweight?

1 2 3 4 9 **9**

f. Overwork?

1 2 3 4 9 **10**

g. Drinking coffee with caffeine?

1 2 3 4 9 **11**

h. Eating a diet high in animal fat?

1 2 3 4 9 **12**

i. Family history of heart disease?

1 2 3 4 9 **13**

j. High cholesterol?

1 2 3 4 9 **14**

2. The following conditions are related to having a STROKE. In your opinion, which of these conditions MOST increases a person's chances of having a stroke — diabetes, high blood pressure, or high cholesterol?

1 Diabetes
2 High blood pressure
3 High cholesterol
9 DK

15

3. Which one of the following substances in food is MOST often associated with HIGH BLOOD PRESSURE — sodium, cholesterol or sugar?

1 Sodium
2 Cholesterol
3 Sugar
8 Other (Specify) _____
9 DK

16

4. Have you EVER been told by a doctor or other health professional that you had hypertension, sometimes called high blood pressure?

1 Yes
2 No (12)
3 Only during pregnancy (12)

17

5. Were you told two or more DIFFERENT times that you had hypertension or high blood pressure?

1 Yes
2 No
9 DK

18

6. Are you NOW taking any medicine prescribed by a doctor for your hypertension or high blood pressure?

1 Yes (8)
2 No

19

7a. Was any medicine EVER prescribed by a doctor for your hypertension or high blood pressure?

1 Yes
2 No (8)

20

b. Did a doctor advise you to stop taking the medicine?

1 Yes
2 No

21

FOOTNOTES

Section P. HIGH BLOOD PRESSURE – Continued

8. Because of your hypertension or high blood pressure, has a doctor or other health professional EVER advised you to – 	a. Diet to lose weight? 1 <input type="checkbox"/> Yes (9) 22 2 <input type="checkbox"/> No (8b)	b. Cut down on salt or sodium in your diet? 1 <input type="checkbox"/> Yes (9) 23 2 <input type="checkbox"/> No (8c)	c. Exercise? 1 <input type="checkbox"/> Yes (9) 24 2 <input type="checkbox"/> No (11)
9. Have you EVER followed this advice? 	1 <input type="checkbox"/> Yes (10) 25 2 <input type="checkbox"/> No (8b)	1 <input type="checkbox"/> Yes (10) 26 2 <input type="checkbox"/> No (8c)	1 <input type="checkbox"/> Yes (10) 27 2 <input type="checkbox"/> No (11)
10. Are you NOW following this advice? 	1 <input type="checkbox"/> Yes } (8b) 28 2 <input type="checkbox"/> No }	1 <input type="checkbox"/> Yes } (8c) 29 2 <input type="checkbox"/> No }	1 <input type="checkbox"/> Yes } (11) 30 2 <input type="checkbox"/> No }
11a. Do you still have hypertension or high blood pressure? 	1 <input type="checkbox"/> Yes (12) 31 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK		
b. Is this condition completely cured or is it under control? 	1 <input type="checkbox"/> Cured 32 2 <input type="checkbox"/> Under control 9 <input type="checkbox"/> DK		
12a. ABOUT how long has it been since you LAST had your blood pressure taken by a doctor or other health professional? 	_____ Number { <ul style="list-style-type: none"> 2 <input type="checkbox"/> Days 3 <input type="checkbox"/> Weeks 4 <input type="checkbox"/> Months 5 <input type="checkbox"/> Years 33-35		
b. Blood pressure is usually given as one number over another. Were you told what your blood pressure was, in NUMBERS? 	999 <input type="checkbox"/> DK } (13) 000 <input type="checkbox"/> Never }		
c. What was your blood pressure, in NUMBERS? 	_____ / _____ 36 999 999 <input type="checkbox"/> DK 37-39		
d. At that time, was your blood pressure high, low, or normal? 	1 <input type="checkbox"/> High 40-42 2 <input type="checkbox"/> Low 3 <input type="checkbox"/> Normal 8 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> DK 43		
13. Do you NOW have diabetes or sugar diabetes? 	1 <input type="checkbox"/> Yes 44 2 <input type="checkbox"/> No 8 <input type="checkbox"/> Other (Specify) _____		
14. Have you ever been told by a doctor or other health professional that you had high cholesterol? 	1 <input type="checkbox"/> Yes 45 2 <input type="checkbox"/> No		
15. Do you have any kind of heart condition or heart trouble? 	1 <input type="checkbox"/> Yes 46 2 <input type="checkbox"/> No		
16. Have you ever had a stroke? 	1 <input type="checkbox"/> Yes 47 2 <input type="checkbox"/> No		

FOOTNOTES

Section Q. STRESS

48			
<p><i>Read to respondent:</i></p> <p>These next questions are about stress.</p> <p>1. During the past 2 weeks, would you say that you experienced a lot of stress, a moderate amount of stress, relatively little stress, or almost no stress at all?</p>	<p>1 <input type="checkbox"/> A lot 2 <input type="checkbox"/> Moderate 3 <input type="checkbox"/> Relatively little 4 <input type="checkbox"/> Almost none 5 <input type="checkbox"/> DK what stress is (3)</p>		
<p>2. In the past year, how much effect has stress had on your health — a lot, some, hardly any or none?</p>	<p>1 <input type="checkbox"/> A lot 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Hardly any or none</p>		
<p>3a. In the past year, did you think about seeking help for any personal or emotional problems from family or friends?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>		
<p>b. from a helping professional or a self-help group?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>		
<p>Q1 Refer to 3a and b.</p>	<p>1 <input type="checkbox"/> "No" in 3a and 3b (Section R) 8 <input type="checkbox"/> Other (4)</p>		
<p>4a. Did you actually seek any help?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Section R)</p>		
<p>b. From whom did you seek help? Number up to four items in the order mentioned. Do not read list.</p>	<table style="width:100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <p>_____ Family member or relative 54</p> <p>_____ Friend 55</p> <p>_____ Psychologist 56</p> <p>_____ Psychiatrist 57</p> <p>_____ Psychiatric social worker 58</p> <p>_____ Other mental health professional 59</p> <p>_____ Medical doctor 60</p> <p>_____ Religious counselor 61</p> <p>_____ Alcoholics Anonymous 62</p> </td> <td style="width: 50%; border: none;"> <p>_____ Gamblers Anonymous 63</p> <p>_____ Weight Watchers 64</p> <p>_____ Counselor at work 65</p> <p>_____ Counselor at school 66</p> <p>_____ Probation officer 67</p> <p>Other (Specify) _____</p> <p>_____ 68</p> <p>_____ 69</p> <p>_____ 70</p> </td> </tr> </table>	<p>_____ Family member or relative 54</p> <p>_____ Friend 55</p> <p>_____ Psychologist 56</p> <p>_____ Psychiatrist 57</p> <p>_____ Psychiatric social worker 58</p> <p>_____ Other mental health professional 59</p> <p>_____ Medical doctor 60</p> <p>_____ Religious counselor 61</p> <p>_____ Alcoholics Anonymous 62</p>	<p>_____ Gamblers Anonymous 63</p> <p>_____ Weight Watchers 64</p> <p>_____ Counselor at work 65</p> <p>_____ Counselor at school 66</p> <p>_____ Probation officer 67</p> <p>Other (Specify) _____</p> <p>_____ 68</p> <p>_____ 69</p> <p>_____ 70</p>
<p>_____ Family member or relative 54</p> <p>_____ Friend 55</p> <p>_____ Psychologist 56</p> <p>_____ Psychiatrist 57</p> <p>_____ Psychiatric social worker 58</p> <p>_____ Other mental health professional 59</p> <p>_____ Medical doctor 60</p> <p>_____ Religious counselor 61</p> <p>_____ Alcoholics Anonymous 62</p>	<p>_____ Gamblers Anonymous 63</p> <p>_____ Weight Watchers 64</p> <p>_____ Counselor at work 65</p> <p>_____ Counselor at school 66</p> <p>_____ Probation officer 67</p> <p>Other (Specify) _____</p> <p>_____ 68</p> <p>_____ 69</p> <p>_____ 70</p>		
<p>c. Anyone else?</p>	<p><input type="checkbox"/> Yes (Reask 4b and c) <input type="checkbox"/> No</p>		

Section R. EXERCISE

3-4	
5	
<p>R1</p>	<p>1 <input type="checkbox"/> SP is physically handicapped (Describe in footnotes, THEN 1) 8 <input type="checkbox"/> Other (2)</p>
6	
<p><i>Read to respondent:</i></p> <p>These next questions are about physical exercise. Hand calendar.</p> <p>1a. 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?</p>	
<p>b. What were they? Record on next page, THEN 1c.</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (3, page 13)</p>
<p>c. Anything else?</p>	<p><input type="checkbox"/> Yes (Reask 1b and c) <input type="checkbox"/> No (2b)</p>

FOOTNOTES

Section R. EXERCISE – Continued

NOTE – ASK ALL OF 2a BEFORE GOING TO 2b–d.		NOTE: ASK 2b–d FOR EACH ACTIVITY MARKED “YES” IN 2a.					
<p><i>Read to respondent: These next questions are about physical exercise. Hand calendar.</i></p> <p>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) –</p> <p align="right">YES NO</p>		<p>b. How many times in the past 2 weeks did you [play/go/do] (activity in 2a)?</p>		<p>c. On the average, about how many minutes did you actually spend (activity in 2a) on each occasion?</p>		<p>d. (What usually happened to your heart rate or breathing when you (activity in 2a)?) Did you have a small, moderate, or large increase, or no increase at all in your heart rate or breathing?</p>	
<p>(1) Walking for exercise? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 7</p>		<p>(1) _____ Times 8–9</p>		<p>_____ Minutes 10–12</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 13 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>R2 Refer to age. 1 <input type="checkbox"/> SP is 75+ (23) 8 <input type="checkbox"/> Other (2) 14</p>							
<p>(2) Jogging or running? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 15</p>		<p>(2) _____ Times 16–17</p>		<p>_____ Minutes 18–20</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 21 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(3) Hiking? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 22</p>		<p>(3) _____ Times 23–24</p>		<p>_____ Minutes 25–27</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 28 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(4) Gardening or yard work? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 29</p>		<p>(4) _____ Times 30–31</p>		<p>_____ Minutes 32–34</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 35 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(5) Aerobics or aerobic dancing? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 36</p>		<p>(5) _____ Times 37–38</p>		<p>_____ Minutes 39–41</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 42 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(6) Other dancing? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 43</p>		<p>(6) _____ Times 44–45</p>		<p>_____ Minutes 46–48</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 49 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(7) Calisthenics or general exercise? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 50</p>		<p>(7) _____ Times 51–52</p>		<p>_____ Minutes 53–55</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 56 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(8) Golf? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 57</p>		<p>(8) _____ Times 58–59</p>		<p>_____ Minutes 60–62</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 63 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(9) Tennis? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 64</p>		<p>(9) _____ Times 65–66</p>		<p>_____ Minutes 67–69</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 70 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(10) Bowling? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 71</p>		<p>(10) _____ Times 72–73</p>		<p>_____ Minutes 74–76</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 77 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(11) Biking? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 78</p>		<p>(11) _____ Times 79–80</p>		<p>_____ Minutes 81–83</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 84 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(12) Swimming or water exercises? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 85</p>		<p>(12) _____ Times 86–87</p>		<p>_____ Minutes 88–90</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 91 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(13) Yoga? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 92</p>		<p>(13) _____ Times 93–94</p>		<p>_____ Minutes 95–97</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 98 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>R3 Refer to age. 1 <input type="checkbox"/> SP is 65–74 (23) 8 <input type="checkbox"/> Other (14) RT77 3–4 5 6</p>							
<p>(14) Weight lifting or training? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 6</p>		<p>(14) _____ Times 7–8</p>		<p>_____ Minutes 9–11</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 12 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(15) Basketball? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 13</p>		<p>(15) _____ Times 14–15</p>		<p>_____ Minutes 16–18</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 19 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(16) Baseball or softball? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 20</p>		<p>(16) _____ Times 21–22</p>		<p>_____ Minutes 23–25</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 26 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(17) Football? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 27</p>		<p>(17) _____ Times 28–29</p>		<p>_____ Minutes 30–32</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 33 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(18) Soccer? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 34</p>		<p>(18) _____ Times 35–36</p>		<p>_____ Minutes 37–39</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 40 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(19) Volleyball? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 41</p>		<p>(19) _____ Times 42–43</p>		<p>_____ Minutes 44–46</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 47 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(20) Handball, racquetball, or squash? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 48</p>		<p>(20) _____ Times 49–50</p>		<p>_____ Minutes 51–53</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 54 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(21) Skating? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 55</p>		<p>(21) _____ Times 56–57</p>		<p>_____ Minutes 58–60</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 61 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(22) Skiing? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 62</p>		<p>(22) _____ Times 63–64</p>		<p>_____ Minutes 65–67</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 68 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>(23) Have you done any (other) exercises, sports, or physically active hobbies in the past 2 weeks (that I haven't mentioned)? Anything else?</p> <p><input type="checkbox"/> Yes – What were they? <input type="checkbox"/> No 69–70</p>		<p>_____ Times 71–72</p>		<p>_____ Minutes 73–75</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 76 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>_____ 77–78</p>		<p>_____ Times 79–80</p>		<p>_____ Minutes 81–83</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 84 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<p>_____ 77–78</p>		<p>(23) _____ Times</p>		<p>_____ Minutes</p>		<p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	

Section R. EXERCISE – Continued

3. Do you exercise or play sports regularly?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)	85
4. For how long have you exercised or played sports regularly?	_____ Number <div style="display: inline-block; vertical-align: middle; margin-left: 10px;"> { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } </div>	86-88
5a. Would you say that you are physically more active, less active, or about as active as other persons your age?	1 <input type="checkbox"/> More active 2 <input type="checkbox"/> Less active 3 <input type="checkbox"/> About as active (R4) 4 <input type="checkbox"/> Other (Specify) _____ (R4)	89
b. Is that [a lot more or a little more/a lot less or a little less] active?	1 <input type="checkbox"/> A lot more 2 <input type="checkbox"/> A little more 3 <input type="checkbox"/> A lot less 4 <input type="checkbox"/> A little less	90
R4	Refer to "Wa/Wb" boxes in C1 on HIS-1. 1 <input type="checkbox"/> Wa or Wb box marked (6a) 2 <input type="checkbox"/> Other (6c)	91
6a. How much hard physical work is required on your job? Would you say a great deal, a moderate amount, a little, or none?	1 <input type="checkbox"/> Great deal 2 <input type="checkbox"/> Moderate amount 3 <input type="checkbox"/> A little } (7) 4 <input type="checkbox"/> None }	92
b. About how many hours per day do you perform hard physical work on your job?	_____ Hours (7)	93-94
c. How much hard physical work is required in your main daily activity? Would you say a great deal, a moderate amount, a little, or none?	1 <input type="checkbox"/> Great deal 2 <input type="checkbox"/> Moderate amount 3 <input type="checkbox"/> A little } (7) 4 <input type="checkbox"/> None }	95
d. About how many hours per day do you perform hard physical work in your main daily activity?	_____ Hours	96-97
Read to respondent: These next questions are about strengthening the heart and lungs through exercise.	_____ Days 3 <input type="checkbox"/> Other (Specify) _____ 4 <input type="checkbox"/> DK	98
7a. How many days a week do you think a person should exercise to strengthen the heart and lungs?	_____ Days	99-101
b. For how many minutes do you think a person should exercise on EACH occasion so that the heart and lungs are strengthened?	_____ Minutes 5 <input type="checkbox"/> DK	102
Hand card R1 c. (During those (number in 7b) minutes), How fast do you think a person's heart rate and breathing should be to strengthen the heart and lungs? Do you think that the heart and breathing rate should be -- no faster than usual, a little faster than usual, a lot faster but talking is possible, so fast that talking is not possible?	1 <input type="checkbox"/> No faster than usual 2 <input type="checkbox"/> A little faster than usual 3 <input type="checkbox"/> A lot faster but talking is possible 4 <input type="checkbox"/> So fast that talking is not possible 5 <input type="checkbox"/> DK	102

FOOTNOTES

Section S. SMOKING		RT78
		3-4
S1	Refer to "Smoking asked" box on HIS-1.	1 <input type="checkbox"/> "Smoking asked" box marked (4) 8 <input type="checkbox"/> Other (1)
Read to respondent: These next questions are about smoking cigarettes.		6
1. Have you smoked at least 100 cigarettes in your entire life?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (4)
2a. Do you smoke cigarettes now?		1 <input type="checkbox"/> Yes (3) 2 <input type="checkbox"/> No
b. About how long has it been since you last smoked cigarettes fairly regularly?		<div style="display: flex; align-items: center; justify-content: center;"> <div style="margin-right: 10px;">Number</div> <div style="font-size: 2em;">}</div> <div style="margin-right: 10px;">(4)</div> </div> <div style="margin-left: 10px; text-align: left;"> 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years </div>
		8-10
3. On the average, about how many cigarettes a day do you now smoke?		00 <input type="checkbox"/> Less than 1 per day Number
		11-12
4. {These next questions are about smoking cigarettes.} (Hand Card S) Tell me if you think CIGARETTE SMOKING definitely increases, probably increases, probably does not, or definitely does not increase a person's chances of getting the following problems. First —		DEFINITELY INCREASES PROBABLY INCREASES PROBABLY DOES NOT INCREASE DEFINITELY DOES NOT INCREASE DK/NO OPINION
a. Emphysema? (Give me a number from the card.)		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 13
b. Bladder cancer?		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 14
c. Cancer of the larynx (lar'inks) or voice box?		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 15
d. Cataracts?		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 16
e. Cancer of the esophagus?		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 17
f. Chronic bronchitis?		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 18
g. Gallstones?		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 19
h. Lung cancer?		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 20
		21
S2	Refer to age.	1 <input type="checkbox"/> SP is under 45 (4i) 2 <input type="checkbox"/> SP is 45+ (S3)
Read to respondent: Does cigarette smoking during pregnancy definitely increase, probably increase, probably not or definitely not increase the chances of —		DEFINITELY INCREASES PROBABLY INCREASES PROBABLY DOES NOT INCREASE DEFINITELY DOES NOT INCREASE DK/NO OPINION
i. Miscarriage?		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 22
j. Stillbirth?		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 23
k. Premature birth?		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 24
l. Low birth weight of the newborn?		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 25
5a. If a woman takes birth control pills, is she more likely to have a stroke if she smokes than if she does not smoke?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (S3) 9 <input type="checkbox"/> DK
b. Is she much more likely or somewhat more likely to have a stroke?		1 <input type="checkbox"/> Much more 2 <input type="checkbox"/> Somewhat more
		27
S3	Refer to 1.	1 <input type="checkbox"/> "Yes" in 1 (6) 8 <input type="checkbox"/> Other (Section T)
6. Did a doctor EVER advise you to quit or cut down on smoking?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
		29

Section T. ALCOHOL USE

Read to respondent:

30

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

1a. In YOUR ENTIRE LIFE have you had at least 12 drinks of ANY kind of alcoholic beverage?

- 1 Yes
2 No (1d)

b. In ANY ONE YEAR have you had at least 12 drinks of ANY kind of alcoholic beverage?

- 1 Yes
2 No (1d)

31

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

- 1 Yes (2)
2 No

32

d. What is your MAIN reason for not drinking (in the past year)?

- 00 No need/not necessary
01 Don't care for/dislike it
02 Medical/health reasons
03 Religious/moral reasons
04 Brought up not to drink
05 Costs too much
06 Family member an alcoholic or problem drinker
07 Infrequent drinker
08 Other (Specify) _____

(9)

33-34

2. In 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?

Use list to probe, if necessary.

- | | | |
|--|---------------------------------|--|
| 01 <input type="checkbox"/> 14 (Every day) | 12 <input type="checkbox"/> 8-9 | 23 <input type="checkbox"/> 3 |
| 02 <input type="checkbox"/> 13-14 | 13 <input type="checkbox"/> 8 | 24 <input type="checkbox"/> 2-3 |
| 03 <input type="checkbox"/> 13 | 14 <input type="checkbox"/> 7-8 | 25 <input type="checkbox"/> 2 |
| 04 <input type="checkbox"/> 12-13 | 15 <input type="checkbox"/> 7 | 26 <input type="checkbox"/> 1-2 |
| 05 <input type="checkbox"/> 12 | 16 <input type="checkbox"/> 6-7 | 27 <input type="checkbox"/> 1 |
| 06 <input type="checkbox"/> 11-12 | 17 <input type="checkbox"/> 6 | 00 <input type="checkbox"/> None/Never (4) |
| 07 <input type="checkbox"/> 11 | 18 <input type="checkbox"/> 5-6 | 99 <input type="checkbox"/> DK |
| 08 <input type="checkbox"/> 10-11 | 19 <input type="checkbox"/> 5 | |
| 09 <input type="checkbox"/> 10 | 20 <input type="checkbox"/> 4-5 | |
| 10 <input type="checkbox"/> 9-10 | 21 <input type="checkbox"/> 4 | |
| 11 <input type="checkbox"/> 9 | 22 <input type="checkbox"/> 3-4 | |

35-36

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

Use list to probe, if necessary.

- | | |
|---|---|
| 01 <input type="checkbox"/> Twelve or more | 08 <input type="checkbox"/> Three or four |
| 02 <input type="checkbox"/> Seven to eleven | 09 <input type="checkbox"/> Three |
| 03 <input type="checkbox"/> Six | 10 <input type="checkbox"/> Two or three |
| 04 <input type="checkbox"/> Five or six | 11 <input type="checkbox"/> Two |
| 05 <input type="checkbox"/> Five | 12 <input type="checkbox"/> One or two |
| 06 <input type="checkbox"/> Four or five | 13 <input type="checkbox"/> One |
| 07 <input type="checkbox"/> Four | 99 <input type="checkbox"/> DK |

37-38

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

- 1 Yes (5)
2 No

39

b. Was the amount of your drinking during that 2-WEEK period more or less than your drinking during the past 12 months?

- 1 More
2 Less

40

5. During the past 12 months, in how many MONTHS did you have at least one drink of ANY alcoholic beverage?

_____ Months

41-42

6. During [that month/those months], on how many DAYS did you have 9 or more drinks of ANY alcoholic beverage?

_____ Days

000 None or never

43-45

7. During [that month/those months], on how many DAYS did you have 5 or more drinks of ANY alcoholic beverage? (Include the (number in 6) days you had 9 or more drinks.)

_____ Days

000 None or never

46-48

8. During the past year, how many times did you drive when you had perhaps too much to drink?

_____ Times

000 None
998 Don't drive

49-51

FOOTNOTES

Section T. ALCOHOL USE – Continued

<p>9. (Hand Card T) Tell me if you think HEAVY ALCOHOL DRINKING definitely increases, probably increases, probably does not, or definitely does not increase a person's chances of getting the following problems. First –</p>		DEFINITELY INCREASES	PROBABLY INCREASES	PROBABLY DOES NOT INCREASE	DEFINITELY DOES NOT INCREASE	DK/NO OPINION	
a. Throat cancer? (Give me a number from the card.)		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	52
b. Cirrhosis of the liver?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	53
c. Bladder cancer?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	54
d. Cancer of the mouth?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	55
e. Arthritis?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	56
f. Blood clots?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	57
T1	Refer to age.	1 <input type="checkbox"/> SP is under 45 (9g) 2 <input type="checkbox"/> SP is 45+ (Section U)					58
<p><i>Read to respondent :</i></p> <p>Does heavy drinking during pregnancy definitely increase, probably increase, probably not or definitely not increase the chances of –</p>		DEFINITELY INCREASES	PROBABLY INCREASES	PROBABLY DOES NOT INCREASE	DEFINITELY DOES NOT INCREASE	DK/NO OPINION	
g. Miscarriage?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	59
h. Mental retardation of the newborn?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	60
i. Low birth weight of the newborn?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	61
j. Birth defects?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	62
10a. Have you ever heard of FETAL ALCOHOL SYNDROME?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Section U)					63
b. In your opinion, which ONE of the following best describes Fetal Alcohol Syndrome – a baby is born drunk, or born addicted to alcohol, or born with certain birth defects?		1 <input type="checkbox"/> Drunk 2 <input type="checkbox"/> Addicted to alcohol 3 <input type="checkbox"/> With certain birth defects					64

FOOTNOTES

Section U. DENTAL CARE

1. This next question is about preventing TOOTH DECAY . Hand Card U. After I read each of the following, tell me if you think it is definitely important, probably important, probably not, or definitely not important in preventing TOOTH DECAY . First —	DEFINITELY IMPORTANT	PROBABLY IMPORTANT	PROBABLY NOT IMPORTANT	DEFINITELY NOT IMPORTANT	DK/NO OPINION	
a. Seeing a dentist regularly? (Give me a number from the card.)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	65
b. Drinking water with fluoride from early childhood?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	66
c. Regular brushing and flossing of the teeth?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	67
d. Using fluoride toothpaste or fluoride mouth rinse?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	68
e. Avoiding between-meal sweets?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	69
2. Now I'm going to ask about preventing GUM DISEASE . In your opinion, how important or not important is each of the following in preventing GUM DISEASE ? First —						
a. Seeing a dentist regularly?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	70
b. Drinking water with fluoride from early childhood?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	71
c. Regular brushing and flossing of the teeth?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	72
d. Using fluoride toothpaste or fluoride mouth rinse?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	73
e. Avoiding between-meal sweets?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	74
3. In your opinion, which of the following is the MAIN cause of tooth loss in CHILDREN — tooth decay, gum disease, or injury to the teeth?	1 <input type="checkbox"/> Tooth decay 2 <input type="checkbox"/> Gum disease 3 <input type="checkbox"/> Injury to the teeth					75
4. In your opinion, which of the following is the MAIN cause of tooth loss in ADULTS — tooth decay, gum disease, or injury to the teeth?	1 <input type="checkbox"/> Tooth decay 2 <input type="checkbox"/> Gum disease 3 <input type="checkbox"/> Injury to the teeth					76
5a. Have you ever heard of DENTAL SEALANTS ?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Section V)					77
b. Which of the following BEST describes the purpose of dental sealants — to prevent gum disease, to prevent tooth decay, or to hold dentures in place?	1 <input type="checkbox"/> Prevent gum disease 2 <input type="checkbox"/> Prevent tooth decay 3 <input type="checkbox"/> Hold dentures in place					78

FOOTNOTES

Section V. OCCUPATIONAL SAFETY AND HEALTH

V1

Refer to "Wa/Wb" boxes in C1 on HIS-1.

- 1 Wa or Wb box marked (1)
- 8 Other (Cover page)

Read to respondent:

These questions are about your present job.

1a. In your present job, are you exposed to any **SUBSTANCES** that could endanger your health, such as chemicals, dusts, fumes, or gases?

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

b. What substances are you exposed to that could endanger your health?

Enter each substance in a separate column.

Any others?

SUBSTANCE 1

SUBSTANCE 2

7-8

17-18

Ask 1c for each response in 1b.

c. How can (response in 1b) endanger your health?

Record verbatim response(s).

Any other way?

9-16

19-26

99 DK

99 DK

2a. In your present job, are you exposed to any **WORK CONDITIONS** that could endanger your health, such as loud noise, extreme heat or cold, physical or mental stress, or radiation?

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

b. What work conditions are you exposed to that could endanger your health?

Enter each work condition in a separate column.

Any others?

WORK CONDITION 1

WORK CONDITION 2

6-7

16-17

Ask 2c for each response in 2b.

c. How can (response in 2b) endanger your health?

Record verbatim response(s).

Any other way?

8-15

18-26

99 DK

99 DK

3a. In your present job are you exposed to any risks of accidents or injuries?

- 1 Yes
- 2 No
- 9 DK } (Cover Page)

b. What (other) risks of accidents or injuries are you exposed to?

Record verbatim response(s).

c. Any others?

- Yes (Reask 3b and c)
- No
- DK } (Cover Page)

CARD R

RACE

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

HS 501 (1986) (10-20-87)

CARD O

ORIGIN

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

HS 501 (1986) (10-20-87)

Card R

Card O

(Cut along dashed 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

HS 501 (1986) (10-20-87)

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

HS 501 (1986) (10-20-87)

Card I

Card J

(Cut along dashed line.)

CARD N1

Choose two

1. Don't eat at bedtime
2. Eat fewer calories
3. Take diet pills
4. Increase physical activity
5. Eat NO fat
6. Eat grapefruit with each meal

FORM HS-501 (1985) (10-2-84)

CARD N2

1. Have two or more usual doctors or places depending on what is wrong
2. Haven't needed a doctor
3. Previous doctor no longer available
4. Haven't been able to find the right doctor
5. Recently moved to area
6. Can't afford medical care
8. Other reason — Specify

Card N1
Card N2

FORM HS-501 (1985) (10-2-84)

CARD P

1. Definitely increases the chances of heart disease
2. Probably increases the chances of heart disease
3. Probably does not increase the chances of heart disease
4. Definitely does not increase the chances of heart disease
9. Don't know or no opinion

FORM HS-501 (1985) (10-2-84)

CARD R1

1. No faster than usual
2. A little faster than usual
3. A lot faster but talking is possible
4. So fast that talking is not possible

Card P
Card R1

FORM HS-501 (1985) (10-2-84)

FORM HS-501 (1985) (10-2-84)

CARD S

Cigarette smoking —

- 1. Definitely increases the chances**
- 2. Probably increases the chances**
- 3. Probably does not increase the chances**
- 4. Definitely does not increase the chances**
- 9. Don't know or no opinion.**

FORM HS-501 (1982) (10-2-84)

CARD T

Heavy alcohol drinking —

- 1. Definitely increases the chances**
- 2. Probably increases the chances**
- 3. Probably does not increase the chances**
- 4. Definitely does not increase the chances**
- 9. Don't know or no opinion**

FORM HS-501 (1982) (10-2-84)

Card S
Card T

(Continue backside)

CARD U

- 1. Definitely important**
- 2. Probably important**
- 3. Probably not important**
- 4. Definitely not important**
- 9. Don't know or no opinion**

FORM HS-501 (1982) (10-2-84)

1986

The 1986 NHIS was conducted with a sample approximately one-half the size of the full sample because of funding limitations. The 1986 NHIS sample included two of the four panels. The interview sample for 1986 was composed of 23,838 households in which 62,052 persons were interviewed.

In 1986, as in previous years, the NHIS obtained data on acute conditions, episodes of persons injured, restriction in activity, limitation of activity due to chronic conditions, the prevalence of chronic conditions, respondent-assessed health status, and the use of medical services—including physician contacts and short-stay hospitalization.

The current health topics included in the 1986 NHIS were vitamin and mineral intake, employment, dental health, functional limitations, and health insurance. Except for the health insurance questions, the 1986 health topics were included in a separate booklet. Questions on health insurance were included in the health and demographic questionnaire.

The questions on vitamin and mineral intake inquired about the name of the product, the amount taken, the

length of time the product was taken, and if the product was obtained with a doctor's prescription.

The questions pertaining to employment asked about the longest job worked, the kind of work the sample person had been doing the longest, and the kind of business or industry it was.

The questions on dental health pertained to the number of dental visits, the reason for going to the dentist, the brand of toothpaste and fluoride mouthrinses used, the use of fluoride supplements, and the purpose of water fluoridation.

The questions on functional limitations pertained to the activities of daily living and the instrumental activities of daily living. The survey instrument also included questions about the number of steps and the number of floors, and the need for having a walk-in shower and having a bathroom, bedroom, and kitchen on the same floor.

The health insurance questions inquired about Medicare, Medicaid, military, and other health insurance plans and coverage; reasons for not having health insurance; compensation for disability; and coverage during job layoff.

Section M. HEALTH INSURANCE

R1 03
3-4

Read to respondent(s): Medicare is a Social Security health insurance program for disabled persons and for persons 65 years old and over. People covered by Medicare have a card that looks like this. Show card.

1a. Is anyone in this family, that is (read names), now covered by Medicare? Yes No (4) DK

1b. 1 Covered 9 DK 5
2 Not covered

Ask for each person with "Covered" in 1b:

2a. Is --- now covered by the part of Social Security Medicare which pays for hospital bills?

2a. 1 Yes 9 DK 6
2 No

b. Is --- now covered by that part of Medicare which pays for doctor's bills? This is the Medicare plan for which --- or some agency must pay a certain amount each month.

b. 1 Yes 9 DK 7
2 No

Ask for each person with "DK" in 2a and/or b:

3. May I please see the Social Security Medicare card(s) for --- (and ---) to determine the type of coverage? Transcribe the information from the card or mark the "Card N.A." box.

3. 1 Hospital 8
2 Medical
3 Card N.A.

4a. We are interested in all kinds of health insurance plans except those which pay only for accidents. (Not counting Medicare) Is anyone in the family now covered by a health insurance plan which pays any part of a hospital, doctor's, surgeon's or dentist's bill? Yes No (M1) DK (M1)

9

b. What is the name of the plan? Record in Table H.I.

c. Is anyone in the family now covered by any other health insurance plan which pays any part of a hospital, doctor's, surgeon's or dentist's bill? Yes (Reask 4b and c) No

TABLE H.I.

PLAN 1 NAME

10

5a. Is this (name) plan a Health Maintenance Organization or HMO? Yes No DK
1 2 9
11

b. Was this plan obtained through an employer or union? 1 2 (6a) 9 (6a)
12

c. Is it now carried through an employer or union? 1 2 9
13

6a. Does this (name) plan pay any part of hospital expenses? Yes No DK
1 2 9
14

b. Does this plan pay any part of doctor's or surgeon's bills for operations? 1 2 9
15

c. Does it pay for any DENTAL services other than oral surgery? 1 2 9
16

7. Is --- covered under this (name) plan? 7.

1 Covered ... } (NP)
2 Not covered
9 DK

17

PLAN 2 NAME

18

5a. Is this (name) plan a Health Maintenance Organization or HMO? Yes No DK
1 2 9
19

b. Was this plan obtained through an employer or union? 1 2 (6a) 9 (6a)
20

c. Is it now carried through an employer or union? 1 2 9
21

6a. Does this (name) plan pay any part of hospital expenses? Yes No DK
1 2 9
22

b. Does this plan pay any part of doctor's or surgeon's bills for operations? 1 2 9
23

c. Does it pay for any DENTAL services other than oral surgery? 1 2 9
24

7. Is --- covered under this (name) plan? 7.

1 Covered ... } (NP)
2 Not covered
9 DK

25

PLAN 3 NAME

26

5a. Is this (name) plan a Health Maintenance Organization or HMO? Yes No DK
1 2 9
27

b. Was this plan obtained through an employer or union? 1 2 (6a) 9 (6a)
28

c. Is it now carried through an employer or union? 1 2 9
29

6a. Does this (name) plan pay any part of hospital expenses? Yes No DK
1 2 9
30

b. Does this plan pay any part of doctor's or surgeon's bills for operations? 1 2 9
31

c. Does it pay for any DENTAL services other than oral surgery? 1 2 9
32

7. Is --- covered under this (name) plan? 7.

1 Covered ... } (NP)
2 Not covered
9 DK

33

	3-4		3-4		3-4		3-4
1b.	1 <input type="checkbox"/> Covered 2 <input type="checkbox"/> Not covered	9 <input type="checkbox"/> DK	5	1 <input type="checkbox"/> Covered 2 <input type="checkbox"/> Not covered	9 <input type="checkbox"/> DK	5	1b. 1 <input type="checkbox"/> Covered 2 <input type="checkbox"/> Not covered
2a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	9 <input type="checkbox"/> DK	6	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	9 <input type="checkbox"/> DK	6	2a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	9 <input type="checkbox"/> DK	7	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	9 <input type="checkbox"/> DK	7	b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
3.	1 <input type="checkbox"/> Hospital 2 <input type="checkbox"/> Medical 3 <input type="checkbox"/> Card N.A.		8	1 <input type="checkbox"/> Hospital 2 <input type="checkbox"/> Medical 3 <input type="checkbox"/> Card N.A.		8	3. 1 <input type="checkbox"/> Hospital 2 <input type="checkbox"/> Medical 3 <input type="checkbox"/> Card N.A.
			9			9	
			9			9	
			9			9	
7.	1 <input type="checkbox"/> Covered ... 2 <input type="checkbox"/> Not covered 9 <input type="checkbox"/> DK	} (NP)	17	1 <input type="checkbox"/> Covered ... 2 <input type="checkbox"/> Not covered 9 <input type="checkbox"/> DK	} (NP)	17	7. 1 <input type="checkbox"/> Covered ... 2 <input type="checkbox"/> Not covered 9 <input type="checkbox"/> DK
7.	1 <input type="checkbox"/> Covered ... 2 <input type="checkbox"/> Not covered 9 <input type="checkbox"/> DK	} (NP)	25	1 <input type="checkbox"/> Covered ... 2 <input type="checkbox"/> Not covered 9 <input type="checkbox"/> DK	} (NP)	25	7. 1 <input type="checkbox"/> Covered ... 2 <input type="checkbox"/> Not covered 9 <input type="checkbox"/> DK
7.	1 <input type="checkbox"/> Covered ... 2 <input type="checkbox"/> Not covered 9 <input type="checkbox"/> DK	} (NP)	33	1 <input type="checkbox"/> Covered ... 2 <input type="checkbox"/> Not covered 9 <input type="checkbox"/> DK	} (NP)	33	7. 1 <input type="checkbox"/> Covered ... 2 <input type="checkbox"/> Not covered 9 <input type="checkbox"/> DK

FORM HIS-1(1988) (7-3-85)

Section M. HEALTH INSURANCE, Continued

TABLE H.I., Continued

PLAN 4 NAME										34			41	
5a. Is this (name) plan a Health Maintenance Organization or HMO?			Yes	No	DK				35	7. Is --- covered under this (name) plan? 7. <input type="checkbox"/> Covered ... } (NP) <input type="checkbox"/> Not covered <input type="checkbox"/> DK				
b. Was this plan obtained through an employer or union?			1	2 (6a)	9 (6a)				36					
c. Is it now carried through an employer or union?			1	2	9				37					
6a. Does this (name) plan pay any part of hospital expenses?			Yes	No	DK				38	7. Is --- covered under this (name) plan? 7. <input type="checkbox"/> Covered ... } (NP) <input type="checkbox"/> Not covered <input type="checkbox"/> DK				
b. Does this plan pay any part of doctor's or surgeon's bills for operations?			1	2	9				39					
c. Does it pay for any DENTAL services other than oral surgery?			1	2	9				40					
PLAN 5 NAME										42			49	
5a. Is this (name) plan a Health Maintenance Organization or HMO?			Yes	No	DK				43	7. Is --- covered under this (name) plan? 7. <input type="checkbox"/> Covered ... } (NP) <input type="checkbox"/> Not covered <input type="checkbox"/> DK				
b. Was this plan obtained through an employer or union?			1	2 (6a)	9 (6a)				44					
c. Is it now carried through an employer or union?			1	2	9				45					
6a. Does this (name) plan pay any part of hospital expenses?			Yes	No	DK				46	7. Is --- covered under this (name) plan? 7. <input type="checkbox"/> Covered ... } (NP) <input type="checkbox"/> Not covered <input type="checkbox"/> DK				
b. Does this plan pay any part of doctor's or surgeon's bills for operations?			1	2	9				47					
c. Does it pay for any DENTAL services other than oral surgery?			1	2	9				48					
M1										Review 1 and 7 for each person and determine if "Covered" by either Medicare and/or insurance, or "Not covered."		50	<input type="checkbox"/> Covered } (NP) <input type="checkbox"/> Not covered under 65 .. <input type="checkbox"/> Not covered 65 and over <input type="checkbox"/> DK	
Ask for each person "Not covered" in M1. If "Not covered 65 and over," include "or Medicare."												51-52		
8a. (Many people do not carry health insurance for various reasons.) Hand Card M. Which of those statements describes why --- is not covered by any health insurance (or Medicare)? Any other reason? _____ Circle all reasons given.												53-54		
Mark box if only one reason. If "Not covered 65 and over" in M1, include "or Medicare."												55-56		
b. What is the MAIN reason --- is not covered by any health insurance (or Medicare)?												57-58		
Ask only if persons under age 20 in family:														
9a. Does anyone in this family now receive assistance through the "Aid to Families with Dependent Children" program, sometimes called "AFDC" or "ADC"?										<input type="checkbox"/> Yes <input type="checkbox"/> No (10) <input type="checkbox"/> DK				
b. Does --- now receive AFDC or ADC?												59	<input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> No	
10a. Does anyone in this family now receive the "Supplemental Security Income" or "SSI" check?										<input type="checkbox"/> Yes <input type="checkbox"/> No (11) <input type="checkbox"/> DK				
b. Does --- now receive this check?												60	<input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> No	

7.	41 1 <input type="checkbox"/> Covered ... 2 <input type="checkbox"/> Not covered } (NP) 9 <input type="checkbox"/> DK	41 1 <input type="checkbox"/> Covered ... 2 <input type="checkbox"/> Not covered } (NP) 9 <input type="checkbox"/> DK	41 1 <input type="checkbox"/> Covered ... 2 <input type="checkbox"/> Not covered } (NP) 9 <input type="checkbox"/> DK
7.	49 1 <input type="checkbox"/> Covered ... 2 <input type="checkbox"/> Not covered } (NP) 9 <input type="checkbox"/> DK	49 1 <input type="checkbox"/> Covered ... 2 <input type="checkbox"/> Not covered } (NP) 9 <input type="checkbox"/> DK	49 1 <input type="checkbox"/> Covered ... 2 <input type="checkbox"/> Not covered } (NP) 9 <input type="checkbox"/> DK
M1	50 1 <input type="checkbox"/> Covered 2 <input type="checkbox"/> Not covered under 65 .. 3 <input type="checkbox"/> Not covered 65 and over 9 <input type="checkbox"/> DK	50 1 <input type="checkbox"/> Covered 2 <input type="checkbox"/> Not covered under 65 .. 3 <input type="checkbox"/> Not covered 65 and over 9 <input type="checkbox"/> DK	50 1 <input type="checkbox"/> Covered 2 <input type="checkbox"/> Not covered under 65 .. 3 <input type="checkbox"/> Not covered 65 and over 9 <input type="checkbox"/> DK
8a.	51-52 1 2 3 4 5 6 7 8 ▾ Specify	51-52 1 2 3 4 5 6 7 8 ▾ Specify	51-52 1 2 3 4 5 6 7 8 ▾ Specify
b.	53-54 55-56 57-58 00 <input type="checkbox"/> Only one reason 1 2 3 4 5 6 7 8 ▾ Specify	53-54 55-56 57-58 00 <input type="checkbox"/> Only one reason 1 2 3 4 5 6 7 8 ▾ Specify	53-54 55-56 57-58 00 <input type="checkbox"/> Only one reason 1 2 3 4 5 6 7 8 ▾ Specify
9b.	59 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	59 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	59 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
10b.	60 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	60 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	60 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK

FORM HIS-1(1986) (7-3-85)

Section M. HEALTH INSURANCE, Continued

<p>11a. There is a national program called Medicaid which pays for health care for persons in need. (In this State it is also called <u>(name)</u>.) During the past 12 months, has anyone in this family received health care which has been or will be paid for by Medicaid (or <u>(name)</u>)? <input type="checkbox"/> Yes <input type="checkbox"/> No (12) <input type="checkbox"/> DK</p> <p>b. Has --- received this care in the past 12 months?</p>	<p>11b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 61 2 <input type="checkbox"/> No</p>
<p>12a. Is anyone in the family now have a Medicaid (or <u>(name)</u>) card which looks like this? Show Medicaid card(s). <input type="checkbox"/> Yes <input type="checkbox"/> No (13) <input type="checkbox"/> DK</p> <p>b. Does --- now have this card?</p> <p><i>Ask for each person with "Yes" in 12b:</i></p> <p>c. May I please see --- (and ---) card(s)? Mark appropriate box(es) in person's column.</p>	<p>12b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 62 2 <input type="checkbox"/> No</p> <p>c. <input type="checkbox"/> Medicaid card seen <input checked="" type="checkbox"/> 1 <input type="checkbox"/> Current 2 <input type="checkbox"/> Expired 3 <input type="checkbox"/> No card seen 8 <input type="checkbox"/> Other card seen _____ <i>Specify</i></p> <p align="right">63</p>
<p>13a. Is anyone in the family now covered by any other public assistance program that pays for health care? <input type="checkbox"/> Yes <input type="checkbox"/> No (14) <input type="checkbox"/> DK</p> <p>b. Is --- now covered?</p>	<p>13b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 64 2 <input type="checkbox"/> No</p>
<p>14a. Does anyone in the family now receive military retirement payments from any branch of the Armed Forces or a pension from the Veterans' Administration? Do not include VA disability compensation. <input type="checkbox"/> Yes <input type="checkbox"/> No (15) <input type="checkbox"/> DK</p> <p>b. Does --- now receive military retirement or a VA pension?</p> <p><i>Ask for each person with "Yes" in 14b:</i></p> <p>c. Which does --- receive — the Armed Forces retirement, the VA pension or both?</p>	<p>14b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 65 2 <input type="checkbox"/> No</p> <p>c. 1 <input type="checkbox"/> Armed Forces 2 <input type="checkbox"/> VA 3 <input type="checkbox"/> Both</p> <p align="right">66</p>
<p>15a. Is anyone in the family now covered by CHAMPUS, which is a program of medical care for dependents of military personnel? <input type="checkbox"/> Yes <input type="checkbox"/> No (15c) <input type="checkbox"/> DK</p> <p>b. Is --- now covered by CHAMPUS?</p> <p>c. Is anyone in the family now covered by CHAMP-VA, which is medical insurance for dependents or survivors of disabled veterans? <input type="checkbox"/> Yes <input type="checkbox"/> No (16) <input type="checkbox"/> DK</p> <p>d. Is --- now covered by CHAMP-VA?</p>	<p>15b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 67 2 <input type="checkbox"/> No</p> <p>d. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 68 2 <input type="checkbox"/> No</p>
<p>16a. Is anyone in the family now covered by any other program that provides health care for military dependents or survivors of military persons? <input type="checkbox"/> Yes <input type="checkbox"/> No (M2) <input type="checkbox"/> DK</p> <p>b. Is --- now covered?</p>	<p>16b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 69 2 <input type="checkbox"/> No</p>

11b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	9 <input type="checkbox"/> DK	61	
12b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	9 <input type="checkbox"/> DK	62	
c.	<input type="checkbox"/> Medicaid card seen 1 <input type="checkbox"/> Current 2 <input type="checkbox"/> Expired 3 <input type="checkbox"/> No card seen 8 <input type="checkbox"/> Other card seen		63	
	<i>Specify</i>			
13b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	9 <input type="checkbox"/> DK	64	
14b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	9 <input type="checkbox"/> DK	65	
c.	1 <input type="checkbox"/> Armed Forces 2 <input type="checkbox"/> VA 3 <input type="checkbox"/> Both		66	
15b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	9 <input type="checkbox"/> DK	67	
d.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	9 <input type="checkbox"/> DK	68	
16b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	9 <input type="checkbox"/> DK	69	

FORM HIS-1(1989) (7-3-85)

Section M. HEALTH INSURANCE, Continued

M2	Refer to "AF" box above person's column.	M2	1 <input type="checkbox"/> AF box marked (17) 8 <input type="checkbox"/> Other (NP)	70
	17a. Does --- have a disability related to --- service in the Armed Forces of the United States? ----- b. Does --- now receive compensation for this disability from the Veterans' Administration? ----- c. Has --- ever applied for a service-connected disability rating from the Veterans' Administration? ----- d. Was it approved or denied?		17a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP) ----- b. 1 <input type="checkbox"/> Yes (NP) 2 <input type="checkbox"/> No ----- c. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK (NP) 2 <input type="checkbox"/> No (NP) ----- d. 1 <input type="checkbox"/> Approved 3 <input type="checkbox"/> Pending 2 <input type="checkbox"/> Denied 9 <input type="checkbox"/> DK	71 72 73 74
	18a. During the past 12 months, that is since (12-month date) a year ago, have (read names of related HH members 18 or over) been laid off from a job or lost a job? <input type="checkbox"/> Yes <input type="checkbox"/> No (Supplement Booklet) <input type="checkbox"/> DK (Supplement Booklet) ----- b. Who was this? Mark "Laid off/lost job" box in person's column. ----- c. Anyone else? <input type="checkbox"/> Yes (Reask 18b and c) <input type="checkbox"/> No Ask 18d, e, and f for each person with "Laid off/lost job" in 18b. ----- d. How many times has --- been laid off or lost a job during the past 12 months? ----- e. In what month and year was --- laid off or did --- lose a job [(the last time/the time before that)]? ----- f. For ANYTIME during [that/those] job layoff(s) or job loss(es), did --- receive unemployment insurance benefits?		18b. 1 <input type="checkbox"/> Laid off/lost job ----- d. _____ Times ----- e. Mo. Yr. 19 Time 1 ----- Mo. Yr. 19 Time 2 ----- Mo. Yr. 19 Time 3	75 76 77-80 81-84 85-88 89
	19a. Because of (names of persons in 18b) job layoff(s) or job loss(es), did anyone in the family lose any health insurance coverage that had been carried through [that/those] job(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No (Supplement Booklet) <input type="checkbox"/> DK (Supplement Booklet) ----- b. Who was this? Mark "Lost coverage" box in person's column. ----- c. Anyone else? <input type="checkbox"/> Yes (Reask 19b and c) <input type="checkbox"/> No		19b. 1 <input type="checkbox"/> Lost coverage	90
M3	Refer to 19b and mark appropriate box.	M3	1 <input type="checkbox"/> Lost coverage (20) 2 <input type="checkbox"/> Did not lose coverage (NP)	91
	20a. For ANYTIME during [that/those] job layoff(s) or job loss(es), was --- without any type of health insurance coverage? (Do not include health care programs, such as Medicaid, AFDC, or military benefit programs, as health insurance coverage.) ----- b. For how long was --- without some type of health insurance coverage? (How many months is that?)		20a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (21) ----- b. 00 <input type="checkbox"/> Less than 1 month ____ Months	92 93-94
	21a. For ANYTIME during [that/those] job layoff(s) or job loss(es), was --- covered by any health care program, such as Medicaid, AFDC, or a military benefit program? ----- b. For how long was --- covered by some health care program? (How many months is that?)		21a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP) ----- b. 00 <input type="checkbox"/> Less than 1 month ____ Months	95 96-97

FORM **HIS-1(SB) (1986)**
(3-19-88)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR THE
U.S. PUBLIC HEALTH SERVICE

**NATIONAL HEALTH INTERVIEW
SURVEY**

SUPPLEMENT BOOKLET

NOTICE — Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

1.		RT 64	2. R.O. Number		9-10	3. Sample		11-13
		3-7						
		8	Book _____ of _____ books					
4. Control number				5. Beginning time				
PSU		14-16	Segment	17-23	Serial	24-25	26-29	30
								1 a.m.
								2 p.m.

GO TO SECTION N

9. FINAL STATUS OF SUPPLEMENTS

a. Sections N and O
(Household Respondent Section)

43

Interview

- 1 Complete interview (all appropriate sections completed)
- 2 Partial interview (some but not all appropriate sections completed)
(*Explain in notes*)

Noninterview

- 3 Refusal } (*Explain in notes*)
- 8 Other }

b. Section P
(Eligible Person Section)

44

- 0 No person 65+ in this family
- 1 All eligible persons interviewed
- 2 Some but not all eligible persons interviewed (*Explain in notes*)
- 3 No eligible persons interviewed (*Explain in notes*)

10. Ending time

47-50	51
	1 a.m.
	2 p.m.

11. Interviewer identification

Name

Code

52-53

FOOTNOTES

Section N. LONGEST JOB WORKED		PERSON 1		3-4
N1	Refer to age	N1	1 <input type="checkbox"/> Under 25 (NP) 2 <input type="checkbox"/> 25+ (N2)	5
N2	Refer to HIS-1 pages 44, 45, q. 6b/c.	N2	1 <input type="checkbox"/> "NEV" marked in 6b/c (NP) 8 <input type="checkbox"/> All others (1)	6
READ TO RESPONDENT(S): {Now I would like to ask about work experience.}			000 <input type="checkbox"/> Never worked (NP) 905 <input type="checkbox"/> AF	7-9
1. Of all the PAID jobs or businesses — ever had, what kind of work was — doing the longest? <i>(For example, electrical engineer, stock clerk, typist, farmer.)</i>		1.	_____	
			Occupation	
2. How long did — do this kind of work?		2.	1 <input type="checkbox"/> Less than 5 years 2 <input type="checkbox"/> 5 years, less than 10 years 3 <input type="checkbox"/> 10 years, less than 20 years 4 <input type="checkbox"/> 20 or more years	10
<i>Mark box if "AF" marked in 1.</i>		3.	942 <input type="checkbox"/> AF	11-13
3. What kind of business or industry did — work in the longest as a (entry in 1)? <i>(For example, TV and radio manufacturing, retail shoe store, State Labor Department, farm.)</i>			_____	
			Industry	

FOOTNOTES

Section O. DENTAL HEALTH

PERSON 1

3-4

5-6

Now I'm going to ask you some questions about WATER FLUORIDATION.

1. As you understand it, what is the purpose of adding FLUORIDE to the public drinking water?

Do not read answer categories, circle the ONE that best fits respondent's answer.

- 1. Prevent tooth decay, protect teeth, or related response
8. Other (Specify)
9. Don't know

1.

1 8 7 9

(Specify)

2a. Does the water that you drink at home come from a public water system or is it from another source, such as a well?

2a.

- 1 Public water system
8 Other source
9 DK

7

b. Does this drinking water have FLUORIDE in it?

b.

- 1 Yes
2 No
9 DK

8

HAND CALENDAR. These next questions are about receiving dental care.

3a. During the 2 weeks (outlined in red on that calendar), beginning Monday (date) and ending this past Sunday (date), did anyone in the family go to a dentist? Include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists.

Yes No (4)

b. Who was this?

Mark "Dental visit" box in person's column.

3b.

- 1 Dental visit

9

c. During those 2 weeks, did anyone else in the family go to a dentist?

Yes (Reask 3b and c) No

Ask for each person with "Dental visit" in 3b:

d. During those 2 weeks, how many times did -- go to a dentist?

d.

Number of times

10-11

Mark box if under two years old.

4a. During the past 12 months (that is, since (12-month date) a year ago), how many visits did -- make to a dentist? (Include the (Number in 3d) visit(s) you already told me about.)

4a.

- 999 Under 2 (NP)
Visits
000 None

12-14

Mark "2-week dental visit" box in person's column if visit(s) reported in 3d.

b. How long has it been since -- LAST went to a dentist?

b.

- 1 Past 2 weeks not reported (Mark 3b, ask 3d)
2 2-week dental visit
3 Over 2 weeks, less than 6 months
4 6 months, less than 1 year
5 1 year, less than 2 years
6 2 years, less than 5 years
7 5 years or more
0 Never

15

01

Refer to 4b.

01

- 1 Less than 2 years in 4b (5)
8 Other (NP)

16

{Some people go to the dentist because they think they have a problem; other people go to the dentist for a check-up or to have their teeth cleaned. Sometimes when people go for a check-up the dentist discovers a problem that needs to be treated.}

5. What was the MAIN REASON -- last went to the dentist?

Do not read answer categories, circle the ONE main reason.

- 1. Went in on own for check-up, examination or cleaning.
2. Was called in by the dentist for check-up, examination or cleaning.
3. Something was wrong, bothering or hurting --
4. Went for treatment of a condition that dentist discovered at earlier check-up or examination.
8. Other (Specify)
9. Don't know

5.

1 2 3 4 8 7 9

(Specify)

17-18

FOOTNOTES

Section O. DENTAL HEALTH, Continued		PERSON 1												
6a. Is there anyone in the family who has lost ALL of his or her natural teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No (7)														
b. Who is this? Mark "Lost all teeth" box in person's column.		6b. 1 <input type="checkbox"/> Lost all teeth 19												
c. Anyone else? <input type="checkbox"/> Yes (Reask 6b and c) <input type="checkbox"/> No														
02	Refer to 6b for all family members.	02 1 <input type="checkbox"/> "Lost all teeth" marked in 6b for all family members (Section P) 8 <input type="checkbox"/> Other (7) 20												
Do not ask for persons with "Lost all teeth" in 6b. 7a. (Now I am going to ask about some things that people may be doing to take care of their teeth.) What does — — use when — — brushes — — teeth — toothpaste, tooth powder, or something else?		7a. 1 <input type="checkbox"/> Toothpaste (7b) 21 8 <input type="checkbox"/> Other <input checked="" type="checkbox"/> _____ (NP)												
b. What brand did — — use most often during the past two weeks? Do not read answer categories, circle ONE brand. <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">1. Crest</td> <td style="width: 33%;">4. Dentagard</td> <td style="width: 33%;">8. Other (Specify)</td> </tr> <tr> <td>2. Crest Tartar Control</td> <td>5. Aquafresh</td> <td>9. Don't know</td> </tr> <tr> <td>3. Colgate</td> <td>6. Aim</td> <td></td> </tr> </table>		1. Crest	4. Dentagard	8. Other (Specify)	2. Crest Tartar Control	5. Aquafresh	9. Don't know	3. Colgate	6. Aim		b. _____ 22-23 1 2 3 4 5 6 8 - 9 _____ (Specify)			
1. Crest	4. Dentagard	8. Other (Specify)												
2. Crest Tartar Control	5. Aquafresh	9. Don't know												
3. Colgate	6. Aim													
8a. Does anyone in the family now use a FLUORIDE mouthrinse at home? <input type="checkbox"/> Yes <input type="checkbox"/> No (03) <input type="checkbox"/> DK (03)														
b. Who is this? Mark "Fluoride mouthrinse" box in person's column.		8b. 1 <input type="checkbox"/> Fluoride mouthrinse 24												
c. Anyone else? <input type="checkbox"/> Yes (Reask 8b and c) <input type="checkbox"/> No														
Ask for each person with "Fluoride mouthrinse" in 8b: d. What brand did — — use most often during the past 2 weeks? Do not read answer categories, circle ONE brand. <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">1. <input type="checkbox"/> ACT</td> <td style="width: 33%;">2. Prescription fluoride rinse</td> <td style="width: 33%;"></td> </tr> <tr> <td><input type="checkbox"/> Fluorigard</td> <td>8. Other (Specify)</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Listermint with Fluoride</td> <td>9. Don't know</td> <td></td> </tr> <tr> <td><input type="checkbox"/> StanCare</td> <td></td> <td></td> </tr> </table>		1. <input type="checkbox"/> ACT	2. Prescription fluoride rinse		<input type="checkbox"/> Fluorigard	8. Other (Specify)		<input type="checkbox"/> Listermint with Fluoride	9. Don't know		<input type="checkbox"/> StanCare			d. 1 2 8 <input checked="" type="checkbox"/> 9 25-26 _____ (Specify)
1. <input type="checkbox"/> ACT	2. Prescription fluoride rinse													
<input type="checkbox"/> Fluorigard	8. Other (Specify)													
<input type="checkbox"/> Listermint with Fluoride	9. Don't know													
<input type="checkbox"/> StanCare														
03	Refer to age.	03 1 <input type="checkbox"/> Under 17 (9) 27 2 <input type="checkbox"/> 17 and over (NP)												
9. Does — — now take part in a fluoride MOUTHRINSE program at school?		9. 1 <input type="checkbox"/> Yes 28 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK												
10a. Does anyone in the family now take vitamins with FLUORIDE in them or any other kind of FLUORIDE drops, pills, or tablets, either at home or at school? <input type="checkbox"/> Yes <input type="checkbox"/> No (11) <input type="checkbox"/> DK (11)														
b. Who is this? Mark "Fluoride Supplements" box in person's column.		10b. 1 <input type="checkbox"/> Fluoride supplements 29												
c. Anyone else? <input type="checkbox"/> Yes (Reask 10b and c) <input type="checkbox"/> No														
11a. Dental SEALANTS are special plastic coatings that are painted on the tops of the back teeth to prevent tooth decay. They are put on by a dentist or a dental hygienist. They are DIFFERENT from fillings, caps, crowns and fluoride treatments. Has anyone in the family had dental SEALANTS placed on their teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No (Section P) <input type="checkbox"/> DK (Section P)														
b. Who is this? Mark "Dental sealants" box in person's column.		11b. 1 <input type="checkbox"/> Dental sealants 30												
c. Anyone else? <input type="checkbox"/> Yes (Reask 11b and c) <input type="checkbox"/> No														

FOOTNOTES

Section P. FUNCTIONAL LIMITATIONS (FL)

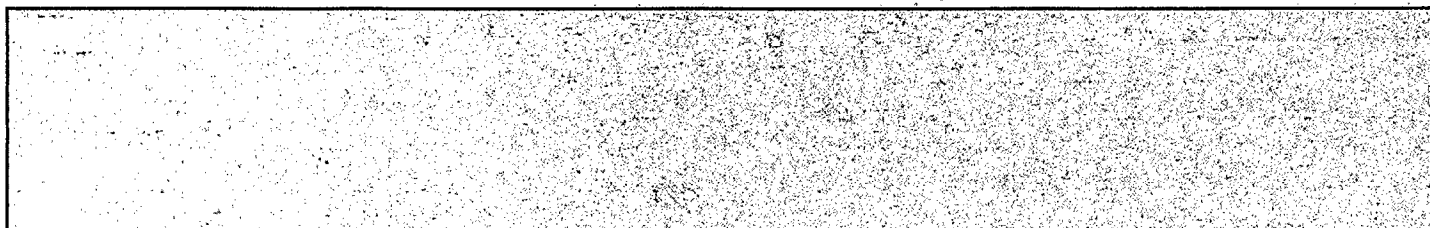
P1	Refer to ages of all family members	<input type="checkbox"/> Persons 65+ in family (Enter person number and first name of EACH person on a separate FL page)	<input type="checkbox"/> No persons 65+ in family (Cover Page)
FL1	Person No. 3-4 First name _____	<input type="checkbox"/> Callback required (Hhld. page, THEN NP)	<input type="checkbox"/> Available (1)
		<input type="checkbox"/> Noninterview (Footnotes, THEN NP)	

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

1. Because of a health or physical problem, do you have ANY difficulty —	(1) 5	(2) 21	(3) 37
Bathing or showering? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason	Dressing? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason	Eating? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason	
Ask 2-5 for each activity marked "Yes" in 1. 2. By yourself and without using special equipment, how much difficulty do you have (activity), some, a lot, or are you unable to do it?	6 6	22 22	38 38
1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable	1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable	1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable	
3. Do you receive help from anyone in (activity)?	7 7	23 23	39 39
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)	
4a. Who gives this help?	4a. Source of help 8-11	4b. Paid 12-16	4a. Source of help 24-27
Anyone else? Mark the S/C/P box without asking if ONLY help is from spouse/children/parents. b. Is this help paid for? Ask if necessary: Which helpers are paid?	HH member 1 <input type="checkbox"/> Relative 2 <input type="checkbox"/> Nonrelative Non-HH member 3 <input type="checkbox"/> Relative 4 <input type="checkbox"/> Nonrelative	0 <input type="checkbox"/> S/C/P (5) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	HH member 1 <input type="checkbox"/> Relative 2 <input type="checkbox"/> Nonrelative Non-HH member 3 <input type="checkbox"/> Relative 4 <input type="checkbox"/> Nonrelative
	40-43 40-43	44-47 44-47	28-31 28-31
	1 <input type="checkbox"/> Relative 2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Relative 2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Relative 2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
5a. Do you use any special equipment or aids in (activity)?	16 16	32 32	48 48
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next activity with "Yes" in 1)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next activity with "Yes" in 1)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next activity with "Yes" in 1)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next activity with "Yes" in 1)
b. What special equipment or aids do you use?	Special equipment or aids	Special equipment or aids	Special equipment or aids
Anything else?	17-18	33-34	49-50
	19-20	35-36	51-52

6a. Do you have difficulty controlling your bowels?	RT 68 3-4	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6c)	5 5
b. How frequently do you have this difficulty — daily, several times a week, once a week, or less than once a week?		1 <input type="checkbox"/> Daily 2 <input type="checkbox"/> Several times a week 3 <input type="checkbox"/> Once a week 4 <input type="checkbox"/> Less than once a week 9 <input type="checkbox"/> DK	6 6
c. Do you have a colostomy or a device to help control bowel movements?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (7)	7 7
d. Do you need help from anyone in taking care of this device?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	8 8
7a. Do you have difficulty controlling urination?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (7c)	9 9
b. How frequently do you have this difficulty — daily, several times a week, once a week, or less than once a week?		1 <input type="checkbox"/> Daily 2 <input type="checkbox"/> Several times a week 3 <input type="checkbox"/> Once a week 4 <input type="checkbox"/> Less than once a week 9 <input type="checkbox"/> DK	10 10
c. Do you have a urinary catheter or a device to help control urination?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (P2)	11 11
d. Do you need help from anyone in taking care of this device?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	12 12

P2	Mark first appropriate box	1 <input type="checkbox"/> Respondent is a proxy 2 <input type="checkbox"/> Person has only been seen in a bed or chair	3 <input type="checkbox"/> Telephone interview (8) 4 <input type="checkbox"/> All other (Page 10)
	Mark if known		13 13
8. Because of a health or physical problem, do you usually —			14 14
a. Stay in bed all or most of the time?		1 <input type="checkbox"/> Yes (Page 10) 2 <input type="checkbox"/> No	
b. Stay in a chair all or most of the time?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	15 15



Reask 1 (4) 53 Getting in and out of bed or chairs? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		(5) 69 Walking? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		(6) 85 Getting outside? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		(7) 101 Using the toilet, including getting to the toilet? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason	
54 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		70 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		86 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		102 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable	
55 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)		71 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)		87 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)		103 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)	
4a. Source of help 56-59 4b. Paid 60-63 HH member 0 <input type="checkbox"/> S/C/P (5) 1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Non-HH member 3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		4a. Source of help 72-75 4b. Paid 76-79 HH member 0 <input type="checkbox"/> S/C/P (5) 1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Non-HH member 3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		4a. Source of help 88-91 4b. Paid 92-95 HH member 0 <input type="checkbox"/> S/C/P (5) 1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Non-HH member 3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		4a. Source of help 104-107 4b. Paid 108-111 HH member 0 <input type="checkbox"/> S/C/P (5) 1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Non-HH member 3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
64 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next activity with "Yes" in 1)		80 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next activity with "Yes" in 1)		96 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next activity with "Yes" in 1)		112 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6)	
Special equipment or aids _____ 65-66 _____ 67-68		Special equipment or aids _____ 81-82 _____ 83-84		Special equipment or aids _____ 97-98 _____ 99-100		Special equipment or aids _____ 113-114 _____ 115-116	

FOOTNOTES

Section P. FUNCTIONAL LIMITATIONS (FL), Continued

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

<p>9. Because of a health or physical problem, do you have ANY difficulty — <i>Ask if "Doesn't do":</i> Is this because of a HEALTH or PHYSICAL problem? <i>If "Yes," mark box 1; if "No," mark box 3</i></p>	<p align="center">(1) 16</p> <p>Preparing your own meals?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason</p>	<p align="center">(2) 27</p> <p>Shopping for personal items, (such as toilet items or medicines)?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason</p>																																
<p><i>Ask 10—12 for each activity marked "Yes" in 9.</i></p> <p>10. By yourself, how much difficulty do you have (activity), some, a lot, or are you unable to do it?</p>	<p align="center">17</p> <p>1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable</p>	<p align="center">28</p> <p>1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable</p>																																
<p>11. Do you receive help from anyone in (activity)?</p>	<p align="center">18</p> <p>1 <input type="checkbox"/> Yes (12) 2 <input type="checkbox"/> No (10 for next activity with "Yes" in 9)</p>	<p align="center">29</p> <p>1 <input type="checkbox"/> Yes (12) 2 <input type="checkbox"/> No (10 for next activity with "Yes" in 9)</p>																																
<p>12a. Who gives this help? Anyone else? <i>Mark the S/C/P box without asking if ONLY help is from spouse/children/parents, THEN 10 for next activity marked "Yes" in 9.</i></p> <p>b. Is this help paid for? <i>Ask if necessary:</i> Which helpers are paid?</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align: center;">12a. Source of help</td> <td style="width:50%; text-align: center;">12b. Paid</td> </tr> <tr> <td style="text-align: center;">19—22</td> <td style="text-align: center;">23—26</td> </tr> <tr> <td>HH member</td> <td>0 <input type="checkbox"/> S/C/P</td> </tr> <tr> <td>1 <input type="checkbox"/> Relative</td> <td>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> <tr> <td>2 <input type="checkbox"/> Nonrelative . . .</td> <td>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> <tr> <td>Non-HH member</td> <td></td> </tr> <tr> <td>3 <input type="checkbox"/> Relative</td> <td>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> <tr> <td>4 <input type="checkbox"/> Nonrelative . . .</td> <td>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table>	12a. Source of help	12b. Paid	19—22	23—26	HH member	0 <input type="checkbox"/> S/C/P	1 <input type="checkbox"/> Relative	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	2 <input type="checkbox"/> Nonrelative . . .	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Non-HH member		3 <input type="checkbox"/> Relative	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	4 <input type="checkbox"/> Nonrelative . . .	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align: center;">12a. Source of help</td> <td style="width:50%; text-align: center;">12b. Paid</td> </tr> <tr> <td style="text-align: center;">30—33</td> <td style="text-align: center;">34—37</td> </tr> <tr> <td>HH member</td> <td>0 <input type="checkbox"/> S/C/P</td> </tr> <tr> <td>1 <input type="checkbox"/> Relative</td> <td>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> <tr> <td>2 <input type="checkbox"/> Nonrelative . . .</td> <td>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> <tr> <td>Non-HH member</td> <td></td> </tr> <tr> <td>3 <input type="checkbox"/> Relative</td> <td>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> <tr> <td>4 <input type="checkbox"/> Nonrelative . . .</td> <td>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table>	12a. Source of help	12b. Paid	30—33	34—37	HH member	0 <input type="checkbox"/> S/C/P	1 <input type="checkbox"/> Relative	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	2 <input type="checkbox"/> Nonrelative . . .	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Non-HH member		3 <input type="checkbox"/> Relative	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	4 <input type="checkbox"/> Nonrelative . . .	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
12a. Source of help	12b. Paid																																	
19—22	23—26																																	
HH member	0 <input type="checkbox"/> S/C/P																																	
1 <input type="checkbox"/> Relative	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																	
2 <input type="checkbox"/> Nonrelative . . .	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																	
Non-HH member																																		
3 <input type="checkbox"/> Relative	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																	
4 <input type="checkbox"/> Nonrelative . . .	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																	
12a. Source of help	12b. Paid																																	
30—33	34—37																																	
HH member	0 <input type="checkbox"/> S/C/P																																	
1 <input type="checkbox"/> Relative	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																	
2 <input type="checkbox"/> Nonrelative . . .	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																	
Non-HH member																																		
3 <input type="checkbox"/> Relative	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																	
4 <input type="checkbox"/> Nonrelative . . .	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																	
<p>P3 <i>Refer to 13 and 14 on other FL pages.</i></p>	<p>1 <input type="checkbox"/> 13 and 14 filled on another FL page (15) 8 <input type="checkbox"/> Other (13)</p>																																	
<p>13a. Is it NECESSARY to go up or down a step to get into this [house/apartment] from the outside?</p>	<p>1 <input type="checkbox"/> No Yes — <i>If not mentioned, ask: Is it one step or more than one step?</i> 2 <input type="checkbox"/> 1 step 3 <input type="checkbox"/> More than 1 step</p>																																	
<p>b. Counting basements and stepdown living areas as separate levels, does this [house/apartment] have more than one floor or level?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (14b)</p>																																	
<p>14a. Does this [house/apartment] have a bathroom, bedroom, and kitchen ALL on the same floor or level?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																																	
<p>b. Does this [house/apartment] have a walk-in shower, that is, where you don't step over the side of the tub to get into the shower?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																																	
<p>15a. Because of a health or physical problem do YOU NEED a bathroom, bedroom, and kitchen ALL on the SAME floor or level?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																																	
<p>b. Because of a health or physical problem do YOU NEED a walk-in shower?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																																	

FOOTNOTES

(3) 38		<i>Reask 9</i> (4) 49		(5) 60		(6) 71	
Managing your money, (such as keeping track of expenses or paying bills)?		Using the telephone?		Doing heavy housework, (such as scrubbing floors, or washing windows)?		Doing light housework, (such as doing dishes, straightening up, or light cleaning)?	
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason	
39		50		61		72	
1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable	
40		51		62		73	
1 <input type="checkbox"/> Yes (12) 2 <input type="checkbox"/> No (10 for next activity with "Yes" in 9)		1 <input type="checkbox"/> Yes (12) 2 <input type="checkbox"/> No (10 for next activity with "Yes" in 9)		1 <input type="checkbox"/> Yes (12) 2 <input type="checkbox"/> No (10 for next activity with "Yes" in 9)		1 <input type="checkbox"/> Yes (12) 2 <input type="checkbox"/> No (P3)	
12a. Source of help 41-44	12b. Paid 45-48	12a. Source of help 52-55	12b. Paid 56-59	12a. Source of help 63-66	12b. Paid 67-70	12a. Source of help 74-77	12b. Paid 78-81
HH member 0 <input type="checkbox"/> S/C/P 1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Non-HH member 3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	HH member 0 <input type="checkbox"/> S/C/P 1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Non-HH member 3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	HH member 0 <input type="checkbox"/> S/C/P 1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Non-HH member 3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	HH member 0 <input type="checkbox"/> S/C/P 1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Non-HH member 3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative . . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

FOOTNOTES

Section P – FUNCTIONAL LIMITATIONS (FL), Continued

Reask 1 (4) 53		(5) 69		(6) 85		(7) 101	
Getting in and out of bed or chairs?		Walking?		Getting outside?		Using the toilet, including getting to the toilet?	
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason	
54		70		86		102	
1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable	
55		71		87		103	
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)	
4a. Source of help 56-59		4b. Paid 60-63		4a. Source of help 72-75		4b. Paid 76-79	
HH member 1 <input type="checkbox"/> Relative 2 <input type="checkbox"/> Nonrelative . . .		0 <input type="checkbox"/> S/C/P (5) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		HH member 1 <input type="checkbox"/> Relative 2 <input type="checkbox"/> Nonrelative . . .		0 <input type="checkbox"/> S/C/P (5) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Non-HH member 3 <input type="checkbox"/> Relative 4 <input type="checkbox"/> Nonrelative . . .		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Non-HH member 3 <input type="checkbox"/> Relative 4 <input type="checkbox"/> Nonrelative . . .		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
64		80		96		112	
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next activity with "Yes" in 1)		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next activity with "Yes" in 1)		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next activity with "Yes" in 1)		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6)	
Special equipment or aids		Special equipment or aids		Special equipment or aids		Special equipment or aids	
_____ 65-66		_____ 81-82		_____ 97-98		_____ 113-114	
_____ 67-68		_____ 83-84		_____ 99-100		_____ 115-116	

FOOTNOTES

Section P. FUNCTIONAL LIMITATIONS (FL), Continued

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

<p>9. Because of a health or physical problem, do you have ANY difficulty — <i>Ask if "Doesn't do":</i> Is this because of a HEALTH or PHYSICAL problem? <i>If "Yes," mark box 1; if "No," mark box 3</i></p>	<p align="center">(1) 16</p> <p>Preparing your own meals?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Doesn't do for other reason</p>	<p align="center">(2) 27</p> <p>Shopping for personal items, (such as toilet items or medicines)?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Doesn't do for other reason</p>				
<i>Ask 10—12 for each activity marked "Yes" in 9.</i>						
<p>10. By yourself, how much difficulty do you have (activity), some, a lot, or are you unable to do it?</p>	<p align="center">17</p> <p>1 <input type="checkbox"/> Some</p> <p>2 <input type="checkbox"/> A lot</p> <p>3 <input type="checkbox"/> Unable</p>	<p align="center">28</p> <p>1 <input type="checkbox"/> Some</p> <p>2 <input type="checkbox"/> A lot</p> <p>3 <input type="checkbox"/> Unable</p>				
<p>11. Do you receive help from anyone in (activity)?</p>	<p align="center">18</p> <p>1 <input type="checkbox"/> Yes (12)</p> <p>2 <input type="checkbox"/> No (10 for next activity with "Yes" in 9)</p>	<p align="center">29</p> <p>1 <input type="checkbox"/> Yes (12)</p> <p>2 <input type="checkbox"/> No (10 for next activity with "Yes" in 9)</p>				
<p>12a. Who gives this help? Anyone else? <i>Mark the S/C/P box without asking if ONLY help is from spouse/children/parents, THEN 10 for next activity marked "Yes" in 9.</i></p> <p>b. Is this help paid for? <i>Ask if necessary:</i> Which helpers are paid?</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align: center;"> <p>12a. Source of help 19—22</p> <p>HH member</p> <p>1 <input type="checkbox"/> Relative</p> <p>2 <input type="checkbox"/> Nonrelative . . .</p> <p>Non-HH member</p> <p>3 <input type="checkbox"/> Relative</p> <p>4 <input type="checkbox"/> Nonrelative . . .</p> </td> <td style="width:50%; text-align: center;"> <p>12b. Paid 23—26</p> <p>0 <input type="checkbox"/> S/C/P</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> </td> </tr> </table>	<p>12a. Source of help 19—22</p> <p>HH member</p> <p>1 <input type="checkbox"/> Relative</p> <p>2 <input type="checkbox"/> Nonrelative . . .</p> <p>Non-HH member</p> <p>3 <input type="checkbox"/> Relative</p> <p>4 <input type="checkbox"/> Nonrelative . . .</p>	<p>12b. Paid 23—26</p> <p>0 <input type="checkbox"/> S/C/P</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align: center;"> <p>12a. Source of help 30—33</p> <p>HH member</p> <p>1 <input type="checkbox"/> Relative</p> <p>2 <input type="checkbox"/> Nonrelative . . .</p> <p>Non-HH member</p> <p>3 <input type="checkbox"/> Relative</p> <p>4 <input type="checkbox"/> Nonrelative . . .</p> </td> <td style="width:50%; text-align: center;"> <p>12b. Paid 34—37</p> <p>0 <input type="checkbox"/> S/C/P</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> </td> </tr> </table>	<p>12a. Source of help 30—33</p> <p>HH member</p> <p>1 <input type="checkbox"/> Relative</p> <p>2 <input type="checkbox"/> Nonrelative . . .</p> <p>Non-HH member</p> <p>3 <input type="checkbox"/> Relative</p> <p>4 <input type="checkbox"/> Nonrelative . . .</p>	<p>12b. Paid 34—37</p> <p>0 <input type="checkbox"/> S/C/P</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>12a. Source of help 19—22</p> <p>HH member</p> <p>1 <input type="checkbox"/> Relative</p> <p>2 <input type="checkbox"/> Nonrelative . . .</p> <p>Non-HH member</p> <p>3 <input type="checkbox"/> Relative</p> <p>4 <input type="checkbox"/> Nonrelative . . .</p>	<p>12b. Paid 23—26</p> <p>0 <input type="checkbox"/> S/C/P</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>					
<p>12a. Source of help 30—33</p> <p>HH member</p> <p>1 <input type="checkbox"/> Relative</p> <p>2 <input type="checkbox"/> Nonrelative . . .</p> <p>Non-HH member</p> <p>3 <input type="checkbox"/> Relative</p> <p>4 <input type="checkbox"/> Nonrelative . . .</p>	<p>12b. Paid 34—37</p> <p>0 <input type="checkbox"/> S/C/P</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>					
<p>P3 <i>Refer to 13 and 14 on other FL pages.</i></p>	<p>1 <input type="checkbox"/> 13 and 14 filled on another FL page (15)</p> <p>8 <input type="checkbox"/> Other (13)</p>					
<p>13a. Is it NECESSARY to go up or down a step to get into this [house/apartment] from the outside?</p>	<p>1 <input type="checkbox"/> No</p> <p><i>Yes — If not mentioned, ask: Is it one step or more than one step?</i></p> <p>2 <input type="checkbox"/> 1 step</p> <p>3 <input type="checkbox"/> More than 1 step</p>					
<p>b. Counting basements and stepdown living areas as separate levels, does this [house/apartment] have more than one floor or level?</p>	<p>1 <input type="checkbox"/> Yes</p>	<p>2 <input type="checkbox"/> No (14b)</p>				
<p>14a. Does this [house/apartment] have a bathroom, bedroom, and kitchen ALL on the same floor or level?</p>	<p>1 <input type="checkbox"/> Yes</p>	<p>2 <input type="checkbox"/> No</p>				
<p>b. Does this [house/apartment] have a walk-in shower, that is, where you don't step over the side of the tub to get into the shower?</p>	<p>1 <input type="checkbox"/> Yes</p>	<p>2 <input type="checkbox"/> No</p>				
<p>15a. Because of a health or physical problem do YOU NEED a bathroom, bedroom, and kitchen ALL on the SAME floor or level?</p>	<p>1 <input type="checkbox"/> Yes</p>	<p>2 <input type="checkbox"/> No</p>				
<p>b. Because of a health or physical problem do YOU NEED a walk-in shower?</p>	<p>1 <input type="checkbox"/> Yes</p>	<p>2 <input type="checkbox"/> No</p>				

FOOTNOTES

(3) 38		<i>Reask 9</i> (4) 49		(5) 60		(6) 71									
Managing your money, (such as keeping track of expenses or paying bills)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		Using the telephone? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		Doing heavy housework, (such as scrubbing floors, or washing windows)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		Doing light housework, (such as doing dishes, straightening up, or light cleaning)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason									
39		50		61		72									
1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable									
40		51		62		73									
1 <input type="checkbox"/> Yes (12) 2 <input type="checkbox"/> No (10 for next activity with "Yes" in 9)		1 <input type="checkbox"/> Yes (12) 2 <input type="checkbox"/> No (10 for next activity with "Yes" in 9)		1 <input type="checkbox"/> Yes (12) 2 <input type="checkbox"/> No (10 for next activity with "Yes" in 9)		1 <input type="checkbox"/> Yes (12) 2 <input type="checkbox"/> No (P3)									
12a. Source of help 41-44		12b. Paid 45-48		12a. Source of help 52-55		12b. Paid 56-59		12a. Source of help 63-66		12b. Paid 67-70		12a. Source of help 74-77		12b. Paid 78-81	
HH member 1 <input type="checkbox"/> Relative 2 <input type="checkbox"/> Nonrelative . . .		0 <input type="checkbox"/> S/C/P 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		HH member 1 <input type="checkbox"/> Relative 2 <input type="checkbox"/> Nonrelative . . .		0 <input type="checkbox"/> S/C/P 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		HH member 1 <input type="checkbox"/> Relative 2 <input type="checkbox"/> Nonrelative . . .		0 <input type="checkbox"/> S/C/P 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		HH member 1 <input type="checkbox"/> Relative 2 <input type="checkbox"/> Nonrelative . . .		0 <input type="checkbox"/> S/C/P 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Non-HH member 3 <input type="checkbox"/> Relative 4 <input type="checkbox"/> Nonrelative . . .		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Non-HH member 3 <input type="checkbox"/> Relative 4 <input type="checkbox"/> Nonrelative . . .		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Non-HH member 3 <input type="checkbox"/> Relative 4 <input type="checkbox"/> Nonrelative . . .		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Non-HH member 3 <input type="checkbox"/> Relative 4 <input type="checkbox"/> Nonrelative . . .		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	

FOOTNOTES

CARD R

RACE

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

HS-501 (1988) (10-20-87)

CARD O

ORIGIN

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

Card R
Card O

Cut along broken line.

HS-501 (1988) (10-20-87)

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

HS-501 (1988) (10-20-87)

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

Card I
Card J

Cut along broken line.

HS-501 (1988) (10-20-87)

The 1987 NHIS was conducted with a full sample that comprised 47,240 households containing 122,859 household members. In addition to the basic health and demographic questionnaire, the 1987 survey included questions on the following special health topics: cancer risk factors, child adoption, poliomyelitis, and Acquired Immunodeficiency Syndrome (AIDS).

The questions pertaining to cancer risk factors comprised a separate booklet. One-half of the households were asked the epidemiology questionnaire for cancer risk factors and the other one-half of the households were asked the cancer control study questionnaire. The Hispanic population was oversampled for the cancer risk factor questionnaires. The interviews in Hispanic households were conducted using a Spanish translation guide. The guide is not included in this report.

The special health topic on AIDS asked questions concerning knowledge of AIDS and attitudes about AIDS. A self-response questionnaire was administered between August and December 1987. The interview, initially administered with a paper questionnaire, was converted to a computer-assisted personal interview (CAPI).

The questions were designed to determine what a person knew about AIDS. The person was asked if he or

she had ever heard of AIDS, what was their source of information about AIDS, true or false statements about AIDS, and questions about ways a person contracts AIDS.

Approximately 21,000 randomly selected NHIS household members 18 years of age and older responded to the questions. Data from the AIDS health topic were produced on a monthly basis and published in *Advance Data reports*.

Questions concerning child adoption were included in the basic health and demographic questionnaire. Women in the family 20–54 years of age were eligible to respond to the questions on child adoption. The survey instrument included questions that asked about the number of children adopted, how many of the adopted children were living in the household, the date the child began living in the household, the date of birth, the country of birth (United States or foreign country), their relation to child prior to adoption, and through whom the adoption was arranged.

The questions on poliomyelitis were also included in the basic health and demographic questionnaire. The questions were designed as screener questions intended to identify individuals having post-polio symptoms. Persons 26 years of age and over were asked the screener questions.

FORM HIS-1A (1987)
(7-28-86)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR THE
U.S. PUBLIC HEALTH SERVICE

NATIONAL HEALTH INTERVIEW SURVEY

CANCER CONTROL

NOTICE — Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

RT 65

1. Book <u>8</u> of <u>8</u> books	2. R.O. number <u>9-10</u>	3. Sample <u>11-13</u>
4. Control number PSU <u>14-16</u> Segment <u>17-23</u> Serial <u>24-25</u>	5. Beginning time <u>26-29</u> <u>30</u> 1 a.m. 2 p.m.	

6a. FAMILY ROSTER

List all nondeleted family members 18+ by age (oldest to youngest).

6b. Hispanic oversample

1

SP1	32	33-34	35-36	Name	"X" if Hisp. marked	SP2-3 Hisp. Line No.
Line No.	Person No.	Age				
1					<input type="checkbox"/> Hisp.	
2					<input type="checkbox"/> Hisp.	
3					<input type="checkbox"/> Hisp.	
4					<input type="checkbox"/> Hisp.	
5					<input type="checkbox"/> Hisp.	
6					<input type="checkbox"/> Hisp.	
7					<input type="checkbox"/> Hisp.	
8					<input type="checkbox"/> Hisp.	
9					<input type="checkbox"/> Hisp.	

Refer to the appropriate section of the sample person selection label and circle as applicable. THEN circle the "SP1" Line No. in item 6a and mark "SP" box on the HIS-1 for the selected sample person. THEN go to Section O.

7. FINAL STATUS

No person 18+ in this family (Household Page)

Noninterview

Interview

- 1 Complete interview (all appropriate sections completed)
- 2 Partial interview (some but not all appropriate sections completed) — Explain

- 3 Refusal (Explain in Notes)
- 4 SP temporarily absent
- 5 SP mentally or physically incapable
- 6 Other — Explain

37

8. Ending time <u>38-41</u> <u>42</u> 1 a.m. 2 p.m.	9. Interview mode <u>43</u> 1 <input type="checkbox"/> Personal 2 <input type="checkbox"/> Telephone	10. Language of interview <u>44</u> 1 <input type="checkbox"/> English 3 <input type="checkbox"/> Both English and Spanish 2 <input type="checkbox"/> Spanish 4 <input type="checkbox"/> Other	11. Interviewer identification <u>45-46</u> Name _____ Code _____
---	--	--	--

TRANSCRIPTION FROM COMPLETED HIS-1

12. Sex of SP (Page 2 or 55, question 3). <u>47</u> 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	13. Education of SP (Page 42 or 43, question 2a) <u>48-49</u> 00 <input type="checkbox"/> Never attended or kindergarten Elem: 1 2 3 4 5 6 7 8 High: 9 10 11 12 College: 1 2 3 4 5 6+ Finish grade/year (Question 2b) <u>50</u> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	14. Main race of SP (Page 42 or 43, question 3a/b) <u>51</u> 1 2 3 4 5 — Specify <input checked="" type="checkbox"/>
15. Marital status (Page 46 or 47, question 7) <u>52</u> 1 <input type="checkbox"/> Married — spouse in HH 2 <input type="checkbox"/> Married — spouse not in HH 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced 5 <input type="checkbox"/> Separated 6 <input type="checkbox"/> Never married	16. Family income (Page 46, question 8b) <u>53-54</u> 00 <input type="checkbox"/> A 07 <input type="checkbox"/> H 14 <input type="checkbox"/> O 21 <input type="checkbox"/> V 01 <input type="checkbox"/> B 08 <input type="checkbox"/> I 15 <input type="checkbox"/> P 22 <input type="checkbox"/> W 02 <input type="checkbox"/> C 09 <input type="checkbox"/> J 16 <input type="checkbox"/> Q 23 <input type="checkbox"/> X 03 <input type="checkbox"/> D 10 <input type="checkbox"/> K 17 <input type="checkbox"/> R 24 <input type="checkbox"/> Y 04 <input type="checkbox"/> E 11 <input type="checkbox"/> L 18 <input type="checkbox"/> S 25 <input type="checkbox"/> Z 05 <input type="checkbox"/> F 12 <input type="checkbox"/> M 19 <input type="checkbox"/> T 26 <input type="checkbox"/> ZZ 06 <input type="checkbox"/> G 13 <input type="checkbox"/> N 20 <input type="checkbox"/> U (Transcribe from 8a if 8b blank) 27 <input type="checkbox"/> \$20,000 or more 28 <input type="checkbox"/> Less than \$20,000	17. Person No. _____ <u>55-56</u> 18. Age _____ <u>57-58</u> 19. Booklet type <u>59</u> <input checked="" type="checkbox"/> Cancer control

Section O – ACCULTURATION

3-4

5

01

SP Status at initial interview

- 1 Available (02)
- 2 Callback required (Household page)
- 8 Noninterview (Cover page)

02

Refer to hispanic origin from family roster and expected language for this supplement.

- 1 Hispanic/English Supp. interview (1a)
- 2 Hispanic/Spanish Supp. interview (1b)
- 8 Other (section P)

6

7

Read to respondent:

I'm going to be asking questions that are related to health concerns, such as smoking, eating practices, doctor visits and so forth. Before I ask these questions I would like to ask a few questions about the language you use most often.

1a. Do you speak any Spanish?

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

8

Read to respondent:

I'm going to be asking questions that are related to health concerns, such as smoking, eating practices, doctor visits and so forth. Before I ask these questions I would like to ask a few questions about the language you use most often.

b. Do you speak any English?

- 1 Yes
- 2 No (4)

9

2. Would you say that you speak mostly Spanish, mostly English, or do you speak Spanish and English about the same?

- 1 Mostly Spanish
- 2 Mostly English
- 3 Both about the same

10

3. What language do you prefer: Spanish only, mostly Spanish, mostly English, English only, or Spanish and English about equally?

- 1 Spanish only
- 2 Mostly Spanish
- 3 Mostly English
- 4 English only
- 5 Spanish and English equally

11

4. Can you read Spanish?

- 1 Yes
- 2 No

12

5. Can you read English?

- 1 Yes
- 2 No

13

If "Yes" to both 4 and 5 ask:

6. In which language do you read better?

- 1 Spanish
- 2 English
- 3 Both the same

14

7. Can you write in Spanish?

- 1 Yes
- 2 No

15

8. Can you write in English?

- 1 Yes
- 2 No

16

If "Yes" to both 7 and 8 ask:

9. In which language do you write better?

- 1 Spanish
- 2 English
- 3 Both the same

17

If self-reported on HIS-1, mark box without asking.

HAND CARD O, read categories if telephone interview.

- 1 Puerto Rican
- 2 Cuban
- 3 Mexican/Mexicano
- 4 Mexican American
- 5 Chicano
- 6 Other Latin American
- 7 Other Spanish
- 8 Other (Specify) ↴

10. Which of these groups best describes your ethnic identification?

18

11. Which of these groups best describes your mother's ethnic identification?

- 1 Puerto Rican
- 2 Cuban
- 3 Mexican/Mexicano
- 4 Mexican American
- 5 Chicano
- 6 Other Latin American
- 7 Other Spanish
- 8 Other (Specify) ↴

19

12. Which of these groups best describes your father's ethnic identification?

- 1 Puerto Rican
- 2 Cuban
- 3 Mexican/Mexicano
- 4 Mexican American
- 5 Chicano
- 6 Other Latin American
- 7 Other Spanish
- 8 Other (Specify) ↴

Section O – ACCULTURATION – Continued

If self-reported on HIS-1, mark box without asking.

13. In what country or state were you born?

- 1 U.S., except Puerto Rico
- 2 Puerto Rico
- 3 Cuba
- 4 Mexico
- 8 Other (Specify) ↴

20

14. In what country or state was your father born?

- 1 U.S., except Puerto Rico
- 2 Puerto Rico
- 3 Cuba
- 4 Mexico
- 8 Other (Specify) ↴

21

15. In what country or state was your mother born?

- 1 U.S., except Puerto Rico
- 2 Puerto Rico
- 3 Cuba
- 4 Mexico
- 8 Other (Specify) ↴

22

Notes

Section P – MEDICAL CARE

<p>(I'm going to be asking questions that are related to health concerns, such as smoking, eating practices, doctor visits and so forth.)</p> <p>These questions are about medical care you may have needed in the past year.</p> <p>1 a. During the past 12 months, that is, since (12-month date) a year ago, have you NEEDED any medical care or advice?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No (2)</p> <p align="right">23</p>
<p>b. During the past 12 months, was there ever a time when you did not get the medical care or advice that you needed?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No (2)</p> <p align="right">24</p>
<p>c. Why didn't you get the care that you needed?</p> <p><i>Mark all mentioned, do not probe.</i></p>	<p>1 <input type="checkbox"/> Procrastinated/Put it off 25</p> <p>1 <input type="checkbox"/> Did not have health insurance 26</p> <p>1 <input type="checkbox"/> Care was not available when needed 27</p> <p>1 <input type="checkbox"/> Cost too much 28</p> <p>1 <input type="checkbox"/> Didn't know where to go 29</p> <p>1 <input type="checkbox"/> Didn't know what kind of doctor to see 30</p> <p>1 <input type="checkbox"/> Didn't have a way to get there 31</p> <p>1 <input type="checkbox"/> Hours not convenient 32</p> <p>1 <input type="checkbox"/> Fear of being treated rudely or unkindly 33</p> <p>1 <input type="checkbox"/> Other reason (Specify) <input checked="" type="checkbox"/> 34</p> <hr/> <p>1 <input type="checkbox"/> DK 35</p>
<p>2. Is there a particular doctor's office, clinic, health center, or other place that you usually go to if you are sick or need advice about your health?</p>	<p>1 <input type="checkbox"/> Yes 36</p> <p>2 <input type="checkbox"/> No } (4)</p> <p>9 <input type="checkbox"/> DK }</p>
<p>3. What kind of place is it — a doctor's office, a hospital, a clinic, a health center, or some other place?</p> <p><i>If hospital: Is this an outpatient clinic or an emergency room?</i></p> <p><i>If clinic: Is this a public health clinic or some other kind of clinic?</i></p>	<p>1 <input type="checkbox"/> Doctor's office (private group practice or doctor's clinic) 37</p> <p>2 <input type="checkbox"/> Hospital emergency room</p> <p>3 <input type="checkbox"/> Hospital outpatient clinic</p> <p>4 <input type="checkbox"/> Health center or private neighborhood health clinic</p> <p>5 <input type="checkbox"/> Public health clinic (5)</p> <p>6 <input type="checkbox"/> Health clinic at work</p> <p>7 <input type="checkbox"/> HMO/prepaid group practice/"Group Health"</p> <p>8 <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/></p>
<p>4. Where do you go when you are sick or need advice about your health?</p> <p><i>Mark all mentioned, do not probe.</i></p>	<p>1 <input type="checkbox"/> Doctor's office (private group practice or doctor's clinic) 38</p> <p>1 <input type="checkbox"/> Hospital emergency room 39</p> <p>1 <input type="checkbox"/> Hospital outpatient clinic 40</p> <p>1 <input type="checkbox"/> Health center or private neighborhood health clinic 41</p> <p>1 <input type="checkbox"/> Public health clinic 42</p> <p>1 <input type="checkbox"/> Health clinic at work 43</p> <p>1 <input type="checkbox"/> HMO/prepaid group practice/"Group Health" 44</p> <p>1 <input type="checkbox"/> Haven't needed a doctor 45</p> <p>1 <input type="checkbox"/> Don't go anywhere 46</p> <p>1 <input type="checkbox"/> Have two or more doctors or usual places depending on what is wrong 47</p> <p>1 <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> 48</p> <hr/> <p>1 <input type="checkbox"/> DK 49</p>
<p>5. Where do you get your most useful information about how to prevent illness and improve your health?</p> <p><i>Mark all mentioned, do not probe.</i></p>	<p>1 <input type="checkbox"/> Telephone Information - Public Service or Hotline 50</p> <p>1 <input type="checkbox"/> Family 51</p> <p>1 <input type="checkbox"/> Friends 52</p> <p>1 <input type="checkbox"/> Doctor 53</p> <p>1 <input type="checkbox"/> Work 54</p> <p>1 <input type="checkbox"/> Television 55</p> <p>1 <input type="checkbox"/> Radio 56</p> <p>1 <input type="checkbox"/> Books 57</p> <p>1 <input type="checkbox"/> Newspaper 58</p> <p>1 <input type="checkbox"/> Magazines 59</p> <p>1 <input type="checkbox"/> Pamphlets in doctor's office 60</p> <p>1 <input type="checkbox"/> Other source 61</p> <p>1 <input type="checkbox"/> Nowhere/Don't get information 62</p> <p>1 <input type="checkbox"/> DK 63</p>

Section Q – FOOD KNOWLEDGE

3-4

1 a. Have you ever made any LASTING and MAJOR changes in what you eat and drink for health reasons?

- 1 Yes
- 2 No (2)

5

b. In making these changes, what foods do you eat MORE of?

MORE

Enter responses verbatim, one food per line. Do not probe.

6-8

9-11

12-14

15-17

- 000 None
- 999 DK

c. What foods do you eat LESS of?

LESS

Enter responses verbatim, one food per line. Do not probe.

18-20

21-23

24-26

27-29

- 000 None
- 999 DK

d. Have you made these changes in what you eat and drink in the past 5 years?

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

30

e. Did you make these changes in the past year?

- 1 Yes } (3)
- 2 No } (3)

31

2. Please tell me whether the following statements are true for you. First –

Yes (True) No (False)

(a) It seems that everything you eat is bad for you so why bother changing. (Is that true for you?)

- 1 2

32

(b) I enjoy the things I eat and I don't want to change.

- 1 2

33

(c) There are so many different recommendations, it's hard for me to know which ones to follow.

- 1 2

34

(d) I eat out so much that making changes would be hard.

- 1 2

35

(e) Making changes in the kind of food I eat would be expensive.

- 1 2

36

(f) I would like to change but the rest of my family won't change.

- 1 2

37

(g) The things I eat and drink are healthy so there is no reason for me to make changes.

- 1 2

38

3. I am going to read two (more) statements. Please tell me which one you agree with most.

39

(a) What people eat or drink has little effect on whether they will develop major diseases.

- 1 a (7)

OR

(b) By eating the right kinds of foods, people can reduce their chances of developing major diseases.

- 2 b (4)

- 9 DK (5)

4. Which major diseases do you think may be related to what people eat and drink?

Mark all mentioned, do not probe.

- 1 Cancer
- 1 Heart disease
- 1 Obesity/overweight
- 1 Diabetes
- 1 Hypertension or High Blood Pressure
- 1 Other
- 1 None
- 1 DK

40

41

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47

Q1

Refer to 4

- 1 Cancer in 4 (6)
- 8 Other (5)

48

Section Q – FOOD KNOWLEDGE – Continued

5. Do you think cancer may be related to what people eat and drink?

- 1 Yes
- 2 No (8)
- 3 Probably/maybe/could be/etc.
- 9 DK (8)

49

6a. What foods do you think people should eat or drink MORE of to help prevent cancer?

Enter responses verbatim, one food per line. Do not probe.

MORE

- 000 None
- 999 DK

60-52
63-55
56-58
59-61

b. What foods should people eat or drink LESS of to help prevent cancer?

Enter responses verbatim, one food per line. Do not probe.

LESS

- 000 None
- 999 DK

62-64
65-67
68-70
71-73

c. What kinds of cancer do you think may be related to the things people eat and drink?

Mark all mentioned, do not probe.

- 1 All kinds of cancer
- 1 Breast cancer
- 1 Bladder cancer
- 1 Cancer of the mouth/throat/esophagus
- 1 Cancer of the colon/bowel/intestine/rectum
- 1 Stomach cancer
- 1 Prostate cancer
- 1 Cancer of the uterus
- 1 Lung cancer
- 1 Liver cancer
- 1 Other
- 1 DK

(8)

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85

7a. Have you heard or read ANYTHING about how eating more of some foods and less of other foods can help prevent some major diseases?

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

86

b. Which major diseases have you heard may be related to what people eat and drink?

Mark all mentioned, do not probe.

- 1 Cancer
- 1 Heart disease
- 1 Obesity/overweight
- 1 Diabetes
- 1 Hypertension or High Blood Pressure
- 1 Other
- 1 None
- 1 DK

87
88
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92
93
94

8a. Some foods contain fiber. Have you heard of fiber?

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

95

b. Overall, would you say your diet is high, medium, or low in fiber?

- 1 High
- 2 Medium
- 3 Low
- 9 DK

96

HAND CARD Q1, read list if telephone interview.

c. Here is a list of foods. Please tell me which ones you think are high in fiber.

Mark all mentioned, do not probe.

- 1 Bran flakes
- 1 Corn flakes
- 1 Hamburgers
- 1 Lettuce
- 1 Baked beans
- 1 Carrots
- 1 White rice
- 1 Raw apples
- 1 None
- 1 DK

97
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105
106

Section Q – FOOD KNOWLEDGE – Continued

3-4

9a. Overall, would you say your diet is high, medium, or low in fat?

- 1 High
- 2 Medium
- 3 Low
- 4 DK

5

HAND CARD Q2, read list if telephone interview.

b. Here is [a/another] list of foods. Please tell me which ones you think are high in fat.

Mark all mentioned, do not probe.

- 1 Fried chicken
- 1 White bread
- 1 Soda or soft drinks
- 1 Peanut butter
- 1 Broiled fish
- 1 Bananas
- 1 Cold cuts or lunch meats
- 1 Doughnuts
- 1 None
- 1 DK

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10. Thinking about what you eat and drink, which of the following are IMPORTANT concerns for you?

- (a) Avoiding foods with too much salt or sodium. (Is that an important concern for you?)**
- (b) Avoiding foods with too much sugar.**
- (c) Eating foods to lower cholesterol.**
- (d) Not having enough money to buy food.**
- (e) Being overweight.**
- (f) Being too thin.**

- 1 Yes 2 No
- 1 Yes 2 No
- 1 Yes 2 No
- 1 Yes 2 No
- 1 Yes (*section R*) 2 No
- 1 Yes 2 No

16
17
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21

Notes

Section R – GENERAL KNOWLEDGE AND ATTITUDES

These next questions are about cancer risks.

Hand Card R1, read categories if telephone interview.

1 a. Which of these things do you think increases a person's chances of getting cancer?

Mark all mentioned in first column, do not probe.

If two or fewer responses in 1a, mark 1b without asking and skip to 2

b. In your opinion, of the things you just mentioned which TWO are responsible for the MOST cases of cancer in this country?

Mark box in second column next to the 2 items mentioned.

INCREASE CHANCES

TWO MOST RESPONSIBLE

- | | | | |
|-------------------------------|--|-----------|-----------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> Stress | 22 | 23 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Inherited make-up or heredity | 24 | 25 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Exposure to x-rays | 26 | 27 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Poor eating practices | 28 | 29 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Using chewing tobacco, snuff, pipes or cigars | 30 | 31 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Air pollution | 32 | 33 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Water pollution | 34 | 35 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Some cloth dyes | 36 | 37 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Exposure to toxic waste dumps | 38 | 39 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Exposure to toxic substances on the job | 40 | 41 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Exposure to people with cancer | 42 | 43 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Excessive drinking of alcoholic beverages | 44 | 45 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Exposure to the sun | 46 | 47 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Cigarette smoking | 48 | 49 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Exposure to nuclear waste | 50 | 51 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Some strong soaps and detergents | 52 | 53 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Viruses | 54 | 55 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Some medicines | 56 | 57 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Medical procedures using radiation | 58 | 59 |
| <input type="checkbox"/> 1 DK | <input type="checkbox"/> DK | 60 | 61 |

Hand Card R2

2. Please tell me whether you strongly agree, agree, disagree, or strongly disagree with this statement, or if you have no opinion –

There is very little a person can do to reduce his or her chances of getting cancer.

- 1 Strongly agree
 2 Agree
 3 Disagree
 4 Strongly disagree
 5 No opinion

3. What do you think are the warning signs or symptoms of cancer?

Mark all mentioned, do not probe.

- | | |
|---|-----------|
| <input type="checkbox"/> Weight loss/loss of appetite | 63 |
| <input type="checkbox"/> Change in bowel or bladder habits | 64 |
| <input type="checkbox"/> Unusual bleeding or discharge | 65 |
| <input type="checkbox"/> Lump in breast or elsewhere | 66 |
| <input type="checkbox"/> Indigestion | 67 |
| <input type="checkbox"/> Difficulty in swallowing | 68 |
| <input type="checkbox"/> Change in a wart or mole | 69 |
| <input type="checkbox"/> Naggig cough or hoarseness | 70 |
| <input type="checkbox"/> Chest pain | 71 |
| <input type="checkbox"/> Shortness of breath | 72 |
| <input type="checkbox"/> Sores that don't heal | 73 |
| <input type="checkbox"/> Tired/fatigued | 74 |
| <input type="checkbox"/> Changes on skin/rash/blemish/sunspots/blotches | 75 |
| <input type="checkbox"/> Other (Specify) <i>7</i> | 76 |
| <input type="checkbox"/> DK | 77 |

Section R – GENERAL KNOWLEDGE AND ATTITUDES – Continued

4a. If you were offered a free 2 hour class on how to reduce your chances of getting cancer, would you be interested in going to it if it were convenient?

- 1 Yes
- 2 No (*section S*)
- 3 Maybe
- 9 DK

78

Hand Card R3, read categories if telephone interview.

b. If you were going to attend such a class, which of these places would be convenient for you?

Mark all mentioned, do not probe.

- 1 Church
- 1 Local school
- 1 Hospital
- 1 Club meeting
- 1 Workplace
- 1 Home
- 1 Senior center
- 1 Community center
- 1 Other place
- 1 DK

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88

Notes

Section S – CANCER SCREENING KNOWLEDGE AND PRACTICE – Continued

5a. Have you ever had a Pap smear where the results were NOT normal?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (S3) 9 <input type="checkbox"/> DK }	43
b. Because of the abnormal results, did you have any additional tests?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	44
c. Because of the abnormal results, did you have any surgery or other treatment?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	45
d. Did the [Pap smear/additional tests/surgery or other treatment] indicate that you had cancer?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (S3) 9 <input type="checkbox"/> DK }	46
e. When were you diagnosed as having cancer?	____ mo. / 19 year OR ____ <div style="display: inline-block; vertical-align: middle; margin-left: 10px;"> { 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago 999 <input type="checkbox"/> DK </div>	47-50
S3 Refer to 1c and 1f.	1 <input type="checkbox"/> More than 3 years in 1c or 1f (6) 8 <input type="checkbox"/> Other (7)	51-53 54
6. What is the most important reason why you have [never had a Pap smear/not had a Pap smear in the past few years]?	00 <input type="checkbox"/> Procrastinated/Put it off 01 <input type="checkbox"/> Had a hysterectomy (8) 02 <input type="checkbox"/> Didn't know I should 03 <input type="checkbox"/> Not needed/not necessary 04 <input type="checkbox"/> Cost too much 05 <input type="checkbox"/> No insurance coverage 06 <input type="checkbox"/> Don't go to doctors 07 <input type="checkbox"/> Don't have a doctor 08 <input type="checkbox"/> Not recommended by doctor/Dr. never said it was needed 09 <input type="checkbox"/> Dr. said it wasn't needed 10 <input type="checkbox"/> Too embarrassing 11 <input type="checkbox"/> Haven't had any problems 12 <input type="checkbox"/> Fear 98 <input type="checkbox"/> Other 99 <input type="checkbox"/> DK	55-56
7a. Do you have menstrual periods?	1 <input type="checkbox"/> Yes (8) 2 <input type="checkbox"/> No (7b) 3 <input type="checkbox"/> Never had menstrual periods (7c)	57
b. Did they stop due to surgery?	1 <input type="checkbox"/> Yes } (8) 2 <input type="checkbox"/> No }	58
c. Was this due to surgery?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	59
8a. Do you know how to examine your own breasts for lumps?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (S4)	60
b. About how often do you examine your breasts for lumps?	Times per <div style="display: inline-block; vertical-align: middle; margin-left: 10px;"> { 1 <input type="checkbox"/> Day 2 <input type="checkbox"/> Week 3 <input type="checkbox"/> Month 4 <input type="checkbox"/> Year </div> 000 <input type="checkbox"/> Never 999 <input type="checkbox"/> Other (Specify) ▾ 999 <input type="checkbox"/> DK	61-63
c. Who taught you how to examine your breasts? Mark all mentioned, do not probe.	1 <input type="checkbox"/> Doctor 1 <input type="checkbox"/> Nurse 1 <input type="checkbox"/> Other health professional 1 <input type="checkbox"/> Learned in a class/meeting 1 <input type="checkbox"/> Read in a book, pamphlet, magazine, etc. 1 <input type="checkbox"/> Television 1 <input type="checkbox"/> Other (Specify) ▾ 1 <input type="checkbox"/> DK	64 65 66 67 68 69 70 71

Section S — CANCER SCREENING KNOWLEDGE AND PRACTICE — Continued

S4	Refer to age.	1 <input type="checkbox"/> Under 40 (39) 2 <input type="checkbox"/> 40 and over (9)	72
9a. A breast physical exam is when the breast is felt for lumps by a doctor or medical assistant. Have you ever heard of a breast physical examination?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (15) 9 <input type="checkbox"/> DK }	73
b. Have you ever had a breast physical exam?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (14) 9 <input type="checkbox"/> DK (15)	74
c. When did you have your last breast physical exam? ___ / 19___ OR ___ {		1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago 999 <input type="checkbox"/> DK (9d)	75-78
d. Was it within the past year or a year or more ago?		1 <input type="checkbox"/> Within past year (9e) 2 <input type="checkbox"/> 1 year or more (9f) 9 <input type="checkbox"/> DK (12)	79-81 82
e. Was it less than three months, or 3 or more months ago?		1 <input type="checkbox"/> Less than 3 months 2 <input type="checkbox"/> 3 or more months } (10) 9 <input type="checkbox"/> DK	83
f. Was it 3 years ago or less, between three and 5 years, or 5 or more years ago?		1 <input type="checkbox"/> 3 years or less (10) 2 <input type="checkbox"/> Between 3 and 5 years } (12) 3 <input type="checkbox"/> 5 or more years 9 <input type="checkbox"/> DK	84
10. Where was this exam done — in a doctor's office, a clinic, a hospital, or some other place?		1 <input type="checkbox"/> Doctor's office 2 <input type="checkbox"/> Clinic 3 <input type="checkbox"/> Hospital 8 <input type="checkbox"/> Other place (Specify) _____ 9 <input type="checkbox"/> DK	85
11a. Did you go for your last breast physical exam because of a health problem?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (11c) 9 <input type="checkbox"/> DK	86
b. What was the problem? Mark all mentioned, do not probe.		1 <input type="checkbox"/> Follow-up tests/treatment 1 <input type="checkbox"/> Soreness 1 <input type="checkbox"/> Swelling 1 <input type="checkbox"/> Lumps 1 <input type="checkbox"/> Pain 1 <input type="checkbox"/> Discharge 1 <input type="checkbox"/> Complications related to breast feeding 1 <input type="checkbox"/> Unrelated medical problem 1 <input type="checkbox"/> Other 1 <input type="checkbox"/> DK	87 88 89 90 91 92 93 94 95 96
c. How were you told the results of the test — in person, over the telephone, through the mail, or some other way?		1 <input type="checkbox"/> In person 2 <input type="checkbox"/> Telephone 3 <input type="checkbox"/> Through the mail 4 <input type="checkbox"/> Combination of methods 5 <input type="checkbox"/> Never told; meaning results normal 6 <input type="checkbox"/> Never told; DK if problem 8 <input type="checkbox"/> Other	97
S5	Refer to 11a.	1 <input type="checkbox"/> Yes (13). 2 <input type="checkbox"/> No } (12) 9 <input type="checkbox"/> DK	98
12a. Have you EVER had a breast physical exam because of a health problem?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (13) 9 <input type="checkbox"/> DK	99
b. What was the problem? Mark all mentioned, do not probe.		1 <input type="checkbox"/> Follow-up tests/treatment 1 <input type="checkbox"/> Soreness 1 <input type="checkbox"/> Swelling 1 <input type="checkbox"/> Lumps 1 <input type="checkbox"/> Pain 1 <input type="checkbox"/> Discharge 1 <input type="checkbox"/> Complications related to breast feeding 1 <input type="checkbox"/> Unrelated medical problem 1 <input type="checkbox"/> Other 1 <input type="checkbox"/> DK	100 101 102 103 104 105 106 107 108 109

Section S — CANCER SCREENING KNOWLEDGE AND PRACTICE — Continued

3-4

13a. Have you ever had a breast physical exam where the results were NOT normal?

- 1 Yes
- 2 No
- 9 DK } (S6)

5

b. Because of the abnormal results, did you have any additional tests?

- 1 Yes
- 2 No
- 9 DK

6

c. Because of the abnormal results, did you have any surgery or other treatment?

- 1 Yes
- 2 No
- 9 DK

7

d. Did the [breast physical exam/additional tests/surgery or other treatment] indicate that you had cancer?

- 1 Yes
- 2 No
- 9 DK } (S6)

8

e. When were you diagnosed as having cancer?

____ / 19 ____ OR ____
 mo. year

- 1 Days ago
- 2 Weeks ago
- 3 Months ago
- 4 Years ago
- 999 DK

9-12

S6

Refer to 9c and 9f.

- 1 More than 3 years in 9c or 9f (14)
- 8 Other (15)

13-15

16

14. What is the most important reason why you have [never had a breast physical exam/not had a breast physical exam in the past few years] by a doctor or other health professional?

- 00 Procrastinated/Put it off
- 01 Didn't know I should
- 02 Not needed/not necessary
- 03 Cost too much
- 04 No insurance coverage
- 05 Don't go to doctors
- 06 Don't have a doctor
- 07 Not recommended by doctor/Dr. never said it was needed
- 08 Dr. said it wasn't needed
- 09 Too embarrassing
- 10 Haven't had any problems
- 11 Fear
- 12 Examine own breasts
- 88 Other
- 99 DK

17-18

Notes

Section S – CANCER SCREENING KNOWLEDGE AND PRACTICE – Continued

HAND CARD S			19
15a. A mammogram is when an x-ray is taken only of the breasts by a machine that presses against the breast while the picture is taken. Have you ever heard of a mammogram?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (21) 9 <input type="checkbox"/> DK		
b. Have you ever had a mammogram?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (20) 9 <input type="checkbox"/> DK (21)		20
c. When did you have your last mammogram?	___/___/19___ OR ___/___/19___ mo. year	{ 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago } If 3 years ago or less (16) If more than 3 years ago (18)	21-24
d. Was it within the past year or a year or more ago?	1 <input type="checkbox"/> Within past year (15e) 2 <input type="checkbox"/> 1 year or more (15f)	9 <input type="checkbox"/> DK (18)	25-27 28
e. Was it less than three months, or 3 or more months ago?	1 <input type="checkbox"/> Less than 3 months 2 <input type="checkbox"/> 3 or more months } (16) 9 <input type="checkbox"/> DK		29
f. Was it 3 years ago or less, between three and 5 years, or 5 or more years ago?	1 <input type="checkbox"/> 3 years or less (16) 2 <input type="checkbox"/> Between 3 and 5 years } (18) 3 <input type="checkbox"/> 5 or more years 9 <input type="checkbox"/> DK		30
16. Where was this test done – in a doctor's office, a clinic, a hospital, or some other place?	1 <input type="checkbox"/> Doctor's office 2 <input type="checkbox"/> Clinic 3 <input type="checkbox"/> Hospital 4 <input type="checkbox"/> Imaging center/x-ray lab 8 <input type="checkbox"/> Other place (Specify) _____ 9 <input type="checkbox"/> DK		31
17a. Did you go for your last mammogram because of a health problem?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (17c) 9 <input type="checkbox"/> DK		32
b. What was the problem? <i>Mark all mentioned, do not probe.</i>	1 <input type="checkbox"/> Thickening 1 <input type="checkbox"/> Soreness 1 <input type="checkbox"/> Swelling 1 <input type="checkbox"/> Lumps 1 <input type="checkbox"/> Pain 1 <input type="checkbox"/> Discharge 1 <input type="checkbox"/> Unrelated medical problem 1 <input type="checkbox"/> Other 1 <input type="checkbox"/> DK		33 34 35 36 37 38 39 40 41
c. How were you told the results of the test – in person, over the telephone, through the mail, or some other way?	1 <input type="checkbox"/> In person 2 <input type="checkbox"/> Telephone 3 <input type="checkbox"/> Through the mail 4 <input type="checkbox"/> Combination of methods 5 <input type="checkbox"/> Never told; meaning results normal 6 <input type="checkbox"/> Never told; DK if problem 8 <input type="checkbox"/> Other		42
S7 Refer to 17a.	1 <input type="checkbox"/> Yes (19) 2 <input type="checkbox"/> No } (18) 9 <input type="checkbox"/> DK		43
18a. Have you EVER had a mammogram because of a health problem?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (19) 9 <input type="checkbox"/> DK		44
b. What was the problem? <i>Mark all mentioned, do not probe.</i>	1 <input type="checkbox"/> Thickening 1 <input type="checkbox"/> Soreness 1 <input type="checkbox"/> Swelling 1 <input type="checkbox"/> Lumps 1 <input type="checkbox"/> Pain 1 <input type="checkbox"/> Discharge 1 <input type="checkbox"/> Unrelated medical problem 1 <input type="checkbox"/> Other 1 <input type="checkbox"/> DK		45 46 47 48 49 50 51 52 53

Section S – CANCER SCREENING KNOWLEDGE AND PRACTICE – Continued

19a. Have you ever had a mammogram where the results were NOT normal?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (SB)	54
b. Because of the abnormal results, did you have any additional tests?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	55
c. Because of the abnormal results, did you have any surgery or other treatment?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	56
d. Did the [mammogram/additional tests/surgery or other treatment] indicate that you had cancer?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (SB)	57
e. When were you diagnosed as having cancer?	<div style="display: flex; align-items: center; justify-content: center;"> <div style="margin-right: 20px;"> ____ / 19 ____ mo. year </div> <div style="margin-right: 20px;">OR</div> <div style="margin-right: 20px;"> _____ </div> <div style="font-size: 3em; margin-right: 10px;">}</div> <div style="font-size: 0.8em;"> 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago 999 <input type="checkbox"/> DK </div> </div>	58-61
<div style="border: 1px solid black; padding: 5px; display: inline-block; width: 50px; text-align: center;">S8</div> <div style="margin-left: 10px;">Refer to 15c and 15f.</div>	1 <input type="checkbox"/> More than 3 years in 15c or 15f (20) 8 <input type="checkbox"/> Other (21)	62-64 65
20. What is the most important reason why you have [never had a mammogram/not had a mammogram in the past few years]?	00 <input type="checkbox"/> Procrastinated/Put it off 01 <input type="checkbox"/> Didn't know I should 02 <input type="checkbox"/> Not needed/not necessary 03 <input type="checkbox"/> Cost too much 04 <input type="checkbox"/> No insurance coverage 05 <input type="checkbox"/> Don't go to doctors 06 <input type="checkbox"/> Don't have a doctor 07 <input type="checkbox"/> Not recommended by doctor/Dr. never said it was needed 08 <input type="checkbox"/> Dr. said it wasn't needed 09 <input type="checkbox"/> Too embarrassing 10 <input type="checkbox"/> Haven't had any problems 11 <input type="checkbox"/> Fear 12 <input type="checkbox"/> Fear of radiation 13 <input type="checkbox"/> Painful procedure 14 <input type="checkbox"/> Unpredictable results 88 <input type="checkbox"/> Other 99 <input type="checkbox"/> DK	66-67

Notes

Section S – CANCER SCREENING KNOWLEDGE AND PRACTICE – Continued

3-4
5

25a. Have you ever had a digital rectal exam where the results were NOT normal?

b. Because of the abnormal results, did you have any additional tests?

c. Because of the abnormal results, did you have any surgery or other treatment?

d. Did the [digital rectal exam/additional tests/surgery or other treatment] indicate that you had cancer?

e. When were you diagnosed as having cancer?

- 1 Yes
- 2 No
- 9 DK } (S10)

- 1 Yes
- 2 No
- 9 DK

- 1 Yes
- 2 No
- 9 DK

- 1 Yes
- 2 No
- 9 DK } (S10)

____/ 19 ____ OR ____

mo. year

- 1 Days ago
- 2 Weeks ago
- 3 Months ago
- 4 Years ago
- 999 DK

6

7

8

9-12

13-15

S10

Refer to 21c and 21f.

- 1 More than 3 years in 21c or 21f (26)
- 8 Other (27)

16

26. What is the most important reason why you have [never had a digital rectal exam/not had a digital rectal exam in the past years]?

- 00 Procrastinated/Put it off
- 01 Didn't know I should
- 02 Not needed/not necessary
- 03 Cost too much
- 04 No insurance coverage
- 05 Don't go to doctors
- 06 Don't have a doctor
- 07 Not recommended by doctor/Dr. never said it was needed
- 08 Doctor said it wasn't needed
- 09 Too embarrassing
- 10 Fear
- 11 Haven't had any problems
- 12 Painful procedure
- 13 Unpredictable results
- 88 Other
- 99 DK

17-18

Notes

Section S — CANCER SCREENING KNOWLEDGE AND PRACTICE

33a. A proctoscopic exam is when a tube is inserted in the rectum to check for problems. Have you ever heard of a proctoscopic exam?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (S15) 9 <input type="checkbox"/> DK }	70
b. Have you ever had a proctoscopic exam?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (38) 9 <input type="checkbox"/> DK (S15)	71
c. When did you have your last proctoscopic exam?	___ / 19 ___ mo. year OR { <ul style="list-style-type: none"> 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago } If 3 years ago or less (34) If more than 3 years ago (36) 999 <input type="checkbox"/> DK (33d)	72-75
d. Was it within the past year or a year or more ago?	1 <input type="checkbox"/> Within past year (33e) 9 <input type="checkbox"/> DK (36) 2 <input type="checkbox"/> 1 year or more (33f)	76-78 79
e. Was it less than three months, or 3 or more months ago?	1 <input type="checkbox"/> Less than 3 months } (34) 2 <input type="checkbox"/> 3 or more months } 9 <input type="checkbox"/> DK	80
f. Was it 3 years ago or less, between three and 5 years, or 5 or more years ago?	1 <input type="checkbox"/> 3 years or less (34) 2 <input type="checkbox"/> Between 3 and 5 years } (36) 3 <input type="checkbox"/> 5 or more years } 9 <input type="checkbox"/> DK	81
34. Where was this exam done — in a doctor's office, a clinic, a hospital, or some other place?	1 <input type="checkbox"/> Doctor's office 2 <input type="checkbox"/> Clinic 3 <input type="checkbox"/> Hospital 4 <input type="checkbox"/> Other place (Specify) ↴ _____ 9 <input type="checkbox"/> DK	82
35a. Did you go for your last proctoscopic exam because of a health problem?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (35c) 9 <input type="checkbox"/> DK }	83
b. What was the problem? <i>Mark all mentioned, do not probe.</i>	1 <input type="checkbox"/> Bleeding 1 <input type="checkbox"/> Pain 1 <input type="checkbox"/> Constipation 1 <input type="checkbox"/> Bowel trouble 1 <input type="checkbox"/> Blood in stool 1 <input type="checkbox"/> Unrelated medical problem 1 <input type="checkbox"/> Other 1 <input type="checkbox"/> DK	84 85 86 87 88 89 90 91
c. How were you told the results of the test — in person, over the telephone, through the mail, or some other way?	1 <input type="checkbox"/> In person 2 <input type="checkbox"/> Telephone 3 <input type="checkbox"/> Through the mail 4 <input type="checkbox"/> Combination of methods 5 <input type="checkbox"/> Never told; meaning results normal 6 <input type="checkbox"/> Never told; DK if problem 8 <input type="checkbox"/> Other	92
S13 Refer to 35a.	1 <input type="checkbox"/> Yes (37) 2 <input type="checkbox"/> No } (36) 9 <input type="checkbox"/> DK }	93
36a. Have you EVER had a proctoscopic exam because of a health problem?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (37)	94
b. What was the problem? <i>Mark all mentioned, do not probe.</i>	1 <input type="checkbox"/> Bleeding 1 <input type="checkbox"/> Pain 1 <input type="checkbox"/> Constipation 1 <input type="checkbox"/> Bowel trouble 1 <input type="checkbox"/> Blood in stool 1 <input type="checkbox"/> Unrelated medical problem 1 <input type="checkbox"/> Other 1 <input type="checkbox"/> DK	95 96 97 98 99 100 101 102

Section S – CANCER SCREENING KNOWLEDGE AND PRACTICE – Continued

3-4

39. A breast physical exam is when the breast is felt for lumps by a doctor or medical assistant. Have you ever heard of a breast physical exam?

- 1 Yes
- 2 No
- 9 DK

5

Hand Card S

40. A mammogram is when an x-ray is taken only of the breasts by a machine that presses against the breast while the picture is taken. Have you ever heard of a mammogram?

- 1 Yes
- 2 No
- 9 DK

6

(These next questions are about certain kinds of medical tests and examinations.)

41. A digital rectal exam is when a finger is inserted in the rectum to check for problems. Have you ever heard of a digital rectal exam?

- 1 Yes
- 2 No
- 9 DK

7

42. A blood stool test is when the stool is examined to determine whether it contains blood. Have you ever heard of a blood stool test?

- 1 Yes
- 2 No
- 9 DK

8

43. A proctoscopic exam is when a tube is inserted in the rectum to check for problems. Have you ever heard of a proctoscopic exam?

- 1 Yes
- 2 No
- 9 DK

9

S15

Refer to sex.

- 1 Male (47)
- 8 Female (44)

10

Mark box if "No" or "DK" in 1a.

44. About how often do you think a woman should have a Pap smear test?

- 000 No/DK
- Every _____ Number $\left\{ \begin{array}{l} 1 \text{ Week(s)} \\ 2 \text{ Month(s)} \\ 3 \text{ Year(s)} \end{array} \right.$
- 777 Never
- 888 Other (Specify) ∇ _____
- 666 Only if problem/symptoms
- 999 DK

11-13

Mark box if "No" or "DK" in 9a or 39.

45. About how often do you think a woman age 50 and over should have a breast physical examination by a doctor or health professional?

- 000 No/DK
- Every _____ Number $\left\{ \begin{array}{l} 1 \text{ Week(s)} \\ 2 \text{ Month(s)} \\ 3 \text{ Year(s)} \end{array} \right.$
- 777 Never
- 888 Other (Specify) ∇ _____
- 666 Only if problem/symptoms
- 999 DK

14-16

Mark box if "No" or "DK" in 15a or 40.

46. About how often do you think a woman age 50 and over should have a mammogram?

- 000 No/DK
- Every _____ Number $\left\{ \begin{array}{l} 1 \text{ Week(s)} \\ 2 \text{ Month(s)} \\ 3 \text{ Year(s)} \end{array} \right.$
- 777 Never
- 888 Other (Specify) ∇ _____
- 666 Only if problem/symptoms
- 999 DK

17-19

Mark box if "No" or "DK" in 21a or 41.

47. About how often do you think a person age 40 and over should have digital rectal exam?

- 000 No/DK
- Every _____ Number $\left\{ \begin{array}{l} 1 \text{ Week(s)} \\ 2 \text{ Month(s)} \\ 3 \text{ Year(s)} \end{array} \right.$
- 777 Never
- 888 Other (Specify) ∇ _____
- 666 Only if problem/symptoms
- 999 DK

20-22

Section S – CANCER SCREENING KNOWLEDGE AND PRACTICE – Continued

Mark box if "No" or "DK" in 27a or 42.

48. About how often do you think a person age 40 and over should have a blood stool test?

23-25

000 No/DK

Every _____ Number $\left\{ \begin{array}{l} 1 \text{ Week(s)} \\ 2 \text{ Month(s)} \\ 3 \text{ Year(s)} \end{array} \right.$

777 Never

888 Other (Specify) ∇ _____

666 Only if problem/symptoms

999 DK

Mark box if "No" or "DK" in 33a or 43.

49. About how often do you think a person age 40 and over should have a proctoscopic exam?

26-28

000 No/DK

Every _____ Number $\left\{ \begin{array}{l} 1 \text{ Week(s)} \\ 2 \text{ Month(s)} \\ 3 \text{ Year(s)} \end{array} \right.$

777 Never

888 Other (Specify) ∇ _____

666 Only if problem/symptoms

999 DK

50. Has a doctor or other health professional ever told you that you had any kind of cancer (including any cancer you have already mentioned)?

29

1 Yes

2 No (section T)

51 a. What kind of cancer was it?

30-22

_____ (52)

799 DK (51b)

b. What part of the body was affected?

DK

52. How old were you when this cancer was first diagnosed by a doctor?

33-24

_____ Age

99 DK

53. Besides this cancer, has a doctor ever told you that you had any other kind of cancer?

35

1 Yes

2 No (section T)

54 a. What kind of cancer was it?

36-38

_____ (55)

799 DK (54b)

b. What part of the body was affected?

DK

55. How old were you when THIS cancer was first diagnosed by a doctor?

39-40

_____ Age

99 DK

Notes

Section T – SMOKING HABITS

<p>These next questions are about cigarette smoking.</p> <p>1. Have you smoked at least 100 cigarettes in your entire life? <i>If asked: approximately 5 packs</i></p>	<p align="right">41</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (4)</p>
<p>2. How old were you when you first started smoking cigarettes fairly regularly?</p>	<p align="right">42–43</p> <p align="center">_____ Age</p> <p>00 <input type="checkbox"/> Never smoked regularly (4) 99 <input type="checkbox"/> DK</p>
<p>3. Do you smoke cigarettes now?</p>	<p align="right">44</p> <p>1 <input type="checkbox"/> Yes (section V) 2 <input type="checkbox"/> No (section U)</p>
<p>4. When you are inside public places that have no rules about smoking and someone lights up a cigarette, what are you most likely to do – ask the person not to smoke, move away from the person, just do nothing, or something else?</p>	<p align="right">45</p> <p>1 <input type="checkbox"/> Ask person not to smoke 2 <input type="checkbox"/> Move away 3 <input type="checkbox"/> Do nothing 8 <input type="checkbox"/> Something else } (section W)</p>

Notes

Section U – FORMER SMOKER

<p>1. About how long has it been since you last smoked cigarettes regularly?</p>	<p align="right">48-49</p> <p>000 <input type="checkbox"/> Never smoked regularly (<i>section W</i>)</p> <p>_____ { <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years</p> <p>999 <input type="checkbox"/> DK</p>
<p>2. On the average, how many cigarettes did you usually smoke a day?</p>	<p align="right">49-50</p> <p>00 <input type="checkbox"/> Less than one cigarette per day</p> <p>_____ Cigarettes per day</p> <p>99 <input type="checkbox"/> DK</p>
<p>3. How many minutes or hours after awakening did you usually have your first cigarette?</p>	<p align="right">51-52</p> <p>000 <input type="checkbox"/> Immediately</p> <p>_____ { <input type="checkbox"/> Minutes <input type="checkbox"/> Hours</p> <p>999 <input type="checkbox"/> DK</p>
<p>4. Before you quit (<i>entry in 1</i>) ago, did you make any other serious attempts to stop smoking?</p>	<p align="right">54</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (<i>7</i>)</p>
<p>5. Including the last time you quit smoking, how many times did you make a serious attempt to stop smoking cigarettes?</p>	<p align="right">55-56</p> <p>_____ Times</p> <p>99 <input type="checkbox"/> DK</p>
<p>6. Before you quit smoking (<i>entry in 1</i>) ago, what was the longest period you stayed off cigarettes?</p>	<p align="right">57-59</p> <p>000 <input type="checkbox"/> Less than one day</p> <p>_____ { <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years</p> <p>999 <input type="checkbox"/> DK</p>
<p>7. For how many years were you a regular smoker (do not include the times when you stayed off cigarettes)?</p>	<p align="right">60-61</p> <p>00 <input type="checkbox"/> Less than one year</p> <p>_____ Years</p> <p>99 <input type="checkbox"/> DK</p>
<p>I'm going to read a list of methods which some people use to stop smoking cigarettes.</p>	
<p>8a. [When you quit did you ever/in any of your quit attempts did you ever] –</p>	<p align="center">Yes No</p>
<p>1) switch to lower tar or nicotine cigarettes?</p>	<p>1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p align="right">62</p>
<p>2) use special filters or cigarette holders to regulate the amount of smoke inhaled?</p>	<p>1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p align="right">63</p>
<p>3) gradually decrease the number of cigarettes you smoked in a day?</p>	<p>1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p align="right">64</p>
<p>4) use prescription chewing gum called "nicorette"?</p>	<p>1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p align="right">65</p>
<p>5) participate in the Great American Smoke-out?</p>	<p>1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p align="right">66</p>
<p>6) stop smoking along with friends or relatives who were also trying to quit?</p>	<p>1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p align="right">67</p>
<p>7) stop by following instructions in a book or pamphlet?</p>	<p>1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p align="right">68</p>
<p>8) stop "cold turkey", that is, stopping all at once without cutting down?</p>	<p>1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p align="right">69</p>
<p>9) use some other method?</p>	<p>1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p align="right">70</p>
<p><i>If "No" in 4 or only 1 method in 8a, mark box(es) without asking and skip to 9; otherwise ask:</i></p>	<p>1 <input type="checkbox"/> Switch to lower tar/nicotine cigarettes 71</p> <p>1 <input type="checkbox"/> Use special filters/cigarette holders 72</p> <p>1 <input type="checkbox"/> Gradually decrease number smoked 73</p> <p>1 <input type="checkbox"/> Use "nicorette" 74</p> <p>1 <input type="checkbox"/> Great American Smoke-out 75</p> <p>1 <input type="checkbox"/> Stop with friends or relatives 76</p> <p>1 <input type="checkbox"/> Follow instructions in pamphlet or book 77</p> <p>1 <input type="checkbox"/> Stop "cold turkey" 78</p> <p>1 <input type="checkbox"/> Other 79</p> <p>1 <input type="checkbox"/> DK 80</p>
<p>b. Thinking of the methods you just mentioned, which ones did you use the last time you quit smoking?</p> <p><i>Mark all applicable boxes, do not probe.</i></p>	

Section U – FORMER SMOKER – Continued

<p>9. Thinking of the time(s) you tried to quit smoking, please tell me the reasons you had for trying to quit.</p> <p><i>Mark all mentioned, do not probe.</i></p> <p><i>If for health reasons in general ask:</i></p> <p>Was that concern for your health at the time or concern for your future health?</p>	<p> <input type="checkbox"/> Health symptom/problem <input type="checkbox"/> Present health <input type="checkbox"/> Future health <input type="checkbox"/> Both present and future health <input type="checkbox"/> Cost of cigarettes <input type="checkbox"/> Pressure from family and friends <input type="checkbox"/> Advice from my doctor <input type="checkbox"/> Setting a good example for children <input type="checkbox"/> Effect my smoking had on others <input type="checkbox"/> Pregnancy <input type="checkbox"/> Lost desire <input type="checkbox"/> Dirty habit <input type="checkbox"/> Other <input type="checkbox"/> DK </p>	<p>5 6 7 8 9 10 11 12 13 14 15 16 17 18</p>
<p>10a. Did you ever try to quit smoking because of a health condition you had at the time?</p>	<p> <input type="checkbox"/> Yes <input type="checkbox"/> No (11) </p>	<p>19</p>
<p>b. What was the health condition?</p> <p><i>Mark all mentioned, do not probe.</i></p>	<p> <input type="checkbox"/> Heart trouble/problem <input type="checkbox"/> High blood pressure <input type="checkbox"/> Cancer <input type="checkbox"/> Emphysema <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cold/flu/virus <input type="checkbox"/> Other respiratory problem <input type="checkbox"/> Sore throat <input type="checkbox"/> Pregnancy <input type="checkbox"/> Other <input type="checkbox"/> DK </p>	<p>20 21 22 23 24 25 26 27 28 29 30 31</p>
<p>11. Did a doctor ever advise you to quit smoking?</p>	<p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK </p>	<p>32</p>
<p>12a. Do you believe your smoking affected your health in any way?</p>	<p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK } (13) </p>	<p>33</p>
<p>b. How did smoking affect your health?</p> <p><i>Mark all mentioned, do not probe.</i></p>	<p> <input type="checkbox"/> Heart trouble/problem <input type="checkbox"/> High blood pressure <input type="checkbox"/> Cancer <input type="checkbox"/> Emphysema <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cold/flu/virus <input type="checkbox"/> Other respiratory problem <input type="checkbox"/> Sore throat <input type="checkbox"/> Other <input type="checkbox"/> DK </p>	<p>34 35 36 37 38 39 40 41 42 43 44</p>
<p>13. When you are inside public places that have no rules about smoking and someone lights up a cigarette, what are you most likely to do — ask the person not to smoke, move away from the person, just do nothing, or something else?</p>	<p> <input type="checkbox"/> Ask person not to smoke <input type="checkbox"/> Move away <input type="checkbox"/> Do nothing <input type="checkbox"/> Something else </p> <p style="text-align: right;">} (section W)</p>	<p>45</p>

Notes

Section V — CURRENT SMOKER

If telephone interview, skip to 1b.

1a. In order to get an accurate record of the brand of cigarette you smoke most often, I'd like to see the cigarette package. Do you have the pack handy?

Yes (Record UPC, THEN 3)

46-57

No

b. What brand or type of cigarette do you smoke most often?

58-60

_____ Brand/Type name

2. What type of cigarettes are the (brand in 1b) that you smoke? Are they —

61

a. filter tip or non-filter tip?

1 Filter tip
2 Non-filter tip

b. hard pack or soft pack?

1 Hard pack
2 Soft pack

62

c. menthol or plain?

1 Menthol
2 Plain

63

d. regular, king-size, 100, or 120 millimeter?

1 Regular
2 King-size
3 100 millimeter
4 120 millimeter
9 DK

64

e. regular, lights or ultra lights?

1 Regular
2 Lights
3 Ultra lights
9 DK

65

3. On the average, how many cigarettes do you usually smoke a day?

00 Less than one cigarette per day
_____ Cigarettes per day

66-67

99 DK

4. How many minutes or hours after awakening do you have your first cigarette?

000 Immediately

68-70

_____ } 1 Minutes
 } 2 Hours

999 DK

5. What are the reasons you smoke cigarettes?

Mark all mentioned, do not probe.

- 1 Addicted
- 1 Relaxes or calms me/nerves/stress/helps me cope
- 1 To keep my weight down
- 1 Wakes me up
- 1 Gives me something to do with my hands
- 1 Keeps me going/helps me concentrate/excuse to take a break
- 1 Habit
- 1 I like it/enjoy it
- 1 Social reasons
- 1 Other
- 1 DK

71
72
73
74
75
76
77
78
79
80
81

6a. Have you ever made a serious attempt to stop smoking cigarettes?

1 Yes
2 No } (12)
9 DK }

82

b. Have you made more than one serious attempt?

1 Yes
2 No (6d)

83

c. How many times within the last year have you made a serious attempt to stop smoking cigarettes?

01 Once (6d)
00 Never (6e)
_____ Times } (6e)
99 DK }

84-85

d. When did you make the serious attempt to quit smoking?

_____/ 19 ____ (7a)
month year

86-89

e. When did you last make a serious attempt to quit smoking?

_____/ 19 ____ (7b)
month year

90-93

7a. When you tried to quit, how long did you stay off cigarettes?

000 Less than a day
_____ }
 } 1 Days
 } 2 Weeks
 } 3 Months
 } 4 Years } (8)
999 DK

94-96

Section V – CURRENT SMOKER – Continued

<p>7b. When you tried to quit in (entry in 6e), for how long did you stay off cigarettes?</p>	<p>000 <input type="checkbox"/> Less than a day</p> <p>_____ } <input type="checkbox"/> 1 Days <input type="checkbox"/> 2 Weeks <input type="checkbox"/> 3 Months <input type="checkbox"/> 4 Years</p> <p>999 <input type="checkbox"/> DK</p>	<p>3-4</p> <p>5-7</p>																														
<p>C. Of all the times you have tried to quit smoking, what was the longest period you stayed off cigarettes?</p>	<p>000 <input type="checkbox"/> Less than a day</p> <p>_____ } <input type="checkbox"/> 1 Days <input type="checkbox"/> 2 Weeks <input type="checkbox"/> 3 Months <input type="checkbox"/> 4 Years</p> <p>999 <input type="checkbox"/> DK</p>	<p>8-10</p>																														
<p>I'm going to read a list of methods which some people use to stop smoking cigarettes.</p>																																
<p>8a. [When you tried to quit did you ever/In any of your quit attempts did you ever] --</p> <p>1) switch to lower tar or nicotine cigarettes?</p> <p>2) use special filters or cigarette holders to regulate the amount of smoke inhaled?</p> <p>3) gradually decrease the number of cigarettes you smoked in a day?</p> <p>4) use prescription chewing gum called "nicorette"?</p> <p>5) participate in the Great American Smoke-out?</p> <p>6) stop smoking along with friends or relatives who were also trying to quit?</p> <p>7) stop by following instructions in a book or pamphlet?</p> <p>8) stop "cold turkey", that is, stopping all at once without cutting down?</p> <p>9) use some other method?</p>	<table border="0"> <tr> <td>Yes</td> <td>No</td> <td></td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>11</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>12</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>13</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>14</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>15</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>16</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>17</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>18</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>19</td> </tr> </table>	Yes	No		1 <input type="checkbox"/>	2 <input type="checkbox"/>	11	1 <input type="checkbox"/>	2 <input type="checkbox"/>	12	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13	1 <input type="checkbox"/>	2 <input type="checkbox"/>	14	1 <input type="checkbox"/>	2 <input type="checkbox"/>	15	1 <input type="checkbox"/>	2 <input type="checkbox"/>	16	1 <input type="checkbox"/>	2 <input type="checkbox"/>	17	1 <input type="checkbox"/>	2 <input type="checkbox"/>	18	1 <input type="checkbox"/>	2 <input type="checkbox"/>	19	
Yes	No																															
1 <input type="checkbox"/>	2 <input type="checkbox"/>	11																														
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1 <input type="checkbox"/>	2 <input type="checkbox"/>	17																														
1 <input type="checkbox"/>	2 <input type="checkbox"/>	18																														
1 <input type="checkbox"/>	2 <input type="checkbox"/>	19																														
<p><i>If "No" in 6b, or only 1 method in 8a, mark box(es) without asking and skip to 9, otherwise ask:</i></p> <p>b. Thinking of the methods you just mentioned, which ones did you use the last time you tried to quit smoking?</p> <p><i>Mark all applicable boxes, do not probe.</i></p>	<p>1 <input type="checkbox"/> Switch to lower tar/nicotine cigarettes</p> <p>1 <input type="checkbox"/> Use special filters/cigarette holders</p> <p>1 <input type="checkbox"/> Gradually decrease number smoked</p> <p>1 <input type="checkbox"/> Use "nicorette"</p> <p>1 <input type="checkbox"/> Great American Smoke-out</p> <p>1 <input type="checkbox"/> Stop with friends or relatives</p> <p>1 <input type="checkbox"/> Follow instructions in pamphlet or book</p> <p>1 <input type="checkbox"/> Stop "cold turkey"</p> <p>1 <input type="checkbox"/> Other</p> <p>1 <input type="checkbox"/> DK</p>	<p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p> <p>26</p> <p>27</p> <p>28</p> <p>29</p>																														
<p>9. Thinking of the time(s) you tried to quit smoking, please tell me the reasons you had for trying to quit.</p> <p><i>Mark all mentioned, do not probe.</i></p> <p><i>If for health reasons in general ask:</i></p> <p>Was that concern for your health at the time or concern for your future health?</p>	<p>1 <input type="checkbox"/> Health symptom/problem</p> <p>1 <input type="checkbox"/> Present health</p> <p>1 <input type="checkbox"/> Future health</p> <p>1 <input type="checkbox"/> Both present and future health</p> <p>1 <input type="checkbox"/> Cost of cigarettes</p> <p>1 <input type="checkbox"/> Pressure from family and friends</p> <p>1 <input type="checkbox"/> Advice from my doctor</p> <p>1 <input type="checkbox"/> Setting a good example for children</p> <p>1 <input type="checkbox"/> Effect my smoking had on others</p> <p>1 <input type="checkbox"/> Pregnancy</p> <p>1 <input type="checkbox"/> Lost desire</p> <p>1 <input type="checkbox"/> Dirty habit</p> <p>1 <input type="checkbox"/> Other</p> <p>1 <input type="checkbox"/> DK</p>	<p>30</p> <p>31</p> <p>32</p> <p>33</p> <p>34</p> <p>35</p> <p>36</p> <p>37</p> <p>38</p> <p>39</p> <p>40</p> <p>41</p> <p>42</p> <p>43</p>																														
<p>10a. Did you ever try to quit smoking because of a health condition you had at the time?</p> <p>b. What was the health condition?</p> <p><i>Mark all mentioned, do not probe.</i></p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No (11)</p> <p>1 <input type="checkbox"/> Heart trouble/problem</p> <p>1 <input type="checkbox"/> High blood pressure</p> <p>1 <input type="checkbox"/> Cancer</p> <p>1 <input type="checkbox"/> Emphysema</p> <p>1 <input type="checkbox"/> Cough</p> <p>1 <input type="checkbox"/> Shortness of breath</p> <p>1 <input type="checkbox"/> Cold/flu/virus</p> <p>1 <input type="checkbox"/> Other respiratory problem</p> <p>1 <input type="checkbox"/> Sore throat</p> <p>1 <input type="checkbox"/> Pregnancy</p> <p>1 <input type="checkbox"/> Other</p> <p>1 <input type="checkbox"/> DK</p>	<p>44</p> <p>45</p> <p>46</p> <p>47</p> <p>48</p> <p>49</p> <p>50</p> <p>51</p> <p>52</p> <p>53</p> <p>54</p> <p>55</p> <p>56</p>																														

Section V – CURRENT SMOKER – Continued

11a. After your attempt(s) to quit, what were the reasons you started to smoke again?

Mark all mentioned, do not probe.

- 00 Fear of gaining weight
- 01 Actual weight gain
- 02 Headaches/irritability/difficulty concentrating/drowsiness
- 03 Bored/blue/depressed
- 04 Nervous/tense/angry/frustrated/stress
- 05 Stressful life event
- 06 Pressure from others to smoke
- 07 No support from others
- 08 Habit/situation where used to smoke regularly
- 09 Addiction/craving
- 10 Pleasure of smoking/enjoy it
- 11 Others smoking around me
- 12 Not ready to quit/didn't want to quit
- 13 Didn't try hard enough/no will power
- 14 Any mention of alcohol
- 88 Other
- 99 DK

- 57-58
- 59-60
- 61-62
- 63-64
- 65-66
- 67-68
- 69-70
- 71-72
- 73-74
- 75-76
- 77-78
- 79-80
- 81-82
- 83-84
- 85-86
- 87-88
- 89-90

If only one reason in 11a, mark box without asking and skip to 12; otherwise ask:

b. Of the reasons you have told me, which of these was the MOST IMPORTANT to you as a reason for starting to smoke again.

MOST IMPORTANT

- | | | |
|-----------------------------|-----------------------------|-----------------------------|
| 00 <input type="checkbox"/> | 06 <input type="checkbox"/> | 12 <input type="checkbox"/> |
| 01 <input type="checkbox"/> | 07 <input type="checkbox"/> | 13 <input type="checkbox"/> |
| 02 <input type="checkbox"/> | 08 <input type="checkbox"/> | 14 <input type="checkbox"/> |
| 03 <input type="checkbox"/> | 09 <input type="checkbox"/> | 88 <input type="checkbox"/> |
| 04 <input type="checkbox"/> | 10 <input type="checkbox"/> | 99 <input type="checkbox"/> |
| 05 <input type="checkbox"/> | 11 <input type="checkbox"/> | |

91-92

12. Have you ever switched to a lower tar and nicotine cigarette just to reduce your health risk?

- 1 Yes
- 2 No

93

13a. Do you believe your smoking has affected your health in any way?

- 1 Yes
- 2 No
- 9 DK } (14)

94

b. How has your smoking affected your health?

Mark all mentioned, do not probe.

- 1 Heart trouble/problem
- 1 High blood pressure
- 1 Cancer
- 1 Emphysema
- 1 Cough
- 1 Shortness of breath
- 1 Cold/flu/virus
- 1 Other respiratory problem
- 1 Other
- 1 DK

- 95
- 96
- 97
- 98
- 99
- 100
- 101
- 102
- 103
- 104

14. Has a doctor ever advised you to quit smoking?

- 1 Yes
- 2 No

105

15. For how many years have you been a regular smoker (do not include the times when you stayed off cigarettes)?

- 00 Less than one year
- _____ Years
- 99 DK

106-107

16a. Could you quit smoking permanently if you wanted to?

- 1 Yes
- 2 No (17)
- 9 DK

108

b. How hard do you think it would be to quit smoking cigarettes entirely – very hard, somewhat hard, or not hard at all?

- 1 Very hard
- 2 Somewhat hard
- 3 Not hard at all
- 9 DK

109

17. When you are inside public places that have no rules about smoking, what are you most likely to do – light up a cigarette if you wish, look around to see if others are smoking and then light up, ask if others would mind, just not smoke, or something else?

- 1 Light up
- 2 Look around
- 3 Ask others
- 4 Not smoke
- 8 Something else

110

Notes

Section W — OTHER TOBACCO USE

3-4

These next questions are about the use of other tobacco products.

- 1 Yes
 2 No (6)
 9 DK Chewing tobacco (6)

5

1 a. Have you ever used chewing tobacco, such as Redman, Levi Garrett, or Beechnut?

b. Have you used chewing tobacco at least 20 times?

- 1 Yes
 2 No } (6)
 9 DK }

6

2. How old were you when you first used chewing tobacco?

_____ Age
 99 DK

7-8

3. Do you use chewing tobacco now?

- 1 Yes
 2 No

9

4. Altogether, about how long [did you use/have you used] chewing tobacco?

000 Less than one month
 _____ { 1 Months
 2 Years
 999 DK

10-12

5 a. On the average, how many days per month [did/do] you use chewing tobacco?

00 Less than one day a month
 97 Never used regularly (6)
 98 Everyday
 _____ Days per month
 99 DK

13-14

b. On the days that you use(d) chewing tobacco, how many times [did/do] you use it?

_____ Times per day
 99 DK

15-16

6 a. Have you ever used snuff, such as Skoal, Skoal Bandits, or Copenhagen?

- 1 Yes
 2 No (12)
 9 DK Snuff (12)

17

b. Have you used snuff at least 20 times?

- 1 Yes
 2 No } (12)
 9 DK }

18

7. How old were you when you first used snuff?

_____ Age
 99 DK

19-20

8. Do you use snuff now?

- 1 Yes
 2 No

21

9. Altogether, about how long [did you use/have you used] snuff?

000 Less than one month
 _____ { 1 Months
 2 Years
 999 DK

22-24

10 a. On the average, how many days per month [did/do] you use snuff?

00 Less than one day a month
 97 Never used regularly (12)
 98 Everyday
 _____ Days per month
 99 DK

25-26

b. On the days you use(d) snuff, how many times [did/do] you use it?

_____ Times per day
 99 DK

27-28

11. [Did/Do] you use snuff by sniffing it or by placing it in your mouth?

- 1 Sniffing
 2 Mouth
 3 Both

29

12 a. Have you ever smoked a pipe?

- 1 Yes
 2 No (17)

30

b. Have you smoked a pipe at least 50 times?

- 1 Yes
 2 No } (17)
 9 DK }

31

13. How old were you when you first smoked a pipe?

_____ Age
 99 DK

32-33

Section W – OTHER TOBACCO USE – Continued

14. Do you smoke a pipe now?	<input type="checkbox"/> Yes <input type="checkbox"/> No	34
15. Altogether, about how long [did you smoke/have you smoked] a pipe?	000 <input type="checkbox"/> Less than one month _____ { <input type="checkbox"/> Months <input type="checkbox"/> Years 999 <input type="checkbox"/> DK	35–37
16a. On the average, how many days per month [did/do] you smoke a pipe?	00 <input type="checkbox"/> Less than one day a month 97 <input type="checkbox"/> Never smoked a pipe regularly (17) 98 <input type="checkbox"/> Everyday _____ Days per month 99 <input type="checkbox"/> DK	38–39
b. On the days you smoke(d) a pipe, how many pipefuls of tobacco [did/do] you smoke?	00 <input type="checkbox"/> Less than one _____ Pipefuls per day 99 <input type="checkbox"/> DK	40–41
17a. Have you ever smoked cigars?	<input type="checkbox"/> Yes <input type="checkbox"/> No (22)	42
b. Have you smoked at least 50 cigars in your entire life?	<input type="checkbox"/> Yes <input type="checkbox"/> No } (22) <input type="checkbox"/> DK }	43
18. How old were you when you first smoked cigars?	_____ Age 99 <input type="checkbox"/> DK	44–45
19. Do you smoke cigars now?	<input type="checkbox"/> Yes <input type="checkbox"/> No	46
20. Altogether, about how long [did you smoke/have you smoked] cigars?	000 <input type="checkbox"/> Less than one month _____ { <input type="checkbox"/> Months <input type="checkbox"/> Years 999 <input type="checkbox"/> DK	47–49
21a. On the average, how many days per month [did/do] you smoke cigars?	00 <input type="checkbox"/> Less than one day a month 97 <input type="checkbox"/> Never smoked cigars regularly (22) 98 <input type="checkbox"/> Everyday _____ Days per month 99 <input type="checkbox"/> DK	50–51
b. On the days you smoke(d) cigars, how many [did/do] you smoke?	00 <input type="checkbox"/> Less than one _____ Cigars per day 99 <input type="checkbox"/> DK	52–53

Notes

Section W — OTHER TOBACCO USE — Continued

22a. Do you believe cigarette smoking is related to —		HAND CARD W ASK 22b for each "Yes" in 22a.		ASK 22c for each "Yes" in 22a.	
		b. Do you think there is a strong, moderate, or slight relationship between cigarette smoking and (condition)?		c. Do you believe that if a person stops smoking completely, his chances of getting (condition) are reduced?	
1) emphysema?	<input type="checkbox"/> Yes } (2) <input type="checkbox"/> No } <input type="checkbox"/> Maybe } <input type="checkbox"/> DK }	<input type="checkbox"/> Strong } (2) <input type="checkbox"/> Moderate } <input type="checkbox"/> Slight } <input type="checkbox"/> DK }	<input type="checkbox"/> Yes } <input type="checkbox"/> No } <input type="checkbox"/> DK }		56
2) gallstones?	<input type="checkbox"/> Yes } (3) <input type="checkbox"/> No } <input type="checkbox"/> Maybe } <input type="checkbox"/> DK }	<input type="checkbox"/> Strong } (3) <input type="checkbox"/> Moderate } <input type="checkbox"/> Slight } <input type="checkbox"/> DK }	<input type="checkbox"/> Yes } <input type="checkbox"/> No } <input type="checkbox"/> DK }		59
3) lung cancer?	<input type="checkbox"/> Yes } (4) <input type="checkbox"/> No } <input type="checkbox"/> Maybe } <input type="checkbox"/> DK }	<input type="checkbox"/> Strong } (4) <input type="checkbox"/> Moderate } <input type="checkbox"/> Slight } <input type="checkbox"/> DK }	<input type="checkbox"/> Yes } <input type="checkbox"/> No } <input type="checkbox"/> DK }		62
4) chronic bronchitis?	<input type="checkbox"/> Yes } (5) <input type="checkbox"/> No } <input type="checkbox"/> Maybe } <input type="checkbox"/> DK }	<input type="checkbox"/> Strong } (5) <input type="checkbox"/> Moderate } <input type="checkbox"/> Slight } <input type="checkbox"/> DK }	<input type="checkbox"/> Yes } <input type="checkbox"/> No } <input type="checkbox"/> DK }		65
5) diabetes?	<input type="checkbox"/> Yes } (6) <input type="checkbox"/> No } <input type="checkbox"/> Maybe } <input type="checkbox"/> DK }	<input type="checkbox"/> Strong } (6) <input type="checkbox"/> Moderate } <input type="checkbox"/> Slight } <input type="checkbox"/> DK }	<input type="checkbox"/> Yes } <input type="checkbox"/> No } <input type="checkbox"/> DK }		68
6) cancer of the mouth and throat?	<input type="checkbox"/> Yes } (7) <input type="checkbox"/> No } <input type="checkbox"/> Maybe } <input type="checkbox"/> DK }	<input type="checkbox"/> Strong } (7) <input type="checkbox"/> Moderate } <input type="checkbox"/> Slight } <input type="checkbox"/> DK }	<input type="checkbox"/> Yes } <input type="checkbox"/> No } <input type="checkbox"/> DK }		71
7) heart disease?	<input type="checkbox"/> Yes } (22b) <input type="checkbox"/> No } <input type="checkbox"/> Maybe } <input type="checkbox"/> DK }	<input type="checkbox"/> Strong } (22c) <input type="checkbox"/> Moderate } <input type="checkbox"/> Slight } <input type="checkbox"/> DK }	<input type="checkbox"/> Yes } <input type="checkbox"/> No } <input type="checkbox"/> DK }		74

W1	Mark appropriate box	<input type="checkbox"/> Sample 871 (23) <input type="checkbox"/> Sample 872—874 (W2)	75
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W2	Mark race. Refer to question 3, page 42 or 43 on HIS-1.	<input type="checkbox"/> White (section X) <input type="checkbox"/> All others (23)	76
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23a. Do you think that using chewing tobacco on a regular basis can increase a person's chances of getting mouth and throat cancer?		HAND CARD W Ask 23b for each "Yes" in 23a			
		b. Do you think there is a strong, moderate or slight connection between mouth and throat cancer and (YES in 23a)?		What about (YES in 23a)?	
1) Using chewing tobacco?	<input type="checkbox"/> Yes } (2) <input type="checkbox"/> No } <input type="checkbox"/> DK }	<input type="checkbox"/> Strong } <input type="checkbox"/> Moderate } <input type="checkbox"/> Slight } <input type="checkbox"/> DK }	<input type="checkbox"/> Strong } <input type="checkbox"/> Moderate } <input type="checkbox"/> Slight } <input type="checkbox"/> DK }		78
What about —					
2) Using snuff by mouth?	<input type="checkbox"/> Yes } (3) <input type="checkbox"/> No } <input type="checkbox"/> DK }	<input type="checkbox"/> Strong } <input type="checkbox"/> Moderate } <input type="checkbox"/> Slight } <input type="checkbox"/> DK }	<input type="checkbox"/> Strong } <input type="checkbox"/> Moderate } <input type="checkbox"/> Slight } <input type="checkbox"/> DK }		80
3) Smoking a pipe?	<input type="checkbox"/> Yes } (4) <input type="checkbox"/> No } <input type="checkbox"/> DK }	<input type="checkbox"/> Strong } <input type="checkbox"/> Moderate } <input type="checkbox"/> Slight } <input type="checkbox"/> DK }	<input type="checkbox"/> Strong } <input type="checkbox"/> Moderate } <input type="checkbox"/> Slight } <input type="checkbox"/> DK }		82
4) Smoking cigars?	<input type="checkbox"/> Yes } (23b) <input type="checkbox"/> No } <input type="checkbox"/> DK }	<input type="checkbox"/> Strong } <input type="checkbox"/> Moderate } <input type="checkbox"/> Slight } <input type="checkbox"/> DK }	<input type="checkbox"/> Strong } <input type="checkbox"/> Moderate } <input type="checkbox"/> Slight } <input type="checkbox"/> DK }		84

Section W – OTHER TOBACCO USE – Continued

HAND CARD R2

24. Now I'm going to read a list of statements about cigarette smoking. After I read each one, please tell me whether you strongly agree, agree, disagree, or strongly disagree, or if you have no opinion.

- 1 Strongly agree
- 2 Agree
- 3 Disagree
- 4 Strongly disagree
- 5 No opinion

85

a. Everything causes cancer anyway so it doesn't really matter if you smoke.

b. Smoking by a pregnant woman may harm the baby.

- 1 Strongly agree
- 2 Agree
- 3 Disagree
- 4 Strongly disagree
- 5 No opinion

86

c. The smoke from someone else's cigarette is harmful to you.

- 1 Strongly agree
- 2 Agree
- 3 Disagree
- 4 Strongly disagree
- 5 No opinion

87

d. Most deaths from lung cancer are caused by cigarette smoking.

- 1 Strongly agree
- 2 Agree
- 3 Disagree
- 4 Strongly disagree
- 5 No opinion

88

e. People who smoke low tar and nicotine cigarettes are less likely to get cancer than people who smoke high tar and nicotine cigarettes.

- 1 Strongly agree
- 2 Agree
- 3 Disagree
- 4 Strongly disagree
- 5 No opinion

89

f. If people want to smoke, they should not do so inside public places where it might disturb others.

- 1 Strongly agree
- 2 Agree
- 3 Disagree
- 4 Strongly disagree
- 5 No opinion

90

Notes

Section X – OCCUPATIONAL EXPOSURE

X1	Refer to HIS-1, C1	1 <input type="checkbox"/> Wa/Wb box marked (1) 8 <input type="checkbox"/> All others (8)	5
1. On your current job, are you exposed to any substances that would be harmful if you breathed them or got them on your skin?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (3a) 9 <input type="checkbox"/> DK	6
2a. Do you know how these substances could affect your health?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (3a)	7
b. Where did you learn how these substances could affect your health? Mark all mentioned, do not probe.		1 <input type="checkbox"/> Employer 1 <input type="checkbox"/> Union 1 <input type="checkbox"/> Health clinic at work 1 <input type="checkbox"/> Magazines 1 <input type="checkbox"/> Newspapers 1 <input type="checkbox"/> Notices posted at work 1 <input type="checkbox"/> Doctor 1 <input type="checkbox"/> Television 1 <input type="checkbox"/> Read container label 1 <input type="checkbox"/> Other 1 <input type="checkbox"/> DK	8 9 10 11 12 13 14 15 16 17 18
3a. Do you spend at least half your work day in an office building or some other type of building or do you work mostly outside?		1 <input type="checkbox"/> Inside 2 <input type="checkbox"/> Outside } (6) 9 <input type="checkbox"/> DK	19
b. Are there at least five other people working in the building?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (6) 9 <input type="checkbox"/> DK	20
4a. Is smoking allowed where you work?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (4c) 9 <input type="checkbox"/> DK (6)	21
b. Do you have smoking and non-smoking areas where you work?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (5) 9 <input type="checkbox"/> DK	22
c. Does your employer restrict smoking (to certain areas) for health reasons and personal comfort, or for some other reasons?		1 <input type="checkbox"/> Health/personal comfort 2 <input type="checkbox"/> Other reasons 3 <input type="checkbox"/> Both 9 <input type="checkbox"/> DK	23
If "No" in 4a, skip to 6; otherwise ask: 5. Would you say your immediate work area is very smoky from tobacco, somewhat smoky, or not smoky at all?		1 <input type="checkbox"/> Very smoky 2 <input type="checkbox"/> Somewhat smoky 3 <input type="checkbox"/> Not smoky at all 9 <input type="checkbox"/> DK	24
6. In general, would you say the smoke from other people's cigarettes is very annoying to you, somewhat annoying to you, or not at all annoying to you?		1 <input type="checkbox"/> Very annoying 2 <input type="checkbox"/> Somewhat annoying 3 <input type="checkbox"/> Not at all annoying	25

Notes

Section Y -- HEIGHT AND WEIGHT

1. About how tall are you without shoes?

26-28

_____ Feet

_____ Inches

2. About how much do you weigh without shoes?

29-31

_____ Pounds

3. When you weighed the most, how much did you weigh (do not include pregnancy)?

32-34

_____ Pounds

Notes

FORM HIS-1B (1987)
(8-1-86)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR THE
U.S. PUBLIC HEALTH SERVICE

NATIONAL HEALTH INTERVIEW SURVEY

EPIDEMIOLOGY STUDY

NOTICE — Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

1. RT 77 3-7 8		2. R.O. number	9-10	3. Sample	11-13
Book _____ of _____ books					
4. Control number PSU		14-16	Segment	17-23	Serial
		24-25		26-29	30
				5. Beginning time 1 a.m. 2 p.m.	

6a. FAMILY ROSTER
List all nondeleted family members 18 + by age (oldest to youngest).

6b. Hispanic oversample 31

SP1	32	33-34	35-36	Name	"X" if Hisp. marked	SP2-3 Hisp. Line No.
Line No.	Person No.	Age				
1					<input type="checkbox"/> Hisp.	
2					<input type="checkbox"/> Hisp.	
3					<input type="checkbox"/> Hisp.	
4					<input type="checkbox"/> Hisp.	
5					<input type="checkbox"/> Hisp.	
6					<input type="checkbox"/> Hisp.	
7					<input type="checkbox"/> Hisp.	
8					<input type="checkbox"/> Hisp.	
9					<input type="checkbox"/> Hisp.	

Refer to the appropriate section of the sample person selection label and circle as applicable. THEN circle the "SP1" Line No. in item 6a and mark "SP" box on the HIS-1 for the selected sample person. THEN go to Section AA.

7. FINAL STATUS

No person 18+ in this family (Household Page)

Interview

Complete interview (all appropriate sections completed)

Partial interview (some but not all appropriate sections completed) — Explain

Noninterview

Refusal (Explain in Notes)

SP temporarily absent

SP mentally or physically incapable

Other — Explain

37

8. Ending time 38-41 42 1 a.m. 2 p.m.	9. Interview mode 1 <input type="checkbox"/> Personal 2 <input type="checkbox"/> Telephone	10. Language of interview 1 <input type="checkbox"/> English 3 <input type="checkbox"/> Both English and Spanish 2 <input type="checkbox"/> Spanish 8 <input type="checkbox"/> Other	44	11. Interviewer identification Name _____ Code _____	45-46
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TRANSCRIPTION FROM COMPLETED HIS-1

12. Sex of SP (Page 2 or 55, question 3) 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	13. Education of SP (Page 42 or 43, question 2a) 00 <input type="checkbox"/> Never attended or kindergarten Elem: 1 2 3 4 5 6 7 8 High: 9 10 11 12 College: 1 2 3 4 5 6 + Finish grade/year (Question 2b) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	14. Main race of SP (Page 42 or 43, question 3a/b) 1 2 3 4 5 — Specify <input type="checkbox"/>
---	--	---

15. Marital status (Page 46 or 47, question 7) 1 <input type="checkbox"/> Married — spouse in HH 2 <input type="checkbox"/> Married — spouse not in HH 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced 5 <input type="checkbox"/> Separated 6 <input type="checkbox"/> Never married	16. Family income (Page 46, question 8b) 00 <input type="checkbox"/> A 07 <input type="checkbox"/> H 14 <input type="checkbox"/> O 21 <input type="checkbox"/> V 01 <input type="checkbox"/> B 08 <input type="checkbox"/> I 15 <input type="checkbox"/> P 22 <input type="checkbox"/> W 02 <input type="checkbox"/> C 09 <input type="checkbox"/> J 16 <input type="checkbox"/> Q 23 <input type="checkbox"/> X 03 <input type="checkbox"/> D 10 <input type="checkbox"/> K 17 <input type="checkbox"/> R 24 <input type="checkbox"/> Y 04 <input type="checkbox"/> E 11 <input type="checkbox"/> L 18 <input type="checkbox"/> S 25 <input type="checkbox"/> Z 05 <input type="checkbox"/> F 12 <input type="checkbox"/> M 19 <input type="checkbox"/> T 26 <input type="checkbox"/> ZZ 06 <input type="checkbox"/> G 13 <input type="checkbox"/> N 20 <input type="checkbox"/> U (Transcribe from 8a if 8b blank) 27 <input type="checkbox"/> \$20,000 or more 28 <input type="checkbox"/> Less than \$20,000	17. Person No. _____	18. Age _____	19. Booklet type 2 <input checked="" type="checkbox"/> Epidemiology study
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Section AA – ACCULTURATION

3-4

AA1	SP Status at initial interview	1 <input type="checkbox"/> Available (AA2) 2 <input type="checkbox"/> Callback required (Household page) 8 <input type="checkbox"/> Noninterview (Cover page)	5
AA2	Refer to hispanic origin from family roster and expected language for this supplement.	1 <input type="checkbox"/> Hispanic/English Supp. interview (1a) 2 <input type="checkbox"/> Hispanic/Spanish Supp. interview (1b) 8 <input type="checkbox"/> Other (section BB)	6
Read to respondent: I'm going to be asking questions that are related to health concerns, such as smoking, eating practices, vitamin use and so forth. Before I ask these questions I would like to ask a few questions about the language you use most often.			7
1 a.	Do you speak any Spanish?	1 <input type="checkbox"/> Yes (2) 2 <input type="checkbox"/> No (4)	8
Read to respondent: I'm going to be asking questions that are related to health concerns, such as smoking, eating practices, vitamin use and so forth. Before I ask these questions I would like to ask a few questions about the language you use most often.			9
b.	Do you speak any English?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (4)	9
2.	Would you say that you speak mostly Spanish, mostly English, or do you speak Spanish and English about the same?	1 <input type="checkbox"/> Mostly Spanish 2 <input type="checkbox"/> Mostly English 3 <input type="checkbox"/> Both about the same	10
3.	What language do you prefer: Spanish only, mostly Spanish, mostly English, English only, or Spanish and English about equally?	1 <input type="checkbox"/> Spanish only 2 <input type="checkbox"/> Mostly Spanish 3 <input type="checkbox"/> Mostly English 4 <input type="checkbox"/> English only 5 <input type="checkbox"/> Spanish and English equally	11
4.	Can you read Spanish?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	12
5.	Can you read English?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	13
If "Yes" to both 4 and 5 ask:			13
6.	In which language do you read better?	1 <input type="checkbox"/> Spanish 2 <input type="checkbox"/> English 3 <input type="checkbox"/> Both the same	14
7.	Can you write in Spanish?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	15
8.	Can you write in English?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	16
If "Yes" to both 7 and 8 ask:			16
9.	In which language do you write better?	1 <input type="checkbox"/> Spanish 2 <input type="checkbox"/> English 3 <input type="checkbox"/> Both the same	17
If self-reported on HIS-1, mark box without asking.			17
HAND CARD O, read categories if telephone interview.			17
10.	Which of these groups best describes your ethnic identification?	1 <input type="checkbox"/> Puerto Rican 2 <input type="checkbox"/> Cuban 3 <input type="checkbox"/> Mexican/Mexicano 4 <input type="checkbox"/> Mexican American 5 <input type="checkbox"/> Chicano 6 <input type="checkbox"/> Other Latin American 7 <input type="checkbox"/> Other Spanish 8 <input type="checkbox"/> Other (Specify) <input type="checkbox"/>	18
11.	Which of these groups best describes your mother's ethnic identification?	1 <input type="checkbox"/> Puerto Rican 2 <input type="checkbox"/> Cuban 3 <input type="checkbox"/> Mexican/Mexicano 4 <input type="checkbox"/> Mexican American 5 <input type="checkbox"/> Chicano 6 <input type="checkbox"/> Other Latin American 7 <input type="checkbox"/> Other Spanish 8 <input type="checkbox"/> Other (Specify) <input type="checkbox"/>	19
12.	Which of these groups best describes your father's ethnic identification?	1 <input type="checkbox"/> Puerto Rican 2 <input type="checkbox"/> Cuban 3 <input type="checkbox"/> Mexican/Mexicano 4 <input type="checkbox"/> Mexican American 5 <input type="checkbox"/> Chicano 6 <input type="checkbox"/> Other Latin American 7 <input type="checkbox"/> Other Spanish 8 <input type="checkbox"/> Other (Specify) <input type="checkbox"/>	19

Section AA – ACCULTURATION – Continued

If self-reported on HIS-1, mark box without asking.

13. In what country or state were you born?

- 1 U.S., except Puerto Rico
 - 2 Puerto Rico
 - 3 Cuba
 - 4 Mexico
 - 8 Other (Specify) ▾
-

20

14. In what country or state was your father born?

- 1 U.S., except Puerto Rico
 - 2 Puerto Rico
 - 3 Cuba
 - 4 Mexico
 - 8 Other (Specify) ▾
-

21

15. In what country or state was your mother born?

- 1 U.S., except Puerto Rico
 - 2 Puerto Rico
 - 3 Cuba
 - 4 Mexico
 - 8 Other (Specify) ▾
-

22

Notes

Section BB -- FOOD FREQUENCY

Read to respondent: (I'm going to be asking questions that are related to health concerns, such as smoking, eating practices, vitamin use and so forth.) These next questions are about the foods you eat. Please tell me how often you eat each one, for example, twice a week, three times a month and so forth. Also tell me whether you usually eat a small, medium or large portion of each food. Remember I'm only interested in the foods YOU eat. **HAND FOOD FREQUENCY FLASHCARD BOOKLET.** Please look at List 1 as I ask these first questions.

<p>During the past year or so, how often did you usually [eat/drink] --</p> <p>1. Orange juice or grapefruit juice?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ Day} \\ 2 \text{ Week} \\ 3 \text{ Month} \\ 4 \text{ Year} \end{array} \right.$ 5-8</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (2)</p>	<p>Was it a small, medium or large portion?</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (6 oz.) 3 <input type="checkbox"/> Large</p> <p>9</p>
<p>2. Other fruit juices or fortified fruit drinks?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ Day} \\ 2 \text{ Week} \\ 3 \text{ Month} \\ 4 \text{ Year} \end{array} \right.$ 10-13</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (3)</p>	<p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (6 oz.) 3 <input type="checkbox"/> Large</p> <p>14</p>
<p>3. Oranges?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ Day} \\ 2 \text{ Week} \\ 3 \text{ Month} \\ 4 \text{ Year} \end{array} \right.$ 15-18</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (4)</p>	<p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 med.) 3 <input type="checkbox"/> Large</p> <p>19</p>
<p>4. Grapefruit?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ Day} \\ 2 \text{ Week} \\ 3 \text{ Month} \\ 4 \text{ Year} \end{array} \right.$ 20-23</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (5)</p>	<p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1/2 grapefruit) 3 <input type="checkbox"/> Large</p> <p>24</p>
<p>5. Cantaloupe in season?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ Day} \\ 2 \text{ Week} \\ 3 \text{ Month} \\ 4 \text{ Year} \end{array} \right.$ 25-28</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (6)</p>	<p>A medium serving is 1/4 cantaloupe</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1/4 med.) 3 <input type="checkbox"/> Large</p> <p>29</p>
<p>6. Apples or applesauce?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ Day} \\ 2 \text{ Week} \\ 3 \text{ Month} \\ 4 \text{ Year} \end{array} \right.$ 30-33</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (7)</p>	<p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 med. or 1/2 cup) 3 <input type="checkbox"/> Large</p> <p>34</p>
<p>Now look at List 2.</p> <p>During the past year or so, how often did you usually eat --</p> <p>7. Beans, such as baked, pinto, kidney beans, or in chili? Do not include green beans.</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ Day} \\ 2 \text{ Week} \\ 3 \text{ Month} \\ 4 \text{ Year} \end{array} \right.$ 35-38</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (8)</p>	<p>Small, medium or large?</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (3/4 cup) 3 <input type="checkbox"/> Large</p> <p>39</p>
<p>8. Carrots, or mixed vegetables containing carrots?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ Day} \\ 2 \text{ Week} \\ 3 \text{ Month} \\ 4 \text{ Year} \end{array} \right.$ 40-43</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (9)</p>	<p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1/2 cup) 3 <input type="checkbox"/> Large</p> <p>44</p>
<p>9. Tomatoes, including in salad?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ Day} \\ 2 \text{ Week} \\ 3 \text{ Month} \\ 4 \text{ Year} \end{array} \right.$ 45-48</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (10)</p>	<p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 tomato) 3 <input type="checkbox"/> Large</p> <p>49</p>
<p>10. Green salad?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ Day} \\ 2 \text{ Week} \\ 3 \text{ Month} \\ 4 \text{ Year} \end{array} \right.$ 50-53</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (11)</p>	<p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 med. bowl) 3 <input type="checkbox"/> Large</p> <p>54</p>
<p>11. Salad dressing or mayonnaisse, including on sandwiches?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ Day} \\ 2 \text{ Week} \\ 3 \text{ Month} \\ 4 \text{ Year} \end{array} \right.$ 55-58</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (12)</p>	<p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (2 tbs.) 3 <input type="checkbox"/> Large</p> <p>59</p>

Section BB – FOOD FREQUENCY – Continued

12. Broccoli?	Times per { <ul style="list-style-type: none"> <input type="checkbox"/> 1 Day <input type="checkbox"/> 2 Week <input type="checkbox"/> 3 Month <input type="checkbox"/> 4 Year 0000 <input type="checkbox"/> Less than 6 a year or never (13)	60-83 Small, medium or large? 64 1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1/2 cup) 3 <input type="checkbox"/> Large
13. Spinach?	Times per { <ul style="list-style-type: none"> <input type="checkbox"/> 1 Day <input type="checkbox"/> 2 Week <input type="checkbox"/> 3 Month <input type="checkbox"/> 4 Year 0000 <input type="checkbox"/> Less than 6 a year or never (14)	65-68 Small, medium or large? 69 1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1/2 cup) 3 <input type="checkbox"/> Large
14. Mustard greens, turnip greens or collards?	Times per { <ul style="list-style-type: none"> <input type="checkbox"/> 1 Day <input type="checkbox"/> 2 Week <input type="checkbox"/> 3 Month <input type="checkbox"/> 4 Year 0000 <input type="checkbox"/> Less than 6 a year or never (15)	70-73 Small, medium or large? 74 1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1/2 cup) 3 <input type="checkbox"/> Large
15. Coleslaw, cabbage or sauerkraut?	Times per { <ul style="list-style-type: none"> <input type="checkbox"/> 1 Day <input type="checkbox"/> 2 Week <input type="checkbox"/> 3 Month <input type="checkbox"/> 4 Year 0000 <input type="checkbox"/> Less than 6 a year or never (16)	75-78 Small, medium or large? 79 1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1/2 cup) 3 <input type="checkbox"/> Large
16. French fries or fried potatoes?	Times per { <ul style="list-style-type: none"> <input type="checkbox"/> 1 Day <input type="checkbox"/> 2 Week <input type="checkbox"/> 3 Month <input type="checkbox"/> 4 Year 0000 <input type="checkbox"/> Less than 6 a year or never (17)	80-83 Small, medium or large? 84 1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (3/4 cup) 3 <input type="checkbox"/> Large
17. Potatoes, baked, boiled or mashed?	Times per { <ul style="list-style-type: none"> <input type="checkbox"/> 1 Day <input type="checkbox"/> 2 Week <input type="checkbox"/> 3 Month <input type="checkbox"/> 4 Year 0000 <input type="checkbox"/> Less than 6 a year or never (18)	85-88 Small, medium or large? 89 1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 potato or 1/2 cup) 3 <input type="checkbox"/> Large
18. Sweet potatoes or yams?	Times per { <ul style="list-style-type: none"> <input type="checkbox"/> 1 Day <input type="checkbox"/> 2 Week <input type="checkbox"/> 3 Month <input type="checkbox"/> 4 Year 0000 <input type="checkbox"/> Less than 6 a year or never (19)	90-93 Small, medium or large? 94 1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1/2 cup) 3 <input type="checkbox"/> Large
19. Rice?	Times per { <ul style="list-style-type: none"> <input type="checkbox"/> 1 Day <input type="checkbox"/> 2 Week <input type="checkbox"/> 3 Month <input type="checkbox"/> 4 Year 0000 <input type="checkbox"/> Less than 6 a year or never (20)	95-98 Small, medium or large? 99 1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1/2 cup) 3 <input type="checkbox"/> Large
Now look at List 3. During the past year or so, how often did you usually eat – 20. Hamburgers, cheeseburgers or meatloaf?	Times per { <ul style="list-style-type: none"> <input type="checkbox"/> 1 Day <input type="checkbox"/> 2 Week <input type="checkbox"/> 3 Month <input type="checkbox"/> 4 Year 0000 <input type="checkbox"/> Less than 6 a year or never (21)	100-103 Small, medium or large? 104 1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium 3 <input type="checkbox"/> Large
21. Beef, such as steaks or roasts?	Times per { <ul style="list-style-type: none"> <input type="checkbox"/> 1 Day <input type="checkbox"/> 2 Week <input type="checkbox"/> 3 Month <input type="checkbox"/> 4 Year 0000 <input type="checkbox"/> Less than 6 a year or never (22)	105-108 Small, medium or large? 109 1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (4 oz.) 3 <input type="checkbox"/> Large
22. Beef stew or potpie with vegetables?	Times per { <ul style="list-style-type: none"> <input type="checkbox"/> 1 Day <input type="checkbox"/> 2 Week <input type="checkbox"/> 3 Month <input type="checkbox"/> 4 Year 0000 <input type="checkbox"/> Less than 6 a year or never (23)	110-113 Small, medium or large? 114 1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 cup) 3 <input type="checkbox"/> Large
23. Liver, including chicken liver?	Times per { <ul style="list-style-type: none"> <input type="checkbox"/> 1 Day <input type="checkbox"/> 2 Week <input type="checkbox"/> 3 Month <input type="checkbox"/> 4 Year 0000 <input type="checkbox"/> Less than 6 a year or never (24)	115-118 Small, medium or large? 119 1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (4 oz.) 3 <input type="checkbox"/> Large

Section BB — FOOD FREQUENCY — Continued

<p>24. Pork, such as pork chops or roasts?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \end{array} \right.$</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (25)</p>	<p>5-8</p> <p>A medium serving is 2 pork chops or 4 oz. of roast.</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (2 pork chops or 4 oz. of roast) 3 <input type="checkbox"/> Large</p>	<p>9</p>
<p>25. Fried chicken?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \end{array} \right.$</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (26)</p>	<p>10-13</p> <p>A medium serving is 2 small or 1 large piece.</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (2 sm. or 1 lg. piece) 3 <input type="checkbox"/> Large</p>	<p>14</p>
<p>26. Chicken or turkey, baked, stewed or broiled?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \end{array} \right.$</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (27)</p>	<p>15-18</p> <p>A medium serving is 2 small or 1 large piece.</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (2 sm. or 1 lg. piece) 3 <input type="checkbox"/> Large</p>	<p>19</p>
<p>27. Fried fish or fish sandwiches?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \end{array} \right.$</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (28)</p>	<p>20-23</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (4 oz.) 3 <input type="checkbox"/> Large</p>	<p>24</p>
<p>28. Spaghetti, lasagna or pasta with tomato sauce?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \end{array} \right.$</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (29)</p>	<p>25-28</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 cup) 3 <input type="checkbox"/> Large</p>	<p>29</p>
<p>Now look at List 4. During the past year or so, how often did you usually eat —</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \end{array} \right.$</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (30)</p>	<p>30-33</p> <p>Small, medium, or large?</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 med. bowl) 3 <input type="checkbox"/> Large</p>	<p>34</p>
<p>29. Cooked cereals like oatmeal?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \end{array} \right.$</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (30)</p>	<p>30-33</p> <p>Small, medium, or large?</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 med. bowl) 3 <input type="checkbox"/> Large</p>	<p>34</p>
<p>30. High fiber cereals like bran, granola, or shredded wheat?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \end{array} \right.$</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (31)</p>	<p>35-38</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 med. bowl) 3 <input type="checkbox"/> Large</p>	<p>39</p>
<p>31. Highly fortified cereals like Product 19, Total, or Most?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \end{array} \right.$</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (32)</p>	<p>40-43</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 med. bowl) 3 <input type="checkbox"/> Large</p>	<p>44</p>
<p>32. Other cold cereals like Rice Krispies or corn flakes?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \end{array} \right.$</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (33)</p>	<p>45-48</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 med. bowl) 3 <input type="checkbox"/> Large</p>	<p>49</p>
<p>33. Eggs?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \end{array} \right.$</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (34)</p>	<p>50-53</p> <p>How many eggs?</p> <p>Number _____</p>	<p>54-55</p>
<p>34. Bacon?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \end{array} \right.$</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (35)</p>	<p>56-59</p> <p>How many slices?</p> <p>Number _____</p>	<p>60-61</p>
<p>35. Sausage?</p>	<p>Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \end{array} \right.$</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (36)</p>	<p>62-65</p> <p>How many patties or links?</p> <p>Number _____</p>	<p>66-67</p>

Section BB – FOOD FREQUENCY PAGE – Continued

<p>Now look at List 5.</p> <p>During the past year or so, how often did you usually eat –</p> <p>36. Vegetable soup, vegetable beef, minestrone or tomato soup? Do not include other kinds of soup.</p>	<p>Times per { 1 <input type="checkbox"/> Day 2 <input type="checkbox"/> Week 3 <input type="checkbox"/> Month 4 <input type="checkbox"/> Year</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (37)</p>	<p>5-8 Small, medium or large? 9</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 med. bowl) 3 <input type="checkbox"/> Large</p>
<p>37. Hot dogs?</p>	<p>Times per { 1 <input type="checkbox"/> Day 2 <input type="checkbox"/> Week 3 <input type="checkbox"/> Month 4 <input type="checkbox"/> Year</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (38)</p>	<p>10-13 How many hot dogs? 14-15</p> <p>Amount _____</p>
<p>38. Ham or lunch meats?</p>	<p>Times per { 1 <input type="checkbox"/> Day 2 <input type="checkbox"/> Week 3 <input type="checkbox"/> Month 4 <input type="checkbox"/> Year</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (39)</p>	<p>16-19 Small, medium or large? 20</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (2 slices) 3 <input type="checkbox"/> Large</p>
<p>39. White bread, rolls or crackers, including sandwiches, bagels, and so forth? I'm going to ask about dark bread and corn bread next.</p>	<p>Times per { 1 <input type="checkbox"/> Day 2 <input type="checkbox"/> Week 3 <input type="checkbox"/> Month 4 <input type="checkbox"/> Year</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (40)</p>	<p>21-24 A medium serving is 2 slices or 4 crackers. 25</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (2 slices or 4 crackers) 3 <input type="checkbox"/> Large</p>
<p>40. Dark breads like whole wheat, rye or pumpernickel?</p>	<p>Times per { 1 <input type="checkbox"/> Day 2 <input type="checkbox"/> Week 3 <input type="checkbox"/> Month 4 <input type="checkbox"/> Year</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (41)</p>	<p>26-29 A medium serving is 2 slices. 30</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (2 slices) 3 <input type="checkbox"/> Large</p>
<p>41. Corn bread, corn muffins, corn tortillas, or grits?</p>	<p>Times per { 1 <input type="checkbox"/> Day 2 <input type="checkbox"/> Week 3 <input type="checkbox"/> Month 4 <input type="checkbox"/> Year</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (42)</p>	<p>31-34 Small, medium or large? 35</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 piece or 1/2 cup grits) 3 <input type="checkbox"/> Large</p>
<p>42. Butter on bread, rolls or vegetables? I'll ask about margarine next.</p>	<p>Times per { 1 <input type="checkbox"/> Day 2 <input type="checkbox"/> Week 3 <input type="checkbox"/> Month 4 <input type="checkbox"/> Year</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (43)</p>	<p>36-39 A medium serving is 2 pats. 40</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (2 pats) 3 <input type="checkbox"/> Large</p>
<p>43. Margarine on bread, rolls or vegetables?</p>	<p>Times per { 1 <input type="checkbox"/> Day 2 <input type="checkbox"/> Week 3 <input type="checkbox"/> Month 4 <input type="checkbox"/> Year</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (44)</p>	<p>41-44 A medium serving is 2 pats. 45</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (2 pats) 3 <input type="checkbox"/> Large</p>
<p>44. Cheese or cheese spreads, not including cottage cheese?</p>	<p>Times per { 1 <input type="checkbox"/> Day 2 <input type="checkbox"/> Week 3 <input type="checkbox"/> Month 4 <input type="checkbox"/> Year</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (45)</p>	<p>46-49 Small, medium or large? 50</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (2 slices or 2 oz.) 3 <input type="checkbox"/> Large</p>
<p>45. Peanuts or peanut butter?</p>	<p>Times per { 1 <input type="checkbox"/> Day 2 <input type="checkbox"/> Week 3 <input type="checkbox"/> Month 4 <input type="checkbox"/> Year</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (46)</p>	<p>51-54 Small, medium or large? 55</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (2 tbs.) 3 <input type="checkbox"/> Large</p>
<p>46. Salty snacks like chips or popcorn?</p>	<p>Times per { 1 <input type="checkbox"/> Day 2 <input type="checkbox"/> Week 3 <input type="checkbox"/> Month 4 <input type="checkbox"/> Year</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (47)</p>	<p>56-59 Small, medium or large? 60</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 handful) 3 <input type="checkbox"/> Large</p>
<p>Now look at List 6.</p> <p>During the past year or so, how often did you usually [eat/drink] –</p> <p>47. Ice cream?</p>	<p>Times per { 1 <input type="checkbox"/> Day 2 <input type="checkbox"/> Week 3 <input type="checkbox"/> Month 4 <input type="checkbox"/> Year</p> <p>0000 <input type="checkbox"/> Less than 6 a year or never (48)</p>	<p>61-64 A medium serving is 1 medium scoop. 65</p> <p>1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 med. scoop) 3 <input type="checkbox"/> Large</p>

Section BB – FOOD FREQUENCY – Continued

48. Pie?	Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \\ 0000 \text{ } \square \text{ Less than 6 a year or never (49)} \end{array} \right.$	66-69	Small, medium or large?	70
49. Doughnuts, cookies, cake or pastry?	Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \\ 0000 \text{ } \square \text{ Less than 6 a year or never (50)} \end{array} \right.$	71-74	A medium serving is 1 piece or 3 cookies	75
50. Chocolate candy?	Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \\ 0000 \text{ } \square \text{ Less than 6 a year or never (51)} \end{array} \right.$	76-79	1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 oz.) 3 <input type="checkbox"/> Large	80
51. Sugar in coffee or tea or on cereal?	Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \\ 0000 \text{ } \square \text{ Less than 6 a year or never (52)} \end{array} \right.$	81-84	1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (2 tsp.) 3 <input type="checkbox"/> Large	85
52. Whole milk or drinks made with whole milk, not including on cereal? I'm going to ask about 1%, 2% and skim milk separately.	Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \\ 0000 \text{ } \square \text{ Less than 6 a year or never (53)} \end{array} \right.$	86-89	1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (8 oz. glass) 3 <input type="checkbox"/> Large	90
53. 2% milk or drinks made with 2% milk, not including on cereal?	Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \\ 0000 \text{ } \square \text{ Less than 6 a year or never (54)} \end{array} \right.$	91-94	1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (8 oz. glass) 3 <input type="checkbox"/> Large	95
54. Skim milk, 1% milk or buttermilk, not including on cereal?	Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \\ 0000 \text{ } \square \text{ Less than 6 a year or never (55)} \end{array} \right.$	96-99	1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (8 oz. glass) 3 <input type="checkbox"/> Large	100
55. Milk or cream in coffee or tea?	Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \\ 0000 \text{ } \square \text{ Less than 6 a year or never (56)} \end{array} \right.$	101-104	1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (1 tbs.) 3 <input type="checkbox"/> Large	105
56. Soda or soft drinks with sugar?	Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \\ 0000 \text{ } \square \text{ Less than 6 a year or never (57)} \end{array} \right.$	106-109	1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (12 oz.) 3 <input type="checkbox"/> Large	110
57 a. During the past year or so, how often did you drink beer?	0011 <input type="checkbox"/> Everyday/daily Times per $\left\{ \begin{array}{l} 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \end{array} \right.$	111-114		
b. On the days you drank beer, how many cans, bottles or glasses did you drink?	Number 99 <input type="checkbox"/> DK	115-116		
c. Were they small, medium, or large?	1 <input type="checkbox"/> Small 2 <input type="checkbox"/> Medium (12 oz.) 3 <input type="checkbox"/> Large (16 oz.)	117		

Notes

Section BB – FOOD FREQUENCY – Continued

3-4
5-8

58a. During the past year or so, how often did you drink wine?

- 0011 Everyday/daily
 Times per { 2 Week
 3 Month
 4 Year
 0000 Never (59)

b. On the days you drank wine, how many glasses did you drink?

- Number
 99 DK

c. Were they small, medium, or large?

- 1 Small
 2 Medium (1 med. wine glass)
 3 Large

9-10

11

59a. During the past year or so, how often did you drink liquor?

- 0011 Everyday/daily
 Times per { 2 Week
 3 Month
 4 Year
 0000 Never (60)

b. On the days you drank liquor, how many drinks did you have?

- Number
 99 DK

c. Were they small, medium, or large?

- 1 Small
 2 Medium (1shot)
 3 Large

12-15

16-17

18

60a. Was there ever a period in your life when you drank five or more drinks of any alcoholic beverage almost every day?

- 1 Yes
 2 No } (61)
 9 DK

b. For how long did that period last?

- Number { 1 Days
 2 Weeks
 3 Months
 4 Years
 9999 DK

19

20-23

61. When you eat chicken or other poultry, how often do you eat it with the skin on? Would you say often, sometimes, rarely or never?

- 1 Often or always
 2 Sometimes
 3 Rarely
 4 Never
 0 Don't eat chicken or poultry

24

62. When you eat red meat, how often do you eat the fat? Would you say often, sometimes, rarely or never?

- 1 Often or always
 2 Sometimes
 3 Rarely
 4 Never
 0 Don't eat red meat

25

63a. On most weekdays, how many meals do you usually eat each day?

- 0 Less than one a day
 _____ Meals
 9 DK

b. On most weekdays, how many snacks do you usually eat each day, including snacks after dinner?

- 0 Less than one a day
 _____ Snacks
 9 DK

c. On most Saturdays or Sundays, how many meals do you usually eat each day?

- 0 Less than one a day
 _____ Meals
 9 DK

d. On most Saturdays or Sundays, how many snacks do you usually eat each day?

- 0 Less than one a day
 _____ Snacks
 9 DK

26

27

28

29

64. In a typical week, how many meals do you usually get in restaurants, cafeterias, or fast food places?

- 00 Less than one a week
 _____ Meals
 99 DK

30-31

Notes

Section CC – VITAMIN AND MINERAL INTAKE

1. During the past 12 months, that is, since <i>(12 month date)</i> a year ago, did you take any vitamin or mineral supplements of any kind?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No <i>(section DD)</i>	32
2a. During the past 12 months, that is, since <i>(12 month date)</i> a year ago, did you take any MULTIPLE vitamins?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No <i>(3)</i>	33
b. What is the brand name of the multiple vitamins? <i>If more than one brand, ask:</i> What is the name of the brand you took most often during the past 12 months? <i>If known, mark without asking, otherwise ask:</i> Is that a therapeutic type, a stress-tab type or a one-a-day type? Mark first type listed	_____ Brand Name <input type="checkbox"/> DK/Refused <i>(Ask probe for type)</i>	34–78
c. For how many of the past 12 months did you take <i>[(name in 2b)/multiple vitamins]</i> ?	00 <input type="checkbox"/> Less than one 12 <input type="checkbox"/> All of them _____ Number of months	79
d. During <i>[(the/those) (number in 2c) month(s)]</i> , about how many days per month did you take <i>[(name in 2b)/multiple vitamins]</i> ?	98 <input type="checkbox"/> Everyday _____ Number of days per month 88 <input type="checkbox"/> Other	80–81
e. On the days you took <i>[(name in 2b)/multiple vitamins]</i> , how many pills did you take per day?	_____ Pills per day 99 <input type="checkbox"/> DK	82–83
<i>If less than 12 in 2c, ask:</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	84–85
f. Did you take any multiple vitamins in the past month?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	86
(The following questions are about vitamins not including the multiple vitamins you already told me about.)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No <i>(4)</i>	87
3a. During the past 12 months, did you take any vitamin A?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No <i>(4)</i>	88–89
b. For how many of the past 12 months did you take vitamin A?	00 <input type="checkbox"/> Less than one 12 <input type="checkbox"/> All of them _____ Number of months	90–91
c. During <i>[(the/those) (number in 3b) month(s)]</i> , about how many days per month did you take vitamin A?	98 <input type="checkbox"/> Everyday _____ Number of days per month 88 <input type="checkbox"/> Other	92–93
d. On the days you took vitamin A, how many pills did you usually take per day?	_____ Pills per day 99 <input type="checkbox"/> DK	94–95
e. How many units of vitamin A are in each of the pills you took?	_____ Units 99999 <input type="checkbox"/> DK	99
<i>If less than 12 in 3b, ask:</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	100
f. Did you take any vitamin A in the past month?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	101–102
4a. During the past 12 months, did you take any vitamin C?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No <i>(5)</i>	103–104
b. For how many of the past 12 months did you take vitamin C?	00 <input type="checkbox"/> Less than one 12 <input type="checkbox"/> All of them _____ Number of months	105–106
c. During <i>[(the/those) (number in 4b) month(s)]</i> , about how many days per month did you take vitamin C?	98 <input type="checkbox"/> Everyday _____ Number of days per month 88 <input type="checkbox"/> Other	107–108
d. On the days you took vitamin C, how many pills did you usually take per day?	_____ Pills per day 99 <input type="checkbox"/> DK	109–110
e. How many milligrams of vitamin C are in each of the pills you took?	_____ Mgs. 99999 <input type="checkbox"/> DK	111
<i>If less than 12 in 4b, ask:</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	112
f. Did you take any vitamin C in the past month?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	112

Notes

Section CC – VITAMIN AND MINERAL INTAKE – Continued

<p>5a. During the past 12 months, did you take any vitamin E?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6)</p>	<p>3-4 5</p>
<p>b. For how many of the past 12 months did you take vitamin E?</p>	<p>00 <input type="checkbox"/> Less than one 12 <input type="checkbox"/> All of them _____ Number of months</p>	<p>6-7</p>
<p>c. During [the/those] (number in 5b) month(s), about how many days per month did you take vitamin E?</p>	<p>98 <input type="checkbox"/> Everyday _____ Number of days per month 88 <input type="checkbox"/> Other</p>	<p>8-9</p>
<p>d. On the days you took vitamin E, how many pills did you usually take per day?</p>	<p>_____ Pills per day 99 <input type="checkbox"/> DK</p>	<p>10-11</p>
<p>e. How many units of vitamin E are in each of the pills you took?</p>	<p>_____ Units 99999 <input type="checkbox"/> DK</p>	<p>12-16</p>
<p><i>If less than 12 in 5b, ask:</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>17</p>
<p>f. Did you take any vitamin E in the past month?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>18</p>
<p>6a. During the past 12 months, did you take any calcium?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (section DD)</p>	<p>19-20</p>
<p>b. For how many of the past 12 months did you take calcium?</p>	<p>00 <input type="checkbox"/> Less than one 12 <input type="checkbox"/> All of them _____ Number of months</p>	<p>19-20</p>
<p>c. During [the/those] (number in 6b) month(s), about how many days per month did you take calcium?</p>	<p>98 <input type="checkbox"/> Everyday _____ Number of days per month 88 <input type="checkbox"/> Other</p>	<p>21-22</p>
<p>d. On the days you took calcium, how many pills did you usually take per day?</p>	<p>_____ Pills per day 99 <input type="checkbox"/> DK</p>	<p>23-24</p>
<p>e. How many milligrams of calcium are in each of the pills you took?</p>	<p>_____ Mgs. 99999 <input type="checkbox"/> DK</p>	<p>25-29</p>
<p><i>If less than 12 in 6b, ask:</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>30</p>
<p>f. Did you take any calcium in the past month?</p>		

Notes

Section DD – FOOD KNOWLEDGE

<p>1a. Have you ever made any LASTING and MAJOR changes in what you eat and drink for health reasons?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2)</p>	<p>31</p>																																										
<p>b. In making these changes, what foods do you eat MORE of?</p> <p><i>Enter response verbatim, one food per line. Do not probe.</i></p>	<p>MORE</p>	<p>_____ 32-34</p> <p>_____ 35-37</p> <p>_____ 38-40</p> <p>_____ 41-43</p> <p>000 <input type="checkbox"/> None 999 <input type="checkbox"/> DK</p>																																										
<p>c. What foods do you eat LESS of?</p> <p><i>Enter response verbatim, one food per line. Do not probe.</i></p>	<p>LESS</p>	<p>_____ 44-46</p> <p>_____ 47-49</p> <p>_____ 50-52</p> <p>_____ 53-55</p> <p>000 <input type="checkbox"/> None 999 <input type="checkbox"/> DK</p>																																										
<p>d. Have you made these changes in what you eat and drink in the past five years?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (1f) 9 <input type="checkbox"/> DK }</p>	<p>56</p>																																										
<p>e. Did you make these changes in the past year?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p>57</p>																																										
<p>f. Have there been any changes in the ways your food is cooked?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (2) 9 <input type="checkbox"/> DK }</p>	<p>58</p>																																										
<p>g. What are these changes?</p>	<table style="width:100%; border: none;"> <tr> <td style="text-align: center;">MORE</td> <td style="text-align: center;">LESS</td> <td></td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>Baking</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>Boiling</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>Broiling</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>Steaming</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>Frying</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>Stir-frying/wok</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>Sautéing</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>Grilling/barbecuing</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>Salting</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>Microwaving</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>Pressure-cooking</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>Using non-stick pans</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>Other</td> </tr> </table> <p style="text-align: center;">1 <input type="checkbox"/> DK</p>	MORE	LESS		1 <input type="checkbox"/>	2 <input type="checkbox"/>	Baking	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Boiling	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Broiling	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Steaming	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Frying	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Stir-frying/wok	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Sautéing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Grilling/barbecuing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Salting	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Microwaving	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Pressure-cooking	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Using non-stick pans	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Other	<p>59</p> <p>60</p> <p>61</p> <p>62</p> <p>63</p> <p>64</p> <p>65</p> <p>66</p> <p>67</p> <p>68</p> <p>69</p> <p>70</p> <p>71</p> <p>72</p>
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1 <input type="checkbox"/>	2 <input type="checkbox"/>	Other																																										
<p>2. I am going to read two statements. Please tell me which one you agree with most.</p> <p>(a) What people eat or drink has little effect on whether they will develop major diseases.</p> <p align="center">OR</p> <p>(b) By eating certain kinds of foods, people can reduce their chances of developing major diseases.</p>	<p>1 <input type="checkbox"/> a (5) 2 <input type="checkbox"/> b (3) 9 <input type="checkbox"/> DK (4)</p>	<p>73</p>																																										
<p>3. Which major diseases do you think may be related to what people eat and drink?</p>	<p>1 <input type="checkbox"/> Cancer 1 <input type="checkbox"/> Heart disease 1 <input type="checkbox"/> Obesity/Overweight 1 <input type="checkbox"/> Diabetes 1 <input type="checkbox"/> Hypertension/ High Blood Pressure 1 <input type="checkbox"/> Other 1 <input type="checkbox"/> None 1 <input type="checkbox"/> DK</p>	<p>74</p> <p>75</p> <p>76</p> <p>77</p> <p>78</p> <p>79</p> <p>80</p> <p>81</p>																																										

Section EE – SMOKING HABITS

These next questions are about cigarette smoking.

88

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

If asked: approximately 5 packs

- 1 Yes
 2 No } (section FF)
 9 DK

2. How old were you when you first started smoking cigarettes fairly regularly?

89-90

- _____ Age
 00 Never smoked regularly (section FF)
 99 DK

3. Do you smoke cigarettes now?

91

- 1 Yes (5)
 2 No

4. How old were you when you stopped smoking cigarettes?

92-93

- _____ Age
 99 DK

5. On the average, how many cigarettes [did/do] you usually smoke a day?

94-95

- 00 Less than one cigarette per day
 _____ Cigarettes per day
 99 DK

6. For how many years [have you been/were you] a regular smoker, do not include the times you may have stayed off cigarettes?

96-97

- 00 Less than one year
 _____ Years
 99 DK

Notes

Section FF – OTHER TOBACCO USE

3-4

These next questions are about the use of other tobacco products.

- 1 Yes
 2 No (6)
 9 DK Chewing tobacco (6)

5

1a. Have you ever used chewing tobacco, such as Redman, Levi Garrett, or Beechnut?

b. Have you used chewing tobacco at least 20 times?

- 1 Yes
 2 No } (6)
 9 DK }

6

2. How old were you when you first used chewing tobacco?

_____ Age
 99 DK

7-8

3. Do you use chewing tobacco now?

- 1 Yes
 2 No

9

4. Altogether, about how long [did you use/have you used] chewing tobacco?

000 Less than one month
 _____ } 1 Months
 } 2 Years
 999 DK

10-12

5a. On the average, how many days per month [did/do] you use chewing tobacco?

00 Less than one day a month
 97 Never used regularly (6)
 98 Everyday
 _____ Days per month
 99 DK

13-14

b. On the days that you use(d) chewing tobacco, how many times [did/do] you use it?

_____ Times per day
 99 DK

15-16

6a. Have you ever used snuff, such as Skoal, Skoal Bandits, or Copenhagen?

- 1 Yes
 2 No (12)
 9 DK Snuff (12)

17

b. Have you used snuff at least 20 times?

- 1 Yes
 2 No } (12)
 9 DK }

18

7. How old were you when you first used snuff?

_____ Age
 99 DK

19-20

8. Do you use snuff now?

- 1 Yes
 2 No

21

9. Altogether, about how long [did you use/have you used] snuff?

000 Less than one month
 _____ } 1 Months
 } 2 Years
 999 DK

22-24

10a. On the average, how many days per month [did/do] you use snuff?

00 Less than one day a month
 97 Never used regularly (12)
 98 Everyday
 _____ Days per month
 99 DK

25-26

b. On the days you use(d) snuff, how many times [did/do] you use it?

_____ Times per day
 99 DK

27-28

11. [Did/Do] you use snuff by sniffing it or by placing it in your mouth?

- 1 Sniffing
 2 Mouth
 3 Both

29

12a. Have you ever smoked a pipe?

- 1 Yes
 2 No (17)

30

b. Have you smoked a pipe at least 50 times?

- 1 Yes
 2 No } (17)
 9 DK }

31

13. How old were you when you first smoked a pipe?

_____ Age
 99 DK

32-33

Section FF — OTHER TOBACCO USE — Continued

14. Do you smoke a pipe now?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	34
15. Altogether, about how long [did you smoke/have you smoked] a pipe?	000 <input type="checkbox"/> Less than one month _____ } 1 <input type="checkbox"/> Months } 2 <input type="checkbox"/> Years 999 <input type="checkbox"/> DK	35-37
16a. On the average, how many days per month [did/do] you smoke a pipe?	00 <input type="checkbox"/> Less than one day a month 97 <input type="checkbox"/> Never smoked a pipe regularly (17) 98 <input type="checkbox"/> Everyday _____ Days per month 99 <input type="checkbox"/> DK	38-39
b. On the days you smoke(d) a pipe, how many pipefuls of tobacco [did/do] you smoke?	00 <input type="checkbox"/> Less than one _____ Pipefuls per day 99 <input type="checkbox"/> DK	40-41
17a. Have you ever smoked cigars?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (section GG)	42
b. Have you smoked at least 50 cigars in your entire life?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (section GG) 9 <input type="checkbox"/> DK }	43
18. How old were you when you first smoked cigars?	_____ Age 99 <input type="checkbox"/> DK	44-45
19. Do you smoke cigars now?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	46
20. Altogether, about how long [did you smoke/have you smoked] cigars?	000 <input type="checkbox"/> Less than one month _____ } 1 <input type="checkbox"/> Months } 2 <input type="checkbox"/> Years 999 <input type="checkbox"/> DK	47-49
21a. On the average, how many days per month [did/do] you smoke cigars?	00 <input type="checkbox"/> Less than one day a month 97 <input type="checkbox"/> Never smoked cigars regularly (section GG) 98 <input type="checkbox"/> Everyday _____ Days per month 99 <input type="checkbox"/> DK	50-51
b. On the days you smoke(d) cigars, how many [did/do] you smoke?	00 <input type="checkbox"/> Less than one _____ Cigars per day 99 <input type="checkbox"/> DK	52-53

Notes

Section GG – REPRODUCTION AND HORMONE USE

GG1	<i>Refer to sex</i>	1 <input type="checkbox"/> Male (section HH) 2 <input type="checkbox"/> Female (1)	54
These next questions are about pregnancy and reproduction.		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2)	55
1a. Have you ever given birth to a liveborn infant?			56–57
b. How many live births have you had? _____ Number			58–59
c. How old were you when your (first) child was born? _____ Age (2) 99 <input type="checkbox"/> DK (1d)			60
d. Were you 20 or younger, or older than 20?		1 <input type="checkbox"/> 20 or younger (2) 2 <input type="checkbox"/> Older than 20 (1e) 9 <input type="checkbox"/> DK (2)	61
e. Were you 21 to 24, 25 to 29, 30 to 34, or 35 or older?		1 <input type="checkbox"/> 21–24 4 <input type="checkbox"/> 35+ 2 <input type="checkbox"/> 25–29 9 <input type="checkbox"/> DK 3 <input type="checkbox"/> 30–34	62
2a. (Besides [that pregnancy/those pregnancies]), Have you ever had any (other) pregnancies that lasted six months or more?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (GG2)	63–64
b. How many of those (other) pregnancies have you had? _____ Number			65–66
c. How old were you at the end of [that pregnancy/ the first of those pregnancies]? _____ Age (GG2) 99 <input type="checkbox"/> DK (2d)			67
d. Were you 20 or younger, or older than 20?		1 <input type="checkbox"/> 20 or younger (GG2) 2 <input type="checkbox"/> Older than 20 9 <input type="checkbox"/> DK (GG2)	68
e. Were you 21 to 24, 25 to 29, 30 to 34, or 35 or older?		1 <input type="checkbox"/> 21–24 4 <input type="checkbox"/> 35+ 2 <input type="checkbox"/> 25–29 9 <input type="checkbox"/> DK 3 <input type="checkbox"/> 30–34	69
GG2	<i>Refer to 1a</i>	1 <input type="checkbox"/> "Yes" in 1a (3) 8 <input type="checkbox"/> Other (4)	70
3. Did you breastfeed any of your children?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	71–72
4a. How old were you when your menstrual cycles began? _____ Age (5) 00 <input type="checkbox"/> Never menstruated (7) 99 <input type="checkbox"/> DK (4b)			73
b. Were you younger than 10, 10 to 12, 13 to 15, or 16 or older?		1 <input type="checkbox"/> Younger than 10 2 <input type="checkbox"/> 10–12 3 <input type="checkbox"/> 13–15 4 <input type="checkbox"/> 16+ 9 <input type="checkbox"/> DK	74
5. Have your menstrual cycles stopped permanently?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (8)	75–76
6a. How old were you when they completely stopped? _____ Age (7) 99 <input type="checkbox"/> DK (6b)			77
b. Were you younger than 20, 20 to 29, 30 to 39, 40 to 44, 45 to 49, 50 to 54, or 55 or older?		1 <input type="checkbox"/> Younger than 20 2 <input type="checkbox"/> 20–29 3 <input type="checkbox"/> 30–39 4 <input type="checkbox"/> 40–44 5 <input type="checkbox"/> 45–49 6 <input type="checkbox"/> 50–54 7 <input type="checkbox"/> 55+ 9 <input type="checkbox"/> DK	78
7. [Did they stop/Was this] due to surgery?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	

Section GG – REPRODUCTION AND HORMONE USE – Continued

8a. Have you ever had an operation to remove a lump from your breast that was found to be NONCANCEROUS?	1 <input type="checkbox"/> Yes (8b) 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Lumps removed that were cancerous } (9) 9 <input type="checkbox"/> DK	79
b. How many of these operations have you had?	_____ Number of operations 9 <input type="checkbox"/> DK	80
c. How old were you when you had the (first) operation?	_____ Age at first operation 99 <input type="checkbox"/> DK	81–82
9. Have you ever used birth control pills?	We are interested in learning about the relationship between birth control pills and health . 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (GG 3)	83
10a. How old were you when you started using birth control pills?	_____ Age (11) 99 <input type="checkbox"/> DK (10b)	84–85
b. Were you younger than 25, or 25 or older?	1 <input type="checkbox"/> Younger than 25 (10c) 2 <input type="checkbox"/> 25+ (10d) 9 <input type="checkbox"/> DK (11)	86
c. Were you 18 or younger, 19 to 21, or 22 to 24?	1 <input type="checkbox"/> 18 or younger } (11) 2 <input type="checkbox"/> 19–21 3 <input type="checkbox"/> 22–24 9 <input type="checkbox"/> DK	87
d. Were you 25 to 29, 30 to 34, or 35 or older?	1 <input type="checkbox"/> 25–29 2 <input type="checkbox"/> 30–34 3 <input type="checkbox"/> 35+ 9 <input type="checkbox"/> DK	88
11a. Altogether, about how long did you take birth control pills? Include any breaks in usage that lasted less than one month.	Number { 1 <input type="checkbox"/> Days } (GG3) { 2 <input type="checkbox"/> Months } { 3 <input type="checkbox"/> Years } 000 <input type="checkbox"/> Less than one month (GG3) 888 <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> _____ (GG3) 999 <input type="checkbox"/> DK (11b)	89–91
b. Was it less than a year, or a year or more?	1 <input type="checkbox"/> Less than one year (GG3) 2 <input type="checkbox"/> One year or more (11c) 9 <input type="checkbox"/> DK (GG 3)	92
c. Was it 3 years or less, more than 3 but less than 5, or 5 or more years?	1 <input type="checkbox"/> 3 years or less 2 <input type="checkbox"/> More than 3, less than 5 years 3 <input type="checkbox"/> 5 or more years 9 <input type="checkbox"/> DK	93
GG3	Refer to age 1 <input type="checkbox"/> Under 40 (section HH) 2 <input type="checkbox"/> 40 and over (12)	94
12. Estrogen is a female hormone that may be taken after a hysterectomy or during menopause. Have you ever taken estrogen pills for any reason?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (section HH) 9 <input type="checkbox"/> DK	95
13a. How old were you when you started using estrogen pills?	_____ Age (14) 99 <input type="checkbox"/> DK (13b)	96–97
b. Were you younger than 20, 20 to 29, 30 to 39, 40 to 44, 45 to 49, 50 to 54, or 55 or older?	1 <input type="checkbox"/> Younger than 20 2 <input type="checkbox"/> 20–29 3 <input type="checkbox"/> 30–39 4 <input type="checkbox"/> 40–44 5 <input type="checkbox"/> 45–49 6 <input type="checkbox"/> 50–54 7 <input type="checkbox"/> 55+ 9 <input type="checkbox"/> DK	98

Section GG — REPRODUCTION AND HORMONE USE — Continued

14a. Altogether, about how long did you take estrogen pills? Include any breaks in usage that lasted less than one month.

99-101

Number $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Days} \\ 2 \text{ } \square \text{ Months} \\ 3 \text{ } \square \text{ Years} \end{array} \right\} (15)$

000 Less than one month (15)

000 Other (Specify) ∇

____ (15)

999 DK (14b)

b. Was it less than a year, or a year or more?

102

1 Less than one year (15)

2 One year or more (14c)

9 DK (15)

c. Was it 3 years or less, more than 3 but less than 5, or 5 or more years?

103

1 3 years or less

2 More than 3, less than 5 years

3 5 or more years

9 DK

15. What was the brand name of the estrogen pills?

104-119

Brand name

DK

Notes

Section HH – FAMILY HISTORY OF CANCER

These next questions are about your natural or birth mother and father. Do not include step or adoptive parents.

Ask 1–2 for mother, then for father.		MOTHER	FATHER
		5–8	22–28
1 a. In what year was your natural [mother/father] born?	1 a.	____ Year 9999 <input type="checkbox"/> DK	____ Year 9999 <input type="checkbox"/> DK
b. Is your [mother/father] still living?	b.	1 <input type="checkbox"/> Yes (2) 2 <input type="checkbox"/> No (1c) 9 <input type="checkbox"/> DK (2) 7 <input type="checkbox"/> Never knew natural mother (1 for father)	1 <input type="checkbox"/> Yes (2) 2 <input type="checkbox"/> No (1c) 9 <input type="checkbox"/> DK (2) 7 <input type="checkbox"/> Never knew natural father (3)
c. At what age did your [mother/father] die?	c.	____ Age 99 <input type="checkbox"/> DK	____ Age 99 <input type="checkbox"/> DK
2 a. Was your [mother/father] ever diagnosed by a doctor as having cancer?	2 a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (1 for father) 9 <input type="checkbox"/> DK }	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (3) 9 <input type="checkbox"/> DK }
b. What kind of cancer was it?	b.	____ (2d) 799 <input type="checkbox"/> DK (2c)	____ (2d) 799 <input type="checkbox"/> DK (2c)
c. What part of the body was affected?	c.	____ <input type="checkbox"/> DK	____ <input type="checkbox"/> DK
d. Did your [mother/father] have any other kind of cancer that was diagnosed by a doctor?	d.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (2g) 9 <input type="checkbox"/> DK }	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (2g) 9 <input type="checkbox"/> DK }
e. The FIRST time [she/he] was diagnosed with cancer, what kind of cancer was it?	e.	000 <input type="checkbox"/> Same as 2b/c (2g) ____ (2g) 799 <input type="checkbox"/> DK (2f)	000 <input type="checkbox"/> Same as 2b/c (2g) ____ (2g) 799 <input type="checkbox"/> DK (2f)
f. What part of the body was affected?	f.	____ <input type="checkbox"/> DK	____ <input type="checkbox"/> DK
g. How old was your [mother/father] when cancer was first diagnosed by a doctor?	g.	____ Age } (1 for father) 99 <input type="checkbox"/> DK }	____ Age 99 <input type="checkbox"/> DK

Notes

Section HH – FAMILY HISTORY OF CANCER – Continued

Read to respondent: Now I'm going to ask about your sisters and brothers who have the same natural or birth mother AND father as you. Do not include step, half, or adoptive sisters and brothers.

<p>3a. How many sisters do you have, including any that may have died?</p>		<p>3a. _____ None 39-40 _____ Sisters 99 <input type="checkbox"/> DK</p>		
<p>b. How many brothers do you have, including any that may have died?</p>		<p>b. _____ None 41-42 _____ Brothers 99 <input type="checkbox"/> DK</p>		
<p><i>If "None" in 3a and 3b, skip to 9:</i></p>				
<p>4. Have any of your [brothers/(or) sisters] ever been diagnosed by a doctor as having cancer?</p>		<p>4. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (9) 9 <input type="checkbox"/> DK } 43</p>		
<p>5. What are the first names of your [brothers/(or) sisters] who had cancer? <i>Record each person in a separate column</i> Anyone else?</p>		<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; border-right: 1px solid black; padding: 5px;"> <p align="center">44</p> <p align="center">Name _____</p> <p>Sex: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> DK</p> </td> <td style="width:50%; padding: 5px;"> <p align="center">62</p> <p align="center">Name _____</p> <p>Sex: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> DK</p> </td> </tr> </table>	<p align="center">44</p> <p align="center">Name _____</p> <p>Sex: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> DK</p>	<p align="center">62</p> <p align="center">Name _____</p> <p>Sex: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> DK</p>
<p align="center">44</p> <p align="center">Name _____</p> <p>Sex: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> DK</p>	<p align="center">62</p> <p align="center">Name _____</p> <p>Sex: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> DK</p>			
<p><i>Ask 6-8 for the first person listed in 5 before asking 6-8 for the next person.</i></p>				
<p>6a. What kind of cancer did (name in 5) have?</p>		<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; border-right: 1px solid black; padding: 5px;"> <p align="center">45-47</p> <p align="center">_____ (6c)</p> <p>799 <input type="checkbox"/> DK (6b)</p> </td> <td style="width:50%; padding: 5px;"> <p align="center">63-65</p> <p align="center">_____ (6c)</p> <p>799 <input type="checkbox"/> DK (6b)</p> </td> </tr> </table>	<p align="center">45-47</p> <p align="center">_____ (6c)</p> <p>799 <input type="checkbox"/> DK (6b)</p>	<p align="center">63-65</p> <p align="center">_____ (6c)</p> <p>799 <input type="checkbox"/> DK (6b)</p>
<p align="center">45-47</p> <p align="center">_____ (6c)</p> <p>799 <input type="checkbox"/> DK (6b)</p>	<p align="center">63-65</p> <p align="center">_____ (6c)</p> <p>799 <input type="checkbox"/> DK (6b)</p>			
<p>b. What part of the body was affected?</p>		<p>_____</p> <p align="center"><input type="checkbox"/> DK</p>		
<p>c. Did (name in 5) have any other kind of cancer that was diagnosed by a doctor?</p>		<p>c. 1 <input type="checkbox"/> Yes 48 2 <input type="checkbox"/> No } (7) 9 <input type="checkbox"/> DK } 66</p>		
<p>d. The FIRST time [he/she] was diagnosed with cancer, what kind of cancer was it?</p>		<p>d. 000 <input type="checkbox"/> Same as 6a/b (7) 49-51 _____ (7) 799 <input type="checkbox"/> DK (6e)</p>		
<p>e. What part of the body was affected?</p>		<p>_____</p> <p align="center"><input type="checkbox"/> DK</p>		
<p>7. How old was (name in 5) when cancer was first diagnosed by a doctor?</p>		<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; border-right: 1px solid black; padding: 5px;"> <p align="center">52-53</p> <p align="center">_____ Age 99 <input type="checkbox"/> DK</p> </td> <td style="width:50%; padding: 5px;"> <p align="center">70-71</p> <p align="center">_____ Age 99 <input type="checkbox"/> DK</p> </td> </tr> </table>	<p align="center">52-53</p> <p align="center">_____ Age 99 <input type="checkbox"/> DK</p>	<p align="center">70-71</p> <p align="center">_____ Age 99 <input type="checkbox"/> DK</p>
<p align="center">52-53</p> <p align="center">_____ Age 99 <input type="checkbox"/> DK</p>	<p align="center">70-71</p> <p align="center">_____ Age 99 <input type="checkbox"/> DK</p>			
<p>8a. In what year was (name in 5) born?</p>		<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; border-right: 1px solid black; padding: 5px;"> <p align="center">54-57</p> <p align="center">_____ Year 9999 <input type="checkbox"/> DK</p> </td> <td style="width:50%; padding: 5px;"> <p align="center">72-75</p> <p align="center">_____ Year 9999 <input type="checkbox"/> DK</p> </td> </tr> </table>	<p align="center">54-57</p> <p align="center">_____ Year 9999 <input type="checkbox"/> DK</p>	<p align="center">72-75</p> <p align="center">_____ Year 9999 <input type="checkbox"/> DK</p>
<p align="center">54-57</p> <p align="center">_____ Year 9999 <input type="checkbox"/> DK</p>	<p align="center">72-75</p> <p align="center">_____ Year 9999 <input type="checkbox"/> DK</p>			
<p><i>If known, mark without asking.</i></p>				
<p>b. Is (name in 5) still living?</p>		<p>b. 1 <input type="checkbox"/> Yes (HH1) 58 2 <input type="checkbox"/> No (8c) 9 <input type="checkbox"/> DK (HH1) 76</p>		
<p>c. At what age did (name in 5) die?</p>		<p>c. _____ Age 59-60 99 <input type="checkbox"/> DK 77-78</p>		
<p>HH1</p>	<p><i>Refer to entries in 5.</i></p>	<p>HH1 1 <input type="checkbox"/> Additional siblings (6) 61 2 <input type="checkbox"/> No more siblings (9) 79</p>		

Notes

Section HH – FAMILY HISTORY OF CANCER – Continued

Read to respondent: **These questions are about your natural or birth children. Do not include any children for whom you are an adoptive, step, or foster parent.**

<p>9a. How many daughters do you have, including any that may have died?</p>	9a.	<p>00 <input type="checkbox"/> None 23–24</p> <p>_____ Daughters</p> <p>99 <input type="checkbox"/> DK</p>			
<p>b. How many sons do you have, including any that may have died?</p>	b.	<p>00 <input type="checkbox"/> None 25–26</p> <p>_____ Sons</p> <p>99 <input type="checkbox"/> DK</p>			
<i>If "None" in 9a and 9b, skip to section II.</i>					
<p>10. Have any of your children ever been diagnosed by a doctor as having cancer?</p>	10.	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No } (15)</p> <p>9 <input type="checkbox"/> DK }</p>	27		
<p>11. What are the first names of your children who had cancer?</p> <p><i>Record each person in a separate column</i></p> <p>Anyone else?</p>	11.	<table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"> <p align="center">Name _____</p> <p>Sex: 1 <input type="checkbox"/> Male</p> <p> 2 <input type="checkbox"/> Female</p> </td> <td style="width:50%; border: none;"> <p align="center">Name _____</p> <p>Sex: 1 <input type="checkbox"/> Male</p> <p> 2 <input type="checkbox"/> Female</p> </td> </tr> </table>	<p align="center">Name _____</p> <p>Sex: 1 <input type="checkbox"/> Male</p> <p> 2 <input type="checkbox"/> Female</p>	<p align="center">Name _____</p> <p>Sex: 1 <input type="checkbox"/> Male</p> <p> 2 <input type="checkbox"/> Female</p>	<p>28–35 54–61</p> <p align="center">36 62</p>
<p align="center">Name _____</p> <p>Sex: 1 <input type="checkbox"/> Male</p> <p> 2 <input type="checkbox"/> Female</p>	<p align="center">Name _____</p> <p>Sex: 1 <input type="checkbox"/> Male</p> <p> 2 <input type="checkbox"/> Female</p>				
<i>Ask 12–14 for the first person listed in 11 before asking 12–14 for the next person.</i>					
<p>12a. What kind of cancer did (name in 11) have?</p>	12a.	<p>_____ (12c)</p> <p>799 <input type="checkbox"/> DK (12b)</p>	<p>37–39 63–65</p> <p align="center">36 62</p>		
<p>b. What part of the body was affected?</p>	b.	<p>_____</p> <p><input type="checkbox"/> DK</p>	62		
<p>c. Did (name in 11) have any other kind of cancer that was diagnosed by a doctor?</p>	c.	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No } (13)</p> <p>9 <input type="checkbox"/> DK }</p>	<p>40 66</p>		
<p>d. The FIRST time [he/she] was diagnosed with cancer, what kind of cancer was it?</p>	d.	<p>000 <input type="checkbox"/> Same as 12a/b (13)</p> <p>_____ (13)</p> <p>799 <input type="checkbox"/> DK (12e)</p>	<p>41–43 67–69</p> <p align="center">36 62</p>		
<p>e. What part of the body was affected?</p>	e.	<p>_____</p> <p><input type="checkbox"/> DK</p>	62		
<p>13. How old was (name in 11) when cancer was first diagnosed by a doctor?</p>	13.	<p>_____ Age</p> <p>99 <input type="checkbox"/> DK</p>	<p>44–45 70–71</p> <p align="center">36 62</p>		
<p>14a. In what year was (name in 11) born?</p>	14a.	<p>_____ Year</p> <p>9999 <input type="checkbox"/> DK</p>	<p>46–49 72–75</p> <p align="center">36 62</p>		
<i>If this child in household, mark "Yes" box without asking.</i>					
<p>b. Is (name in 11) still living?</p>	b.	<p>1 <input type="checkbox"/> Yes (HH2)</p> <p>2 <input type="checkbox"/> No (14c)</p> <p>9 <input type="checkbox"/> DK (HH2)</p>	<p>50 76</p>		
<p>c. At what age did (name in 11) die?</p>	c.	<p>_____ Age</p> <p>99 <input type="checkbox"/> DK</p>	<p>51–52 77–78</p> <p align="center">36 62</p>		
<p>HH2</p>	HH2	<p>1 <input type="checkbox"/> Additional children (12)</p> <p>2 <input type="checkbox"/> No more children (15)</p>	<p>53 79</p> <p align="center">36 62</p>		
<p>Notes</p>					

Section HH -- FAMILY HISTORY OF CANCER -- Continued

15. Has the natural [father/mother] of [any of your (other) children/your child] ever been diagnosed by a doctor as having cancer?	15.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (section II) 9 <input type="checkbox"/> DK	5
16a. What is the [father's/mother's] name? _____ Name	16a.		
b. Is (name in 16a) the [father/mother] of all your (other) children?	b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	6
17a. What kind of cancer did (name in 16a) have? _____ (17c) 799 <input type="checkbox"/> DK (17b)	17a.		7-9
b. What part of the body was affected? _____ <input type="checkbox"/> DK	b.		
c. Did (name in 16a) have any other kind of cancer that was diagnosed by a doctor?	c.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (18) 9 <input type="checkbox"/> DK	10
d. The FIRST time [he/she] was diagnosed with cancer, what kind of cancer was it? _____ (18) 799 <input type="checkbox"/> DK (17a)	d.	000 <input type="checkbox"/> Same as 17a/b (18)	11-13
e. What part of the body was affected? _____ <input type="checkbox"/> DK	e.		
18. How old was (name in 16a) when cancer was first diagnosed by a doctor?	18.	_____ Age 99 <input type="checkbox"/> DK	14-15
19a. In what year was (name in 16a) born? _____ Year 9999 <input type="checkbox"/> DK <i>If person in household, mark "Yes" without asking.</i>	19a.		16-19
b. Is (name in 16a) still living?	b.	1 <input type="checkbox"/> Yes (20) 2 <input type="checkbox"/> No (19c) 9 <input type="checkbox"/> DK (20)	20
c. At what age did (name in 16a) die?	c.	_____ Age 99 <input type="checkbox"/> DK	21-22
20a. How many children did you and (name in 16a) have together, including any that may have died?	20a.	_____ No. of children	23-24
b. How many of these children are sons and how many are daughters?	b.	_____ No. of sons _____ No. of daughters	25-26 27-28
c. What are the children's first names?	c.	_____ First name _____ First name _____ First name _____ First name _____ First name _____ First name _____ First name _____ First name _____ First name _____ First name	29-36 37-44 45-62 63-60 61-68 69-76 77-84 85-92
HH3	HH3	1 <input type="checkbox"/> "No" in 16b (15) 8 <input type="checkbox"/> "Yes" in 16b (section II)	93
Refer to 16b.			

Section II – CANCER SURVIVORSHIP

3-4

1. Has a doctor or other health professional ever told you that you had cancer of any kind (including any cancer you have already mentioned)?

- 1 Yes
 2 No (section JJ)

5

2a. What kind of cancer was it?

_____ (3)
 799 DK (2b)

6-8

b. What part of the body was affected?

_____ DK

3. How old were you when this cancer was first diagnosed by a doctor?

_____ Age
 99 DK

9-10

4. Besides this cancer, has a doctor ever told you that you had any other kind of cancer?

- 1 Yes
 2 No (section JJ)

11

5a. What kind of cancer was it?

_____ (6)
 799 DK (5b)

12-14

b. What part of the body was affected?

_____ DK

6. How old were you when THIS cancer was first diagnosed by a doctor?

_____ Age
 99 DK

15-16

Notes

Introduction: These next questions are to determine what people know about AIDS, also called Acquired Immunodeficiency Syndrome.

<p>1a. When was the last time you saw, heard or read something about AIDS?</p>	<p>number (2)</p> <p>001 <input type="checkbox"/> Today 2 <input type="checkbox"/> Days ago 3 <input type="checkbox"/> Weeks ago 4 <input type="checkbox"/> Months ago 5 <input type="checkbox"/> Years ago</p> <p>000 <input type="checkbox"/> Never 999 <input type="checkbox"/> DK when or DK disease (1b)</p> <p style="text-align: right; border: 1px solid black; padding: 2px;">60-62</p>												
<p>1b. Have you ever heard of AIDS?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (SKIP TO ITEM 28, Page 9)</p> <p style="text-align: right; border: 1px solid black; padding: 2px;">63</p>												
<p>2. Compared to most people, how much would you say you know about AIDS...would you say a lot, some, a little, or nothing?</p>	<p>1 <input type="checkbox"/> A lot 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> A little 4 <input type="checkbox"/> Nothing</p> <p style="text-align: right; border: 1px solid black; padding: 2px;">64</p>												
<p>HAND CARD A</p>													
<p>3. After I read each statement, tell me whether you think the statement is definitely true, probably true, probably false, definitely false or you don't know if it is true or false.</p> <p>a. AIDS is a disease caused by a virus.</p>	<table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Def. True</th> <th style="text-align: left; border-bottom: 1px solid black;">Prob. True</th> <th style="text-align: left; border-bottom: 1px solid black;">Prob. False</th> <th style="text-align: left; border-bottom: 1px solid black;">Def. False</th> <th style="text-align: left; border-bottom: 1px solid black;">Don't Know</th> <th style="border: none;"></th> </tr> </thead> <tbody> <tr> <td style="border: none;">1 <input type="checkbox"/></td> <td style="border: none;">2 <input type="checkbox"/></td> <td style="border: none;">3 <input type="checkbox"/></td> <td style="border: none;">4 <input type="checkbox"/></td> <td style="border: none;">9 <input type="checkbox"/></td> <td style="border: 1px solid black; text-align: center; padding: 2px;">65</td> </tr> </tbody> </table>	Def. True	Prob. True	Prob. False	Def. False	Don't Know		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	65
Def. True	Prob. True	Prob. False	Def. False	Don't Know									
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	65								
<p>b. AIDS can cripple the body's natural protection against disease.</p>	<table border="0" style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td style="border: none;">1 <input type="checkbox"/></td> <td style="border: none;">2 <input type="checkbox"/></td> <td style="border: none;">3 <input type="checkbox"/></td> <td style="border: none;">4 <input type="checkbox"/></td> <td style="border: none;">9 <input type="checkbox"/></td> <td style="border: 1px solid black; text-align: center; padding: 2px;">66</td> </tr> </tbody> </table>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	66						
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	66								
<p>c. AIDS is especially common in older people.</p>	<table border="0" style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td style="border: none;">1 <input type="checkbox"/></td> <td style="border: none;">2 <input type="checkbox"/></td> <td style="border: none;">3 <input type="checkbox"/></td> <td style="border: none;">4 <input type="checkbox"/></td> <td style="border: none;">9 <input type="checkbox"/></td> <td style="border: 1px solid black; text-align: center; padding: 2px;">67</td> </tr> </tbody> </table>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	67						
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	67								
<p>d. The AIDS virus can damage the brain.</p>	<table border="0" style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td style="border: none;">1 <input type="checkbox"/></td> <td style="border: none;">2 <input type="checkbox"/></td> <td style="border: none;">3 <input type="checkbox"/></td> <td style="border: none;">4 <input type="checkbox"/></td> <td style="border: none;">9 <input type="checkbox"/></td> <td style="border: 1px solid black; text-align: center; padding: 2px;">68</td> </tr> </tbody> </table>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	68						
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	68								
<p>e. AIDS usually leads to heart disease.</p>	<table border="0" style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td style="border: none;">1 <input type="checkbox"/></td> <td style="border: none;">2 <input type="checkbox"/></td> <td style="border: none;">3 <input type="checkbox"/></td> <td style="border: none;">4 <input type="checkbox"/></td> <td style="border: none;">9 <input type="checkbox"/></td> <td style="border: 1px solid black; text-align: center; padding: 2px;">69</td> </tr> </tbody> </table>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	69						
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	69								
<p>f. AIDS leads to death.</p>	<table border="0" style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td style="border: none;">1 <input type="checkbox"/></td> <td style="border: none;">2 <input type="checkbox"/></td> <td style="border: none;">3 <input type="checkbox"/></td> <td style="border: none;">4 <input type="checkbox"/></td> <td style="border: none;">9 <input type="checkbox"/></td> <td style="border: 1px solid black; text-align: center; padding: 2px;">70</td> </tr> </tbody> </table>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	70						
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	70								

4a. Where do you get most of your information about AIDS?
Any other sources?
(MARK ALL MENTIONED)

All Sources	Main Source	
<input type="checkbox"/>	<input type="checkbox"/> Television	71 91
<input type="checkbox"/>	<input type="checkbox"/> Newspapers	72 92
<input type="checkbox"/>	<input type="checkbox"/> Brochures/Fliers/Pamphlets	73 93
<input type="checkbox"/>	<input type="checkbox"/> Clergy/Church	74 94
<input type="checkbox"/>	<input type="checkbox"/> Doctor/HMO	75 95
<input type="checkbox"/>	<input type="checkbox"/> Company or Industry Clinic	76 96
<input type="checkbox"/>	<input type="checkbox"/> Hospital/Emergency Room/OP Clinic	77 97
<input type="checkbox"/>	<input type="checkbox"/> Other Clinic	78 98
<input type="checkbox"/>	<input type="checkbox"/> Magazines	79 99
<input type="checkbox"/>	<input type="checkbox"/> Medical Journals	80 100
<input type="checkbox"/>	<input type="checkbox"/> Library	81 101
<input type="checkbox"/>	<input type="checkbox"/> AIDS Hot Line	82 102
<input type="checkbox"/>	<input type="checkbox"/> Public Health Dept. (Local/State)	83 103
<input type="checkbox"/>	<input type="checkbox"/> Red Cross/Blood Bank	84 104
<input type="checkbox"/>	<input type="checkbox"/> Radio	85 105
<input type="checkbox"/>	<input type="checkbox"/> Relatives	86 106
<input type="checkbox"/>	<input type="checkbox"/> Friends	87 107
<input type="checkbox"/>	<input type="checkbox"/> School (Class/Clinic)	88 108
<input type="checkbox"/>	<input type="checkbox"/> Other Source - (SPECIFY) _____	89 109
<input type="checkbox"/>	<input type="checkbox"/> Don't Know	90 110

If only one source or DK in 4a,
mark box without asking and skip
to 5a; otherwise ask:

4b. Of the sources you just told me,
from which ONE do you get the
MOST information?

5a. If you wanted more specific information about AIDS, where would you get it? Any other sources? (MARK ALL MENTIONED)

All Sources	Main Source	RT 93
<input type="checkbox"/>	<input type="checkbox"/> Television	5 25
<input type="checkbox"/>	<input type="checkbox"/> Newspapers	6 26
<input type="checkbox"/>	<input type="checkbox"/> Brochures/Fliers/Pamphlets	7 27
<input type="checkbox"/>	<input type="checkbox"/> Clergy/Church	8 28
<input type="checkbox"/>	<input type="checkbox"/> Doctor/HMO	9 29
<input type="checkbox"/>	<input type="checkbox"/> Company or Industry Clinic	10 30
<input type="checkbox"/>	<input type="checkbox"/> Hospital/Emergency Room/OP Clinic	11 31
<input type="checkbox"/>	<input type="checkbox"/> Other Clinic	12 32
<input type="checkbox"/>	<input type="checkbox"/> Magazines	13 33
<input type="checkbox"/>	<input type="checkbox"/> Medical Journals	14 34
<input type="checkbox"/>	<input type="checkbox"/> Library	15 35
<input type="checkbox"/>	<input type="checkbox"/> AIDS Hot Line	16 36
<input type="checkbox"/>	<input type="checkbox"/> Public Health Dept. (Local/State)	17 37
<input type="checkbox"/>	<input type="checkbox"/> Red Cross/Blood Bank	18 38
<input type="checkbox"/>	<input type="checkbox"/> Radio	19 39
<input type="checkbox"/>	<input type="checkbox"/> Relatives	20 40
<input type="checkbox"/>	<input type="checkbox"/> Friends	21 41
<input type="checkbox"/>	<input type="checkbox"/> School (Class/Clinic)	22 42
<input type="checkbox"/>	<input type="checkbox"/> Other Source - (SPECIFY) _____	23 43
<input type="checkbox"/>	<input type="checkbox"/> Don't Know	24 44

If only one place or DK in 5a, mark box without asking and skip to 6; otherwise ask:

5b. Which ONE source would you MOST likely use?

HAND CARD A		Def. True	Prob. True	Prob. False	Def. False	Don't Know		
6.	After I read each statement, tell me whether you think the statement is definitely true, probably true, probably false, definitely false or you don't know if it is true or false.							
a.	A person can be infected with the AIDS virus and not have the disease AIDS.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	45	
b.	You can tell if people have the AIDS virus just by looking at them.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	46	
c.	ANY person with the AIDS virus can pass it on to someone else through sexual intercourse.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	47	
d.	A pregnant woman who has the AIDS virus can give AIDS to her baby.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	48	
e.	There is a vaccine available to the public that protects a person from getting the AIDS virus.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	49	
f.	There is no cure for AIDS at present.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	50	
HAND CARD B								
7.	After I read each statement, tell me if you think it is very likely, somewhat likely, somewhat unlikely, very unlikely, definitely not possible or if you don't know how likely it is that a person will get AIDS or the AIDS virus infection that way.							
	How likely do you think it is that a person will get AIDS or the AIDS virus infection from...	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely	Not Poss.	DK	
a.	receiving a blood transfusion?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	51
	What about...							
b.	donating or giving blood?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	52
c.	living near a hospital or home for AIDS patients?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	53
d.	working near someone with AIDS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	54

How likely do you think it is that a person will get AIDS from...	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely	Not Poss.	DK	
e. eating in a restaurant where the cook has AIDS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	55
f. kissing - with exchange of saliva - a person who has AIDS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	56
g. shaking hands with or touching someone who has AIDS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	57
h. sharing plates, forks, or glasses with someone who has AIDS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	58
i. using public toilets?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	59
j. sharing needles for drug use with someone who has AIDS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	60
k. kissing on the cheek a person who has AIDS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	61
l. being coughed or sneezed on by someone who has AIDS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	62
m. attending school with a child who has AIDS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	63
n. mosquitoes or other insects?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	64
o. pets or animals?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	65
p. having sex with a person who has AIDS?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	66
8. Have you ever heard of a blood test for infection with the AIDS virus?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't Know						67
9. Does this blood test tell whether a person has the disease AIDS?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't Know						68
10. If someone has a positive blood test for infection with the AIDS virus, does this mean that they can give someone else the AIDS virus through sexual intercourse?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't Know						69

<p>15. Have you donated blood since January, 1985?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know</p>	<p>87</p>																																										
<p>16. Have you ever personally known anyone who had the blood test for the AIDS virus infection?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know</p>	<p>88</p>																																										
<p>17. What are the chances of <u>someone you know</u> getting the AIDS virus, would you say high, medium, low or none?</p>	<p>1 <input type="checkbox"/> High 2 <input type="checkbox"/> Medium 3 <input type="checkbox"/> Low 4 <input type="checkbox"/> None 7 <input type="checkbox"/> Refused 9 <input type="checkbox"/> Don't know</p>	<p>89</p>																																										
<p>18. What are <u>your</u> chances of getting the AIDS virus, would you say high, medium, low or none?</p>	<p>1 <input type="checkbox"/> High 2 <input type="checkbox"/> Medium 3 <input type="checkbox"/> Low 4 <input type="checkbox"/> None 7 <input type="checkbox"/> Refused 9 <input type="checkbox"/> Don't know</p>	<p>90</p>																																										
<p>19. Here are methods some people use to prevent getting the AIDS virus through sexual activity.</p> <p>After I read each one, tell me whether you think it is very effective, somewhat effective, not at all effective or if you don't know how effective it is in preventing getting the AIDS virus through sexual activity. How effective is . . .</p>	<table border="0"> <thead> <tr> <th></th> <th>Very effective</th> <th>Somewhat effective</th> <th>Not At All</th> <th>Don't know how effective</th> <th>Don't know method</th> <th></th> </tr> </thead> <tbody> <tr> <td>a. Using a diaphragm?</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td>91</td> </tr> <tr> <td>b. Using a condom?</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td>92</td> </tr> <tr> <td>c. Using a spermicidal jelly, foam, or cream?</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td>93</td> </tr> <tr> <td>d. Being celibate, that is, not having sex at all?</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td>94</td> </tr> <tr> <td>e. Two people who do not have the AIDS virus having a completely monogamous relationship, that is, having sex <u>only</u> with each other?</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td>95</td> </tr> </tbody> </table>		Very effective	Somewhat effective	Not At All	Don't know how effective	Don't know method		a. Using a diaphragm?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	91	b. Using a condom?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	92	c. Using a spermicidal jelly, foam, or cream?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	93	d. Being celibate, that is, not having sex at all?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	94	e. Two people who do not have the AIDS virus having a completely monogamous relationship, that is, having sex <u>only</u> with each other?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	95	
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<p>20. Have you ever discussed AIDS with a friend or relative?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know } (22)</p>	<p>96</p>
<p>21. When was the last time you discussed AIDS with a friend or relative?</p>	<p>_____ number</p> <p>001 <input type="checkbox"/> Today 2 <input type="checkbox"/> days ago 3 <input type="checkbox"/> weeks ago 4 <input type="checkbox"/> months ago 5 <input type="checkbox"/> years ago 999 <input type="checkbox"/> don't know</p>	<p>97-99</p>
<p>22. Do you have any children aged 10 through 17?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (26)</p>	<p>100</p>
<p>23. How many do you have?</p>	<p>_____</p>	<p>101-102</p>
<p>24. Have you ever discussed AIDS with [your child/any of these children]?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>103</p>
<p>25. [Has your child/Have your children] had instruction at school about AIDS?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know</p>	<p>104</p>
<p>26. Have you ever personally known anyone with the AIDS virus?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know if someone had/has AIDS virus</p>	<p>105</p>
<p>27. Have you ever personally known anyone with AIDS?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know if someone had/has AIDS</p>	<p>106</p>
<p>28. The U.S. Public Health Service has said that AIDS is one of the major health problems in the country but exactly how many people it affects is not known. The Surgeon General has proposed that a study be conducted and blood samples be taken to help find out how widespread the problem is.</p> <p>If you were selected in this national sample of people to have their blood tested with assurances of privacy of test results, would you have the test?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (END INTERVIEW) 8 <input type="checkbox"/> Other response (SPECIFY)</p> <p>_____</p> <p>9 <input type="checkbox"/> Don't know (END INTERVIEW)</p>	<p>107</p>
<p>29. Would you want to know the results of the blood test?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know</p>	<p>108</p>

CARD R

RACE

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

HHS 501 (1988) (16-28-87)

CARD O

ORIGIN

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

Card R
Card O

(Including Puerto Rican)

HHS 501 (1988) (16-28-87)

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

HHS 501 (1988) (16-28-87)

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

Card I
Card J

(Including Puerto Rican)

HHS 501 (1988) (16-28-87)

CARD M

Has anyone in the family ever adopted any children?

- (1) Yes
- (2) No

HS 501 (1987) 110-20-86

CARD Q1

- Bran flakes**
- Corn flakes**
- Hamburgers**
- Lettuce**
- Baked beans**
- Carrots**
- White rice**
- Raw apples**

Card M
Card Q1

(Cut along broken line)

HS 501 (1987) 110-20-86

CARD Q2

- Fried chicken**
- White bread**
- Soda or soft drinks**
- Peanut butter**
- Broiled fish**
- Bananas**
- Cold cuts or lunch meats**
- Doughnuts**

HS 501 (1987) 110-20-86

CARD R1

- Stress**
- Inherited make-up or heredity**
- Exposure to X-Rays**
- Poor eating practices**
- Using chewing tobacco, snuff, pipes, or cigars**
- Air pollution**
- Water pollution**
- Some cloth dyes**
- Exposure to toxic waste dumps**
- Exposure to toxic substances on the job**
- Exposure to people with cancer**
- Excessive drinking of alcoholic beverages**
- Exposure to the sun**
- Cigarette smoking**
- Exposure to nuclear waste**
- Some strong soaps and detergents**
- Viruses**
- Some medicines**
- Medical procedures using radiation**

Card Q2
Card R1

(Cut along broken line)

HS 501 (1987) (2-12-87)

CARD R2

- 1. Strongly agree
- 2. Agree
- 3. Disagree
- 4. Strongly disagree
- 5. No opinion

HS 501 119871 (10 20 86)

CARD R3

- Church
- Local school
- Hospital
- Club meeting
- Workplace
- Home
- Senior center
- Community center
- Other place

Card R2

Card R3

(Cut along broken line)

HS 501 119871 (10 20 86)

CARD S



Sketch of woman on whom mammography is being performed using the most common type of X-ray equipment. Other types of X-ray equipment are also used.

HS 501 119871 (10 20 86)

CARD W

- 1. Strong
- 2. Moderate
- 3. Slight

Card S

Card W

(Cut along broken line)

HS 501 119871 (10 20 86)

**LIST 1
FRUITS AND JUICES**

HOW OFTEN DID YOU EAT OR DRINK —	WHAT SIZE PORTION DID YOU USUALLY EAT OR DRINK?
Orange juice or grapefruit juice?	Small, medium, or large?
Other fruit juices or fortified fruit drinks?	
Oranges?	
Grapefruit?	
Cantaloupe in season?	Medium (¼ cant.)
Apples or applesauce?	

HIS-501A (1987) (10-22-86)

**LIST 2
VEGETABLES**

HOW OFTEN DID YOU EAT —	WHAT SIZE PORTION DID YOU USUALLY EAT?
Beans, such as baked beans, pinto, kidney beans, or in chili? Do not include green beans.	Small, medium, or large?
Carrots, or mixed vegetables containing carrots?	
Tomatoes, including in salad?	
Green salad?	
Salad dressing or mayonnaise, including on sandwiches?	
Broccoli?	
Spinach?	
Collards, mustard greens, turnip greens, etc?	
Cole slaw, cabbage, or sauerkraut?	
French fries or fried potatoes?	
Potatoes, baked, boiled, or mashed?	
Sweet potatoes or yams?	
Rice?	

HIS-501A (1987) (10-22-86)

List 1
List 2

(Cut along broken line)

**LIST 3
MEATS AND MIXED DISHES**

HOW OFTEN DID YOU EAT —	WHAT SIZE PORTION DID YOU USUALLY EAT?
Hamburgers, cheeseburgers, or meatloaf?	Small, medium, or large?
Beef, such as steaks, or roasts?	
Beef stew or potpie containing vegetables?	
Liver, including chicken liver?	
Pork, such as chops, or roasts?	Medium (2 chops or 4oz. of roast)
Fried chicken?	Medium (2 small or 1 large piece)
Chicken or turkey, baked, stewed or broiled?	Medium (2 small or 1 large piece)
Fried fish or fish sandwiches?	
Spaghetti, lasagna, or pasta with tomato sauce?	

HIS-501A (1987) (10-22-86)

**LIST 4
BREAKFAST FOODS**

HOW OFTEN DID YOU EAT —	WHAT SIZE PORTION DID YOU USUALLY EAT?
Cooked cereals like oatmeal?	Small, medium, or large?
High fiber cereals like bran, granola, or shredded wheat?	
Highly fortified cereals like Product 19, Total, or Most?	
Other cold cereals like Rice Krispies or corn flakes?	
Eggs?	How many eggs?
Bacon?	How many slices?
Sausage?	How many patties or links?

HIS-501A (1987) (10-22-86)

List 3
List 4

(Cut along broken line)

**LIST 5
BREADS, LUNCHES, AND SNACKS**

HOW OFTEN DID YOU EAT —	WHAT SIZE PORTION DID YOU USUALLY EAT?
Vegetable soup, vegetable beef, minestrone or tomato soup? Do not include other kinds of soup.	Small, medium, or large?
Hot dogs?	How many hot dogs?
Ham or lunch meats?	
White bread, rolls, or crackers, including sandwiches, bagels, and so forth?	Medium (2 slices or 4 crackers)
Dark breads like whole wheat, rye, or pumpernickel?	Medium (2 slices)
Corn bread, corn muffins, corn tortillas, or grits?	
Butter on bread, rolls or on vegetables?	Medium (2 pats)
Margarine on bread, rolls, or on vegetables?	Medium (2 pats)
Cheese or cheese spreads, not including cottage cheese?	
Peanuts or peanut butter?	
Salty snacks like chips or popcorn?	

HIS-501A (1987) (10-22-86)

**LIST 6
SWEETS AND BEVERAGES**

HOW OFTEN DID YOU EAT OR DRINK —	WHAT SIZE PORTION DID YOU USUALLY EAT OR DRINK?
Ice cream?	Small, medium, or large?
Pie?	
Doughnuts, cookies, cake, or pastry?	
Chocolate candy?	
Sugar in coffee or tea, or on cereal?	Medium (2 tsp.)
Whole milk or drinks made with whole milk, NOT including on cereal?	
2% milk or drinks made with 2% milk, NOT including on cereal?	
Skim milk or 1% milk or buttermilk, NOT including on cereal?	
Milk or cream in coffee or tea?	
Soda or soft drinks containing sugar?	
Beer?	a. How often? b. On the days you drank it, how many cans, glasses, or drinks? c. Small, medium or large?
Wine?	
Liquor?	

List 5
List 6

(Cut along broken line)

HIS-501A (1987) (10-22-86)

1988

The 1988 NHIS was conducted with a full sample. The sample consisted of 47,485 households, yielding 122,310 personal interviews. As in prior NHIS survey instruments, the questions asked concerned acute and chronic conditions, episodes of persons injured, restriction in activity, limitation of activity due to chronic conditions, respondent-assessed health status, and the use of medical services—including physician contacts and short-stay hospitalization.

Several health topics were included as part of the 1988 NHIS. The topics included medical device implants, occupational health, alcohol use, child health, and AIDS.

The questions on medical device implants were designed to obtain information as to why the respondent needed the implant(s), problems associated with each implant, and the need for replacement or repair of each implant.

The occupational health questions were concerned with gathering information on respondents' work history, common work-related health problems, work injuries, and factors associated with cigarette smoking.

Questions in the alcohol use section of the current health topic questionnaire asked about the amount and type of alcohol consumed, reasons for avoiding alcohol, family history of alcoholism, and alcohol-related diseases.

The child health section of the survey instrument included a series of questions designed to obtain data on child care, birth history, specific childhood illnesses, conditions and injuries, developmental milestones, use of health services, and behavior problems.

The questions relating to AIDS were separate from the other 1988 current health topic questions. The questions were administered using computer-assisted personal interview (CAPI). The 1988 questions on AIDS were similar to those asked in 1987. The questions inquired about the person's knowledge and attitude about AIDS. In 1988, a series of questions were asked to determine if the household received and read a special brochure containing information about AIDS. This brochure was mailed to each household by the Federal government. The questions asked about pamphlets, brochures, and announcements read or seen by the respondent, discussions held with children about AIDS, knowledge of AIDS, blood donation, a blood test for AIDS, the AIDS virus and sexual activity, the risk of getting the AIDS virus, whether person had known anyone with AIDS, and willingness to participate in sample of persons having their blood tested for AIDS.

FORM HIS-1A (1988)
(10-23-87)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR THE
U.S. PUBLIC HEALTH SERVICE

NATIONAL HEALTH INTERVIEW SURVEY

SUPPLEMENT BOOKLET

NOTICE — Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

1. Book <u>RT 67</u> of <u>3-7</u> books		2. R.O. Number <u>9-10</u>	3. Sample <u>11-13</u>
4. Control number PSU <u>14-16</u> Segment <u>17-23</u> Serial <u>24-25</u>		5. Beginning time <u>26-29</u> <u>30</u> 1 a.m. 2 p.m.	

CHILD AND ADULT SAMPLE SELECTION

6. Are there any nondeleted children 0-17 years old in this family? <u>31</u>	7. Are there any nondeleted persons 18+ years old in this family? <u>32</u>
1 <input type="checkbox"/> Yes (List by age (oldest to youngest) in Table A, THEN 7) 2 <input type="checkbox"/> No (7)	1 <input type="checkbox"/> Yes (List by age (oldest to youngest) in Table B) 2 <input type="checkbox"/> No

8. TABLE A (0-17 year olds)					TABLE B (18+)				
Line No.	Person No.	Name	Sex	Age	Line No.	Person No.	Name	Sex	Age
33	34-35		36	37-39	40	41-42		43	44-45
1			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	1 <input type="checkbox"/> Mos. 2 <input type="checkbox"/> Yrs.	1			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
2			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	1 <input type="checkbox"/> Mos. 2 <input type="checkbox"/> Yrs.	2			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
3			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	1 <input type="checkbox"/> Mos. 2 <input type="checkbox"/> Yrs.	3			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
4			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	1 <input type="checkbox"/> Mos. 2 <input type="checkbox"/> Yrs.	4			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
5			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	1 <input type="checkbox"/> Mos. 2 <input type="checkbox"/> Yrs.	5			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
6			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	1 <input type="checkbox"/> Mos. 2 <input type="checkbox"/> Yrs.	6			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
7			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	1 <input type="checkbox"/> Mos. 2 <input type="checkbox"/> Yrs.	7			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
8			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	1 <input type="checkbox"/> Mos. 2 <input type="checkbox"/> Yrs.	8			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
9			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	1 <input type="checkbox"/> Mos. 2 <input type="checkbox"/> Yrs.	9			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	

Refer to the appropriate sections of the sample person selection label and circle as applicable. THEN circle Person No. in TABLE A and/or TABLE B and mark the "SP" box(es) on the HIS-1 for the selected sample person(s). THEN go to Section M.

9. FINAL STATUS OF SUPPLEMENT

a. Section M (page 2) (Medical Device Implant) <u>46</u> Interview 0 <input type="checkbox"/> No Medical Device Implants 1 <input type="checkbox"/> Complete interview (all persons with MDIs interviewed) 2 <input type="checkbox"/> Partial interview (some but not all persons with MDIs interviewed) (Explain in notes) 3 <input type="checkbox"/> Partial interview (Persons with MDIs not interviewed) (Explain in notes) Noninterview 3 <input type="checkbox"/> Refusal } (Explain in notes) 8 <input type="checkbox"/> Other }	b. Section N (page 36) (Occupational Health) <u>47</u> 0 <input type="checkbox"/> No person 18+ in this family Interview 1 <input type="checkbox"/> Complete interview (all appropriate sections completed) 2 <input type="checkbox"/> Partial interview (some but not all appropriate sections completed) (Explain in notes) Noninterview 3 <input type="checkbox"/> Refusal (Explain in notes) 4 <input type="checkbox"/> SP temporarily absent 5 <input type="checkbox"/> SP mentally or physically incapable 8 <input type="checkbox"/> Other (Explain in notes)	c. Section O (page 60) (Alcohol) <u>48</u> 0 <input type="checkbox"/> No person 18+ in this family Interview 1 <input type="checkbox"/> Complete interview (all appropriate sections and HIS-2/HIS-3 completed) 2 <input type="checkbox"/> Partial interview (some but not all appropriate sections or HIS-2/HIS-3 completed) (Explain in notes) Noninterview 3 <input type="checkbox"/> Refusal (Explain in notes) 4 <input type="checkbox"/> SP temporarily absent 5 <input type="checkbox"/> SP mentally or physically incapable 8 <input type="checkbox"/> Other (Explain in notes)	d. Section P (page 78) (Child Health) <u>49</u> 0 <input type="checkbox"/> No child 0-17 in this family Interview 1 <input type="checkbox"/> Complete interview (all appropriate sections completed) 2 <input type="checkbox"/> Partial interview (some but not all appropriate sections completed) (Explain in notes) Noninterview 3 <input type="checkbox"/> Refusal (Explain in notes) 4 <input type="checkbox"/> Eligible Resp. TA 6 <input type="checkbox"/> No eligible resp. in HHld. 8 <input type="checkbox"/> Other (Explain in notes)
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10. Ending time <u>50-53</u> <u>54</u> 1 a.m. 2 p.m.	11. Interviewer identification Name _____ Code <u>55-56</u>
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Notes

Section M — MEDICAL DEVICE

Section M1 — MEDICAL DEVICE IMPLANT SCREENING

CHECK ITEM 1	Refer to HIS-1. Enter person number of household respondent	_____ Household respondent	3-4
These next questions are about medical devices that are SURGICALLY implanted in the body to help the body function or treat an illness or injury.			5
1a. Does anyone in the family NOW have a joint that has been replaced by an artificial one, such as an artificial hip, knee or finger joint?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (2)	
b. Who is this? _____		Record name and person number in table MDI. Mark "Joint" box.	
c. Anyone else?		<input type="checkbox"/> Yes (Reask 1b and c) <input type="checkbox"/> No	
2a. Does anyone in the family NOW have a fixation device, such as screws, pins, nails, wires or plates implanted to fix or hold bones in place, including skull plates?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (3)	6
b. Who is this? _____		Record name and person number in table MDI. Mark "Fix" box.	
c. Anyone else?		<input type="checkbox"/> Yes (Reask 2b and c) <input type="checkbox"/> No	
3a. Does anyone in the family NOW have an artificial heart valve?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (4)	7
b. Who is this? _____		Record name and person number in table MDI. Mark "HV" box.	
c. Anyone else?		<input type="checkbox"/> Yes (Reask 3b and c) <input type="checkbox"/> No	
4a. Sometimes the lenses of the eyes can be replaced with artificial ones called intraocular lenses, which are sewn into place during surgery. Does anyone in the family NOW have an intraocular lens? Do not count corneal transplants, if volunteered.		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (5)	8
b. Who is this? _____		Record name and person number in table MDI. Mark "IL" box.	
c. Anyone else?		<input type="checkbox"/> Yes (Reask 4b and c) <input type="checkbox"/> No	
5a. Silicone implants are used to reconstruct parts of the body, such as breasts, ears, chin, or nose. Does anyone in the family NOW have a silicone implant? Do not count injected silicone, if volunteered.		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (6)	9
b. Who is this? _____		Record name and person number in table MDI. Enter SILICONE IMPLANT in "Other" column.	
c. Anyone else?		<input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No	
6a. A pacemaker is implanted in the chest to regulate the heartbeat. Does anyone in the family NOW have a pacemaker?		1 <input type="checkbox"/> Yes. 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (7)	10
b. Who is this? _____		Record name and person number in table MDI. Mark "Pace" box.	
c. Anyone else?		<input type="checkbox"/> Yes (Reask 6b and c) <input type="checkbox"/> No	
Notes			

Section M1 — MEDICAL DEVICE IMPLANT SCREENING — Continued

<p>7a. Ear vent tubes are often implanted in the eardrums of children and adults who get frequent ear infections. Does anyone in the family NOW have ear vent tubes?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (8) 9 <input type="checkbox"/> DK }</p>	11
<p>b. Who is this?</p>	<p>Record name and person number in table MDI. Enter EAR VENT TUBES in "Other" column.</p>	
<p>c. Anyone else?</p>	<p><input type="checkbox"/> Yes (Reask 7b and c) <input type="checkbox"/> No</p>	
<p>8a. Infusion pumps are implants that pump medication such as insulin or cancer chemotherapy into the body. Does anyone in the family NOW have an infusion pump?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (9) 9 <input type="checkbox"/> DK }</p>	12
<p>b. Who is this?</p>	<p>Record name and person number in table MDI. Enter INFUSION PUMP in "Other" column.</p>	
<p>c. Anyone else?</p>	<p><input type="checkbox"/> Yes (Reask 8b and c) <input type="checkbox"/> No</p>	
<p>9a. Does anyone in the family NOW have a central nervous system shunt that drains fluid away from the brain or spinal column?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (10) 9 <input type="checkbox"/> DK }</p>	13
<p>b. Who is this?</p>	<p>Record name and person number in table MDI. Enter CENTRAL NERVOUS SYSTEM SHUNT in "Other" column.</p>	
<p>c. Anyone else?</p>	<p><input type="checkbox"/> Yes (Reask 9b and c) <input type="checkbox"/> No</p>	
<p>10a. Does anyone in the family NOW have any type of shunt or catheter implanted in the body (besides the [infusion pump/central nervous system shunt])? <i>Read if necessary: A shunt is a man-made tube through which blood or body fluid is diverted from its natural path.</i> <i>Read if necessary: A catheter is a flexible tube implanted in the body to remove or put in fluid.</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (11) 9 <input type="checkbox"/> DK }</p>	14
<p>b. Who is this?</p>	<p>Record name and person number in table MDI.</p>	
<p>c. What kind of shunt or catheter does — have?</p>	<p>Enter kind of shunt or catheter in "Other" column.</p>	
<p>d. Does anyone else have any type of shunt or catheter implanted in the body?</p>	<p><input type="checkbox"/> Yes (Reask 10b, c, and d) <input type="checkbox"/> No</p>	
<p>11a. Does anyone in the family NOW have any other kind of medical device that has been implanted in the body during SURGERY? Some examples are artificial arteries and veins, ligaments and dental implants.</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Check Item 2) 9 <input type="checkbox"/> DK }</p>	15
<p>b. Who is this?</p>	<p>Record name and person number in table MDI.</p>	
<p>c. What kind of implant does — have?</p>	<p>Enter type of implant in "Other" column.</p>	
<p>d. Does anyone else in the family have any other kind of medical device implanted in the body?</p>	<p><input type="checkbox"/> Yes (Reask 11b, c, and d) <input type="checkbox"/> No (Check Item 2)</p>	
<p>CHECK ITEM 2</p>	<p>Mark appropriate box</p>	16
<p>1 <input type="checkbox"/> One or more MDI's (Check Item 2) 2 <input type="checkbox"/> No MDI's (Section N, page 36)</p>		

Notes

Section M1 — MEDICAL DEVICE IMPLANT SCREENING — Continued

TABLE MDI

Complete the appropriate Medical Device Sections for each person and each device entered below.

Name (a)	Person number (b)	Joint (pg. 6) (c)	Fix (pg. 12) (d)	HV (pg. 16) (e)	IL (pg. 22) (f)	Pace (pg. 28) (g)	Others (pg. 32) (h)
	3-4	5 1 <input type="checkbox"/>	6 2 <input type="checkbox"/>	7 3 <input type="checkbox"/>	8 4 <input type="checkbox"/>	9 5 <input type="checkbox"/>	10-11 1. _____ 12-13 2. _____ 14-15 3. _____
	16-17	18 1 <input type="checkbox"/>	19 2 <input type="checkbox"/>	20 3 <input type="checkbox"/>	21 4 <input type="checkbox"/>	22 5 <input type="checkbox"/>	23-24 1. _____ 25-26 2. _____ 27-28 3. _____
	29-30	31 1 <input type="checkbox"/>	32 2 <input type="checkbox"/>	33 3 <input type="checkbox"/>	34 4 <input type="checkbox"/>	35 5 <input type="checkbox"/>	36-37 1. _____ 38-39 2. _____ 40-41 3. _____
	42-43	44 1 <input type="checkbox"/>	45 2 <input type="checkbox"/>	46 3 <input type="checkbox"/>	47 4 <input type="checkbox"/>	48 5 <input type="checkbox"/>	49-50 1. _____ 51-52 2. _____ 53-54 3. _____
	55-56	57 1 <input type="checkbox"/>	58 2 <input type="checkbox"/>	59 3 <input type="checkbox"/>	60 4 <input type="checkbox"/>	61 5 <input type="checkbox"/>	62-63 1. _____ 64-65 2. _____ 66-67 3. _____
	68-69	70 1 <input type="checkbox"/>	71 2 <input type="checkbox"/>	72 3 <input type="checkbox"/>	73 4 <input type="checkbox"/>	74 5 <input type="checkbox"/>	75-76 1. _____ 77-78 2. _____ 79-80 3. _____
	81-82	83 1 <input type="checkbox"/>	84 2 <input type="checkbox"/>	85 3 <input type="checkbox"/>	86 4 <input type="checkbox"/>	87 5 <input type="checkbox"/>	88-89 1. _____ 90-91 2. _____ 92-93 3. _____
	94-95	96 1 <input type="checkbox"/>	97 2 <input type="checkbox"/>	98 3 <input type="checkbox"/>	99 4 <input type="checkbox"/>	100 5 <input type="checkbox"/>	101-102 1. _____ 103-104 2. _____ 105-106 3. _____

Notes

Section M2 – ARTIFICIAL JOINT PAGE – Continued

<p>10a. Why did you have that artificial (entry in 5) replaced?</p> <p><i>Mark first three mentioned. Do not probe.</i></p> <p><i>Ask for each entry in 10a:</i></p> <p>b. How long after that joint was implanted was this (entry in 10a) first noticed?</p> <p><i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i></p>	<p>01 <input type="checkbox"/> Mechanical failure of the artificial joint 20-21</p> <p>02 <input type="checkbox"/> Loosening of the artificial joint 22-23</p> <p>03 <input type="checkbox"/> Infection 24-25</p> <p>04 <input type="checkbox"/> Increased pain over time</p> <p>88 <input type="checkbox"/> Some other reason — Specify <input type="checkbox"/></p> <hr/> <p>0000 <input type="checkbox"/> Less than 1 day 26-29</p> <p> <input type="checkbox"/> 1 Days 5555 <input type="checkbox"/> Less than 30 days <input type="checkbox"/> 2 Weeks OR 6666 <input type="checkbox"/> 30-90 days <input type="checkbox"/> 3 Months 7777 <input type="checkbox"/> More than 90 days <input type="checkbox"/> 4 Years 9999 <input type="checkbox"/> DK </p> <hr/> <p>0000 <input type="checkbox"/> Less than 1 day 30-33</p> <p> <input type="checkbox"/> 1 Days 5555 <input type="checkbox"/> Less than 30 days <input type="checkbox"/> 2 Weeks OR 6666 <input type="checkbox"/> 30-90 days <input type="checkbox"/> 3 Months 7777 <input type="checkbox"/> More than 90 days <input type="checkbox"/> 4 Years 9999 <input type="checkbox"/> DK </p> <hr/> <p>0000 <input type="checkbox"/> Less than 1 day 34-37</p> <p> <input type="checkbox"/> 1 Days 5555 <input type="checkbox"/> Less than 30 days <input type="checkbox"/> 2 Weeks OR 6666 <input type="checkbox"/> 30-90 days <input type="checkbox"/> 3 Months 7777 <input type="checkbox"/> More than 90 days <input type="checkbox"/> 4 Years 9999 <input type="checkbox"/> DK </p>
<p>11. When did you get the artificial (entry in 5) (you have NOW)?</p>	<p align="right">_____/ 19 ____</p> <p align="center">Month Year</p> <p align="right">38-41</p>
<p><i>Ask if finger joint; otherwise, skip to 13.</i></p> <p>12. Is your artificial finger joint made out of silicone or some other material?</p>	<p>1 <input type="checkbox"/> Silicone 42</p> <p>8 <input type="checkbox"/> Other</p> <p>9 <input type="checkbox"/> DK</p>
<p>13. Why did you need to get your (original) artificial (entry in 5)?</p> <p><i>Mark first three mentioned. Do not probe.</i></p>	<p>01 <input type="checkbox"/> Osteoarthritis 43-44</p> <p>02 <input type="checkbox"/> Rheumatoid arthritis</p> <p>03 <input type="checkbox"/> Arthritis, unspecified</p> <p>04 <input type="checkbox"/> Trauma/Injury</p> <p>05 <input type="checkbox"/> Pain</p> <p>88 <input type="checkbox"/> Some other reason — Specify <input type="checkbox"/></p>
<p>CHECK ITEM 4</p> <p><i>Refer to 7:</i></p>	<p>1 <input type="checkbox"/> Yes in 7 (14b)</p> <p>2 <input type="checkbox"/> No in 7(14a) 45</p>
<p>14a. Since you received the artificial (entry in 5), would you say your mobility in that joint is improved, about the same, or worse than it was before the implant?</p>	<p>1 <input type="checkbox"/> Improved } (15)</p> <p>2 <input type="checkbox"/> Same }</p> <p>3 <input type="checkbox"/> Worse</p> <p align="right">46</p>
<p>b. Since you have had your current artificial (entry in 5), would you say your mobility in that joint is improved, about the same, or worse than it was with the previous artificial (entry in 5)?</p>	<p>1 <input type="checkbox"/> Improved 47</p> <p>2 <input type="checkbox"/> Same</p> <p>3 <input type="checkbox"/> Worse</p>
<p>Please tell me if you have had any of the following problems or complications with your (current) artificial (entry in 5) —</p> <p>15a. Have you had any blood clots?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No } (15c)</p> <p>9 <input type="checkbox"/> DK</p> <p align="right">48</p>
<p>b. How long had you had the artificial (entry in 5) when the blood clots were first noticed?</p> <p><i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i></p>	<p>0000 <input type="checkbox"/> Less than 1 day 49-52</p> <p> <input type="checkbox"/> 1 Days 5555 <input type="checkbox"/> Less than 30 days <input type="checkbox"/> 2 Weeks OR 6666 <input type="checkbox"/> 30-90 days <input type="checkbox"/> 3 Months 7777 <input type="checkbox"/> More than 90 days <input type="checkbox"/> 4 Years 9999 <input type="checkbox"/> DK </p>
<p>c. Have you had an infection?</p>	<p>1 <input type="checkbox"/> Yes 53</p> <p>2 <input type="checkbox"/> No } (15e)</p> <p>9 <input type="checkbox"/> DK</p>
<p>d. How long had you had the artificial (entry in 5) when the infection was first noticed?</p> <p><i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i></p>	<p>0000 <input type="checkbox"/> Less than 1 day 54-57</p> <p> <input type="checkbox"/> 1 Days 5555 <input type="checkbox"/> Less than 30 days <input type="checkbox"/> 2 Weeks OR 6666 <input type="checkbox"/> 30-90 days <input type="checkbox"/> 3 Months 7777 <input type="checkbox"/> More than 90 days <input type="checkbox"/> 4 Years 9999 <input type="checkbox"/> DK </p> <p align="right"><i>Go to 15e</i></p>

Section M2 – ARTIFICIAL JOINT PAGE – Continued

<p>15e. Has the artificial (entry in 5) loosened?</p>	<p align="right">58</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (15g) 9 <input type="checkbox"/> DK</p>
<p>f. How long had you had the artificial (entry in 5) when it was first noticed that the joint was getting loose?</p> <p><i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i></p>	<p align="right">59-62</p> <p>0000 <input type="checkbox"/> Less than 1 day</p> <p> <input type="checkbox"/> 1 Days 5555 <input type="checkbox"/> Less than 30 days <input type="checkbox"/> 2 Weeks OR 6666 <input type="checkbox"/> 30-90 days <input type="checkbox"/> 3 Months 7777 <input type="checkbox"/> More than 90 days <input type="checkbox"/> 4 Years 9999 <input type="checkbox"/> DK </p>
<p>g. Have you had increased pain over time?</p>	<p align="right">63</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (15i) 9 <input type="checkbox"/> DK</p>
<p>h. How long had you had the artificial (entry in 5) when the increased pain was first noticed?</p> <p><i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i></p>	<p align="right">64-67</p> <p>0000 <input type="checkbox"/> Less than 1 day</p> <p> <input type="checkbox"/> 1 Days 5555 <input type="checkbox"/> Less than 30 days <input type="checkbox"/> 2 Weeks OR 6666 <input type="checkbox"/> 30-90 days <input type="checkbox"/> 3 Months 7777 <input type="checkbox"/> More than 90 days <input type="checkbox"/> 4 Years 9999 <input type="checkbox"/> DK </p>
<p>i. Have you had mechanical problems with the artificial (entry in 5) itself?</p>	<p align="right">68</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (15k) 9 <input type="checkbox"/> DK</p>
<p>j. How long had you had the artificial (entry in 5) when the mechanical problem was first noticed?</p> <p><i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i></p>	<p align="right">69-72</p> <p>0000 <input type="checkbox"/> Less than 1 day</p> <p> <input type="checkbox"/> 1 Days 5555 <input type="checkbox"/> Less than 30 days <input type="checkbox"/> 2 Weeks OR 6666 <input type="checkbox"/> 30-90 days <input type="checkbox"/> 3 Months 7777 <input type="checkbox"/> More than 90 days <input type="checkbox"/> 4 Years 9999 <input type="checkbox"/> DK </p>
<p>k. Have you had any other problems or complications with the artificial (entry in 5)?</p>	<p align="right">73</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Next column or next device)</p>
<p>l. What were they?</p> <p><i>Record first three mentioned. Do not probe. Be specific.</i></p>	<p align="right">74-75</p> <p>(1) _____</p> <p align="right">76-77</p> <p>(2) _____</p> <p align="right">78-79</p> <p>(3) _____</p>
<p><i>Ask for each entry in 15t.</i></p> <p>m. How long had you had the artificial (entry in 5) when the (entry in 15t) was first noticed?</p> <p><i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i></p>	<p align="right">80-83</p> <p>0000 <input type="checkbox"/> Less than 1 day</p> <p>(1) { <input type="checkbox"/> 1 Days 5555 <input type="checkbox"/> Less than 30 days <input type="checkbox"/> 2 Weeks OR 6666 <input type="checkbox"/> 30-90 days <input type="checkbox"/> 3 Months 7777 <input type="checkbox"/> More than 90 days <input type="checkbox"/> 4 Years 9999 <input type="checkbox"/> DK</p> <p align="right">84-87</p> <p>(2) { <input type="checkbox"/> 1 Days 5555 <input type="checkbox"/> Less than 30 days <input type="checkbox"/> 2 Weeks OR 6666 <input type="checkbox"/> 30-90 days <input type="checkbox"/> 3 Months 7777 <input type="checkbox"/> More than 90 days <input type="checkbox"/> 4 Years 9999 <input type="checkbox"/> DK</p> <p align="right">88-91</p> <p>(3) { <input type="checkbox"/> 1 Days 5555 <input type="checkbox"/> Less than 30 days <input type="checkbox"/> 2 Weeks OR 6666 <input type="checkbox"/> 30-90 days <input type="checkbox"/> 3 Months 7777 <input type="checkbox"/> More than 90 days <input type="checkbox"/> 4 Years 9999 <input type="checkbox"/> DK</p> <p align="center"><i>Go to next column or next device</i></p>

Notes

Section M3 — FIXATION DEVICE PAGE

1. Enter name and person number from Table MDI.

Name _____ 3-4
5-6
 Person No. _____

2a. Indicate type of respondent.

1 Self - personal } (3) 3 Proxy - personal 7
 2 Self - telephone } 4 Proxy - telephone

b. Relationship of proxy to the person

Relationship _____ 8-9

These next questions are about your skull or bone holding implant.

3a. What kind of implant do you have?
Is it a bone screw, pin, nail, wire or plate?

3a. IMPLANT	3b. NUMBER
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

Ask for each entry in 3a:

b. How many (implants in 3a) do you have?

Ask for each entry in 3a:

c. In what part(s) of the body [is/are] the (implant in 3a) located?

1. _____
 2. _____
 3. _____
 4. _____
 5. _____

d. Do you have any other bone holding implants?

Yes (Reask 3a-d)
 No

Refer to 3a-c.

4. Enter implant and each SEPARATE body part and fill a column for each. Do NOT duplicate body parts. (Enter name and person in each column.)

Implant	Body part
_____	_____

10-11

Complete 5-10 for the FIRST bone holding implant for this person before going to the next.

5. Why did you need to get a (implant in 4)?

Mark first reason mentioned.

01 Injury 12-13
 02 Deformities
 03 Infection
 04 Cancer
 88 Other - Specify

6a. Is the (implant in 4) you have now a replacement for a previous (implant in 4)?

1 Yes 14
 2 No (9)

b. How many times has the (implant in 4) been replaced?

_____ Times 15-16

7. When did you get the (implant in 4) you had before the current one?

_____/19_____
 Month Year 17-20

8a. Why did you have that (implant in 4) replaced?

Mark first three mentioned. Do not probe.

01 Mechanical failure of the implant 21-22
 02 The implant did not work 23-24
 03 Infection 25-28
 04 Healing problem
 05 Pain or irritation
 88 Some other reason - Specify

Ask for each entry in 8a:

b. How long after that (implant in 4) was implanted was this (entry in 8a) first noticed?

Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?

0000 Less than 1 day 27-30
 (1) { 1 Days 5555 Less than 30 days
 2 Weeks OR 6666 More than 90 days
 3 Months 7777 30-90 days
 4 Years 9999 DK

0000 Less than 1 day 31-34
 (2) { 1 Days 5555 Less than 30 days
 2 Weeks OR 6666 More than 90 days
 3 Months 7777 30-90 days
 4 Years 9999 DK

0000 Less than 1 day 35-38
 (3) { 1 Days 5555 Less than 30 days
 2 Weeks OR 6666 More than 90 days
 3 Months 7777 30-90 days
 4 Years 9999 DK

Go to 9

Section M3 — FIXATION DEVICE PAGE — Continued

9. When did you get your (current) (implant in 4)?	_____ / 19____ Month Year
Please tell me if you have you had any of the following problems or complications with your (current) (implant in 4) —	43
10a. Have you had an infection?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (10c)
b. How long had you had your (implant in 4) when the infection was first noticed? Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?	44-47 0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> Weeks OR 6666 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> Months 7777 <input type="checkbox"/> More than 90 days 4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK
c. Have you had any healing problems?	48 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (10e)
d. How long had you had your (implant in 4) when the healing problem was first noticed? Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?	49-52 0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> Weeks OR 6666 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> Months 7777 <input type="checkbox"/> More than 90 days 4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK
e. Have you had any problems with pain or irritation?	53 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (10g)
f. How long had you had your (implant in 4) when the pain or irritation was first noticed? Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?	54-57 0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> Weeks OR 6666 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> Months 7777 <input type="checkbox"/> More than 90 days 4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK
g. Have you had any mechanical problems with your (implant in 4) that is, it has not worked correctly?	58 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (10i)
h. How long had you had your (implant in 4) when the mechanical problems were first noticed? Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?	59-62 0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> Weeks OR 6666 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> Months 7777 <input type="checkbox"/> More than 90 days 4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK
i. Have you had any other problems or complications with the (implant in 4)?	63 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Next column or next device)
j. What were they? Record first three mentioned. Do not probe. Be specific.	64-65 (1) _____ 66-67 (2) _____ 68-69 (3) _____
Ask for each entry in 10j:	70-73
k. How long had you had your (current) (implant in 4) when the (entry in 10j) was first noticed? Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?	(1) _____ { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> Weeks OR 6666 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> Months 7777 <input type="checkbox"/> More than 90 days 4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK
	74-77 (2) _____ { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> Weeks OR 6666 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> Months 7777 <input type="checkbox"/> More than 90 days 4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK
	78-81 (3) _____ { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> Weeks OR 6666 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> Months 7777 <input type="checkbox"/> More than 90 days 4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK Go to next column or next device

Section M4 — HEART VALVE PAGE (HV)

1. Enter name and person number from Table MDI.	Name _____ Person No. _____	3-4 5-6
2a. Indicate type of respondent.	1 <input type="checkbox"/> Self — personal } (3) 2 <input type="checkbox"/> Self — telephone } 3 <input type="checkbox"/> Proxy — personal 4 <input type="checkbox"/> Proxy — telephone	7
b. Relationship of proxy to the person	_____ Relationship	8-9
These next questions are about your artificial heart valve.		
3. At this time, do you have more than one artificial heart valve?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)	10
4. How many artificial heart valves do you NOW have?	_____ Number	11
5. There are four different heart valves — the mitral valve, the aortic valve, the tricuspid valve, and the pulmonic valve. Which of these did you have replaced with (an) artificial valve(s)? <i>If "Yes" in 3, mark each one in a separate column. Also enter name and person number in item 1 of each appropriate column.</i>	1 <input type="checkbox"/> Mitral 2 <input type="checkbox"/> Aortic 3 <input type="checkbox"/> Tricuspid 4 <input type="checkbox"/> Pulmonic 9 <input type="checkbox"/> DK	12
6. Is the artificial [(type in 5)/heart] valve you have now a replacement for a previous artificial [(type in 5)/heart] valve?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (10) 9 <input type="checkbox"/> DK	13
7. How many times has this valve been replaced?	_____ Times	14-16
8. When did you get the artificial [(type in 5)/heart] valve you had before the current one?	_____ / 19 _____ Month Year	18-19
9a. Why did you have that artificial [(type in 5) /heart] valve replaced? <i>Mark first three mentioned, do not probe.</i>	01 <input type="checkbox"/> Blood clots (Thrombus or thrombo embolism) 02 <input type="checkbox"/> Infection 03 <input type="checkbox"/> Bleeding 04 <input type="checkbox"/> Mechanical failure 88 <input type="checkbox"/> Some other reason — Specify <input checked="" type="checkbox"/>	20-21 22-23 24-25
<i>Ask for each entry in 9a:</i>		
b. How long after that heart valve was implanted was this (entry in 9a) first noticed?	0000 <input type="checkbox"/> Less than 1 day (1) — { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> Weeks OR 6666 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> Months 7777 <input type="checkbox"/> More than 90 days 4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK	26-29
<i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	0000 <input type="checkbox"/> Less than 1 day (2) — { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> Weeks OR 6666 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> Months 7777 <input type="checkbox"/> More than 90 days 4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK	30-33
_____ (3) — { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> Weeks OR 6666 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> Months 7777 <input type="checkbox"/> More than 90 days 4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK	34-37	
10. When did you get the artificial [(type in 5)/heart] valve (you have now)?	_____ / 19 _____ Month Year	38-41
11. Some artificial heart valves are mechanical and made from substances such as metal or plastic and others are made from animal or human tissue. What is your artificial [(type in 5)/heart] valve made from?	1 <input type="checkbox"/> Mechanical/man made substance } 2 <input type="checkbox"/> Biological/animal tissue } (12) 3 <input type="checkbox"/> Biological/human tissue } 9 <input type="checkbox"/> DK	42

Section M4 – HEART VALVE PAGE (HV) – Continued

12a. Did you get a registration card for this heart valve from your doctor or from the hospital?

- 1 Yes
- 2 No
- 9 DK

43

b. What is the brand name of this artificial heart valve?

Probe if DK: Who is the manufacturer?

_____ Name

44

13a. Anticoagulants are medications that help prevent blood clots. Do you take anticoagulants regularly?

- 1 Yes
- 2 No
- 9 DK } (14)

45

b. How often do you take them?

- _____ Times {
- 1 A day
 - 2 A week
 - 3 A month
- 999 DK } (14)

46-48

Notes

Section M4 -- HEART VALVE PAGE (HV) -- Continued

<p>Please tell me if you have had any of the following problems or complications with your (current) artificial [(type in 5/heart)] valve --</p> <p>14a. Have you had blood clots?</p>	<p align="right">49</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (14c) 9 <input type="checkbox"/> DK }</p>
<p>b. How long had you had the artificial valve when the blood clots were first noticed?</p> <p><i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i></p>	<p align="right">50-53</p> <p>0000 <input type="checkbox"/> Less than 1 day 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p> <p>OR</p> <p>5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK</p>
<p>c. Have you had an infection or endocarditis?</p>	<p align="right">54</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (14e) 9 <input type="checkbox"/> DK }</p>
<p>d. How long had you had the artificial valve when the infection or endocarditis was first noticed?</p> <p><i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i></p>	<p align="right">55-58</p> <p>0000 <input type="checkbox"/> Less than 1 day 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p> <p>OR</p> <p>5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK</p>
<p>e. Have you had problems with bleeding?</p>	<p align="right">59</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (14g) 9 <input type="checkbox"/> DK }</p>
<p>f. How long had you had the artificial valve when the problem with bleeding was first noticed?</p> <p><i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i></p>	<p align="right">60-63</p> <p>0000 <input type="checkbox"/> Less than 1 day 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p> <p>OR</p> <p>5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK</p>
<p>g. Have you had any mechanical problems with the artificial valve itself?</p>	<p align="right">64</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (14i) 9 <input type="checkbox"/> DK }</p>
<p>h. How long had you had the artificial valve when the mechanical problems were first noticed?</p> <p><i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i></p>	<p align="right">65-68</p> <p>0000 <input type="checkbox"/> Less than 1 day 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p> <p>OR</p> <p>5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK</p>
<p>i. Have you had any other problems or complications?</p>	<p align="right">69</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next column or next device) 9 <input type="checkbox"/> DK }</p>
<p>j. What were they?</p> <p><i>Record first three mentioned. Do not probe. Be specific.</i></p>	<p align="right">70-71</p> <p>(1) _____ 72-73</p> <p>(2) _____ 74-75</p> <p>(3) _____</p>
<p><i>Ask for each entry in 14j:</i></p> <p>k. How long had you had the artificial heart valve when the (entry in 14j) was first noticed?</p> <p><i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i></p>	<p align="right">76-79</p> <p>0000 <input type="checkbox"/> Less than 1 day 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p> <p>OR</p> <p>5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK</p>
	<p align="right">80-83</p> <p>(1) _____</p> <p>0000 <input type="checkbox"/> Less than 1 day 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p> <p>OR</p> <p>5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK</p>
	<p align="right">84-87</p> <p>(2) _____</p> <p>0000 <input type="checkbox"/> Less than 1 day 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p> <p>OR</p> <p>5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK</p>
	<p align="right">88-91</p> <p>(3) _____</p> <p>0000 <input type="checkbox"/> Less than 1 day 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p> <p>OR</p> <p>5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK</p> <p><i>Go to next column or next device</i></p>

Section M5 — INTRAOCULAR LENS PAGE (IL)

1. Enter name and person number from Table MDI.	Name _____ Person No. _____	3-4 5-6
2a. Indicate type of respondent. _____	1 <input type="checkbox"/> Self — personal } (3) 2 <input type="checkbox"/> Self — telephone } 3 <input type="checkbox"/> Proxy — personal 4 <input type="checkbox"/> Proxy — telephone	7
b. Relationship of proxy to the person _____	Relationship _____	8-9
3. Do you now have an intraocular lens in your right eye, left eye, or both eyes? These next questions are about your intraocular lens.	1 <input type="checkbox"/> Right eye 2 <input type="checkbox"/> Left eye 3 <input type="checkbox"/> Both eyes — <i>Fill this column for the "Right eye", mark "Left eye" in next column and enter name and person number in item 1.</i>	10
4. Is the intraocular lens you NOW have in your [right/left] eye a replacement for a previous intraocular lens in THAT eye?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (7)	11
5a. How many times has the intraocular lens in your [right/left] eye been replaced? _____ Times		12-13
b. When did you get the intraocular lens you had before the current one? _____ / 19 _____ Year		14-17
6a. Why did you have the intraocular lens in your [right/left] eye replaced with the current one? <i>Mark first three mentioned, do not probe.</i>	01 <input type="checkbox"/> Injury/trauma 02 <input type="checkbox"/> Mechanical failure 03 <input type="checkbox"/> Glaucoma (after lens implant) 04 <input type="checkbox"/> Irritation or inflammation 05 <input type="checkbox"/> Trouble reading 06 <input type="checkbox"/> Infection 07 <input type="checkbox"/> Movement or displacement of the lens 08 <input type="checkbox"/> Wrong lens power 09 <input type="checkbox"/> Corneal transplant 88 <input type="checkbox"/> Some other reason — <i>Specify</i> ✓ _____	18-19 20-21 22-23
b. How long after that lens was implanted was this (entry in 6a) first noticed? <i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	0000 <input type="checkbox"/> Less than 1 day (1) { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> Weeks OR 6666 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> Months 7777 <input type="checkbox"/> More than 90 days 4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK	24-27
	0000 <input type="checkbox"/> Less than 1 day (2) { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> Weeks OR 6666 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> Months 7777 <input type="checkbox"/> More than 90 days 4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK	28-31
	0000 <input type="checkbox"/> Less than 1 day (3) { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> Weeks OR 6666 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> Months 7777 <input type="checkbox"/> More than 90 days 4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK	32-35
7. When did you get the intraocular lens (that you NOW have) in your [right/left] eye?	_____ / 19 _____ Month Year	36-39
8. Why did you need to get an intraocular lens in your [right/left] eye (in the first place)?	01 <input type="checkbox"/> Cataract 02 <input type="checkbox"/> Injury/Trauma 88 <input type="checkbox"/> Other — <i>Specify</i> ✓ _____ 99 <input type="checkbox"/> DK	40-41
9. Did your doctor tell you that the (current) lens in your [right/left] eye is an experimental or investigational lens?	1 <input type="checkbox"/> Yes } (10) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	42

Section M5 — INTRAOCULAR LENS PAGE (IL) — Continued

10. Does this intraocular lens have a substance in it that absorbs some types of light?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	43
11. Because of the intraocular lens in your [right/left] eye, did your doctor advise you to wear sunglasses when you are in bright light or sunlight?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	44
Please tell me if you have had any of the following problems or complications with the (current) intraocular lens in your [right/left] eye — 12a. Have you had any infection?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (12c)	45
b. How long after your (current) lens was implanted was the infection first noticed? <i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	0000 <input type="checkbox"/> Less than 1 day — { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30–90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK	46–49
c. Have you had healing problems?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (12e)	50
d. How long had you had the lens when the healing problem was first noticed? <i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	0000 <input type="checkbox"/> Less than 1 day — { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30–90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK	51–54
e. Have you had pain, irritation, or inflammation of the inside of the eye?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (12g)	55
f. How long had you had the lens when the pain, irritation, or inflammation was first noticed? <i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	0000 <input type="checkbox"/> Less than 1 day — { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30–90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK	56–59
g. Have you had glaucoma that started after the lens was implanted?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (12i)	60
h. How long had you had the lens when the glaucoma was first noticed? <i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	0000 <input type="checkbox"/> Less than 1 day — { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30–90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK	61–64
i. Have you had problems with clouding or blurred visions?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (12k)	65
j. How long had you had the lens when the clouding or blurred vision was first noticed? <i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	0000 <input type="checkbox"/> Less than 1 day — { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30–90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK	66–69
k. Have you had trouble reading newspaper print?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (12m)	70
l. How long had you had the lens when this trouble was first noticed? <i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	0000 <input type="checkbox"/> Less than 1 day — { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30–90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK <p align="right"><i>Go to 12m</i></p>	71–74

Notes

Section M5 – INTRAOCULAR LENS PAGE (IL) – Continued

12m. Have you had problems with glare or light streaks?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (12o) 9 <input type="checkbox"/> DK }	75
n. How long had you had the lens when the glare or light streaks were first noticed? <i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30–90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK	76–79
o. Have you had problems due to wrong lens power?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (12q) 9 <input type="checkbox"/> DK }	80
p. How long had you had the lens when the wrong lens power was first noticed? <i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30–90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK	81–84
q. Have you had problems with your eyes feeling tired when you wake up?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (12s) 9 <input type="checkbox"/> DK }	85
r. How long had you had the lens when this problem was first noticed? <i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30–90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK	86–89
s. Have you had any other problems or complications with the intraocular lens in your [right/left] eye?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next column or next device) 9 <input type="checkbox"/> DK }	90
t. What were they? <i>Record first three mentioned. Do not probe. Be specific.</i>	(1) _____ (2) _____ (3) _____	91–92 93–94 95–96
<i>Ask for each entry in 12t.</i>	0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30–90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK	97–100
u. How long had you had the lens when the (entry in 12t) was first noticed? <i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	(1) { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30–90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK	101–104
	0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30–90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK	105–108
	0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30–90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK Go to next column or next device	

Notes

Section M6 — PACEMAKER PAGE

1. Enter name and person number from Table MDI.	Name _____ 3-4 Person No. _____ 5-6
2a. Indicate type of respondent.. b. Relationship of proxy to the person	1 <input type="checkbox"/> Self — personal } (3) 3 <input type="checkbox"/> Proxy — personal 7 2 <input type="checkbox"/> Self — telephone } 4 <input type="checkbox"/> Proxy — telephone _____ 8-9 <div style="text-align: center;">Relationship</div>
3a. Is the pacemaker you have now a replacement for a previous pacemaker? b. Altogether, how many times has your pacemaker been replaced?	1 <input type="checkbox"/> Yes 10 2 <input type="checkbox"/> No (7) _____ Times 11-12
4. When did you get the pacemaker you had before the current one?	_____ / 19 _____ 13-16 <div style="text-align: center;">Month Year</div>
5a. Why did you have that pacemaker replaced? <i>Mark first three mentioned. Do not probe.</i>	01 <input type="checkbox"/> Battery failure 17-18 02 <input type="checkbox"/> Lead failure (Lead) 19-20 03 <input type="checkbox"/> Mechanical failure, unspecified 21-22 04 <input type="checkbox"/> Infection 05 <input type="checkbox"/> Healing problem 06 <input type="checkbox"/> Pain or irritation 88 <input type="checkbox"/> Some other reason — Specify <input checked="" type="checkbox"/> _____
<i>Ask for each entry in 5a.</i> b. How long after that pacemaker was implanted was this (entry in 5a) first noticed? <i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	<div style="border-bottom: 1px dashed black; padding-bottom: 5px;"> 0000 <input type="checkbox"/> Less than 1 day 23-26 (1) _____ { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> Weeks OR 6666 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> Months 7777 <input type="checkbox"/> More than 90 days 4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK </div> <div style="border-bottom: 1px dashed black; padding-bottom: 5px;"> 0000 <input type="checkbox"/> Less than 1 day 27-30 (2) _____ { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> Weeks OR 6666 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> Months 7777 <input type="checkbox"/> More than 90 days 4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK </div> <div style="padding-bottom: 5px;"> 0000 <input type="checkbox"/> Less than 1 day 31-34 (3) _____ { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> Weeks OR 6666 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> Months 7777 <input type="checkbox"/> More than 90 days 4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK </div>
6. How was the pacemaker you had before the current one monitored — by telephone, at the doctor's office, at the hospital, or in some other way? <i>Mark first applicable box</i>	01 <input type="checkbox"/> Not monitored 35-36 02 <input type="checkbox"/> Telephone 03 <input type="checkbox"/> Doctor's office 04 <input type="checkbox"/> Hospital 88 <input type="checkbox"/> Other — Specify <input checked="" type="checkbox"/> _____
7. When did you get your (current) pacemaker?	_____ / 19 _____ 37-40 <div style="text-align: center;">Month Year</div>
8. How is this pacemaker monitored — by telephone, at the doctor's office, at the hospital, or in some other way? <i>Mark first applicable box</i>	01 <input type="checkbox"/> Not monitored 41-42 02 <input type="checkbox"/> Telephone 03 <input type="checkbox"/> Doctor's office 04 <input type="checkbox"/> Hospital 88 <input type="checkbox"/> Other — Specify <input checked="" type="checkbox"/> _____
9. Can your (current) pacemaker be programmed or adjusted without surgery?	1 <input type="checkbox"/> Yes } (10) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }

Section M6 – PACEMAKER PAGE – Continued

10a. Have you had any mechanical problems with your (current) pacemaker, such as battery failure or lead (lead) failure?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (11)	44
b. What kind of mechanical problem did it have? <i>Mark all that apply.</i>	01 <input type="checkbox"/> Battery failure 02 <input type="checkbox"/> Lead failure 88 <input type="checkbox"/> Other – Specify <input checked="" type="checkbox"/>	45-46
11. Please tell me if you have had any of the following problems or complications with your (current) pacemaker –	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (11c)	47
a. Have you had an infection?		48-51
b. How long had you had your (current) pacemaker when the infection was first noticed? <i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 30 days 9999 <input type="checkbox"/> DK	48-51
c. Have you had any healing problems?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (11e)	52
d. How long had you had your (current) pacemaker when the healing problem was first noticed? <i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 30 days 9999 <input type="checkbox"/> DK	53-56
e. Have you had any problems with pain or irritation?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (11g)	57
f. How long had you had your (current) pacemaker when pain or irritation was first noticed? <i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 30 days 9999 <input type="checkbox"/> DK	58-61
g. Have you had irregular heart beat with your (current) pacemaker?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (11i)	62
h. How long had you had your pacemaker when the irregular heart beat was first noticed? <i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 30 days 9999 <input type="checkbox"/> DK	63-66
i. Have you had any other problems or complications?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Next column or next device)	67
j. What were they? <i>Record first three mentioned. Be specific. Do not probe.</i>	(1) _____ (2) _____ (3) _____	68-69 70-71 72-73
k. How long had you had your (current) pacemaker when the (entry in 11j) was first noticed? <i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i>	0000 <input type="checkbox"/> Less than 1 day (1) { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 30 days 9999 <input type="checkbox"/> DK	74-77
	0000 <input type="checkbox"/> Less than 1 day (2) { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 30 days 9999 <input type="checkbox"/> DK	78-81
	0000 <input type="checkbox"/> Less than 1 day (3) { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 30 days 9999 <input type="checkbox"/> DK	82-85
	<i>Go to next column or next device</i>	

Section M7 – OTHER DEVICE PAGE

<p>1. Enter name and person number from Table MDI.</p>	<p>Name _____ 3-4</p> <p>Person No. _____ 5-6</p>
<p>2a. Indicate type of respondent.</p>	<p>1 <input type="checkbox"/> Self – personal } (3) 3 <input type="checkbox"/> Proxy – personal</p> <p>2 <input type="checkbox"/> Self – telephone } 4 <input type="checkbox"/> Proxy – telephone 7</p>
<p>b. Relationship of proxy to the person</p>	<p>_____ 8-9</p> <p style="text-align:center">Relationship</p>
<p>3. Enter implanted device from "Other" column of table MDI.</p>	<p>_____ 10-11</p>
<p>These next questions are about your (other) surgically implanted medical device(s).</p>	
<p>4a. Do you have more than one (implant in 3)?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No (4c) 12</p>
<p>b. How many (implant in 3) do you now have?</p>	<p>_____ 13-14</p> <p style="text-align:center">Number</p>
<p>c. In what part(s) of the body [is/are] the (implant in 3) located?</p> <p><i>If multiple parts, enter each different body part in a separate column. Also enter name and person number in item 1.</i></p>	<p>_____ 13-14</p>
<p>CHECK ITEM 5</p>	<p><i>Mark first appropriate box based on the entry in 3 and/or 4c.</i></p> <p>1 <input type="checkbox"/> Injected silicone } (Next column or</p> <p>2 <input type="checkbox"/> Removable by person } next device)</p> <p>8 <input type="checkbox"/> Other (5) 17</p>
<p>5a. Is the (implant in 3/4c) you have now a replacement for a previous (implant in 3/4c)?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No (8) 18</p>
<p>b. How many times has the (implant in 3/4c) been replaced?</p>	<p>_____ Times 19-20</p>
<p>6. When did you get the (implant in 3/4c) you had before the current one?</p>	<p>_____ / 19 _____</p> <p style="text-align:center">Month Year 21-24</p>
<p>7a. Why did you have the previous (implant in 3/4c) replaced?</p> <p><i>Mark first three mentioned. Do not probe.</i></p>	<p>01 <input type="checkbox"/> Infection 25-26</p> <p>02 <input type="checkbox"/> Mechanical failure of the implant 27-28</p> <p>03 <input type="checkbox"/> Implant did not work 29-30</p> <p>04 <input type="checkbox"/> Healing problem</p> <p>05 <input type="checkbox"/> Pain or irritation</p> <p>06 <input type="checkbox"/> Blood clots</p> <p>07 <input type="checkbox"/> Bleeding</p> <p>08 <input type="checkbox"/> Trauma/Injury</p> <p>88 <input type="checkbox"/> Some other reason – Specify ↴</p>
<p><i>Ask for each entry in 7a.</i></p> <p>b. How long had you had your previous (implant in 3/4c) when the (entry in 7a) was first noticed?</p> <p><i>Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?</i></p>	<p>0000 <input type="checkbox"/> Less than 1 day 31-34</p> <p>(1) _____ { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days</p> <p style="margin-left: 100px;">2 <input type="checkbox"/> Weeks 6666 <input type="checkbox"/> 30-90 days</p> <p style="margin-left: 100px;">3 <input type="checkbox"/> Months OR 7777 <input type="checkbox"/> More than 90 days</p> <p style="margin-left: 100px;">4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK</p> <hr/> <p>0000 <input type="checkbox"/> Less than 1 day 35-38</p> <p>(2) _____ { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days</p> <p style="margin-left: 100px;">2 <input type="checkbox"/> Weeks 6666 <input type="checkbox"/> 30-90 days</p> <p style="margin-left: 100px;">3 <input type="checkbox"/> Months OR 7777 <input type="checkbox"/> More than 90 days</p> <p style="margin-left: 100px;">4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK</p> <hr/> <p>0000 <input type="checkbox"/> Less than 1 day 39-42</p> <p>(3) _____ { 1 <input type="checkbox"/> Days 5555 <input type="checkbox"/> Less than 30 days</p> <p style="margin-left: 100px;">2 <input type="checkbox"/> Weeks 6666 <input type="checkbox"/> 30-90 days</p> <p style="margin-left: 100px;">3 <input type="checkbox"/> Months OR 7777 <input type="checkbox"/> More than 90 days</p> <p style="margin-left: 100px;">4 <input type="checkbox"/> Years 9999 <input type="checkbox"/> DK</p>
<p>8. Why did you need to get the (implant in 3/4c) in the first place?</p> <p><i>Mark first one mentioned.</i></p>	<p>01 <input type="checkbox"/> Infection } (9)</p> <p>02 <input type="checkbox"/> Trauma/Injury } 43-44</p> <p>88 <input type="checkbox"/> Some other reason – Specify ↴</p> <p style="text-align:right">_____ (9)</p>

Section M7 — OTHER DEVICE PAGE — Continued

9. When did you get your (current) (implant in 3/4c)?	<div style="float: right; border: 1px solid black; padding: 2px;">45-48</div> <div style="text-align: center;"> _____ / 19 _____ Month Year </div>
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10. Please tell me if you have had any of the following problems or complications with your (current) (implant in 3/4c) —	<div style="float: right; border: 1px solid black; padding: 2px;">49</div> 1 <input type="checkbox"/> Yes — 2 <input type="checkbox"/> No } (10c) 9 <input type="checkbox"/> DK }
--	--

a. Have you had an infection?	<div style="float: right; border: 1px solid black; padding: 2px;">50-53</div> 0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK
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Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?

b. How long had you had your (implant in 3/4c) when the infection was first noticed?	<div style="float: right; border: 1px solid black; padding: 2px;">54</div> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (10e) 9 <input type="checkbox"/> DK }
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c. Have you had any healing problems?	<div style="float: right; border: 1px solid black; padding: 2px;">55-58</div> 0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK
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Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?

d. How long had you had your (implant in 3/4c) when the healing problem was first noticed?	<div style="float: right; border: 1px solid black; padding: 2px;">59</div> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (10g) 9 <input type="checkbox"/> DK }
---	--

e. Have you had any problems with pain or irritation?	<div style="float: right; border: 1px solid black; padding: 2px;">60-63</div> 0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK
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Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?

f. How long had you had your (implant in 3/4c) when the pain or irritation was first noticed?	<div style="float: right; border: 1px solid black; padding: 2px;">64</div> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (10i) 9 <input type="checkbox"/> DK }
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g. Have you had any mechanical problems with your (current) (implant in 3/4c) itself, that is, it has not worked correctly?	<div style="float: right; border: 1px solid black; padding: 2px;">65-68</div> 0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK
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Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?

h. How long had you had your (implant in 3/4c) when the mechanical problem was first noticed?	<div style="float: right; border: 1px solid black; padding: 2px;">66</div> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Next column or next device)
--	--

i. Have you had any other problems or complications?	<div style="float: right; border: 1px solid black; padding: 2px;">70-71</div> (1) _____
j. What were they?	<div style="float: right; border: 1px solid black; padding: 2px;">72-73</div> (2) _____
<i>Record first three mentioned. Do not probe. Be specific.</i>	<div style="float: right; border: 1px solid black; padding: 2px;">74-75</div> (3) _____

k. How long had you had the (implant in 3/4c) when the (problem in 10j) was first noticed?	<div style="float: right; border: 1px solid black; padding: 2px;">76-79</div> 0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK
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Probe if DK: Was it less than 30 days, 30 to 90 days, or more than 90 days?

(1) _____	<div style="float: right; border: 1px solid black; padding: 2px;">80-83</div> 0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK
------------------	---

(2) _____	<div style="float: right; border: 1px solid black; padding: 2px;">84-87</div> 0000 <input type="checkbox"/> Less than 1 day { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years } OR 5555 <input type="checkbox"/> Less than 30 days 6666 <input type="checkbox"/> 30-90 days 7777 <input type="checkbox"/> More than 90 days 9999 <input type="checkbox"/> DK
------------------	---

Go to next column or next device

Section N — OCCUPATIONAL HEALTH

Section N1 — WORK HISTORY

In this part of the survey I will ask about your work experience, certain medical conditions and other health-related matters.

1 a. First, I'll ask about the **KIND OF WORK** you have done the **LONGEST**, not counting work around the house. Thinking of all the jobs or businesses you have ever had, what kind of work did you do the longest? Include work done while in the Armed Forces.

Occupation 990 Never worked (Section N8, page 59) **5-7**

b. When you were doing this kind of work, what were your most important activities or duties?

Duties

2 a. How long did you do this kind of work?

00 Less than 1 year **8-9**
 _____ Years

b. How old were you when you started doing this kind of work?

_____ Age **10-11**

3 a. In what kind of business or industry did you do this kind of work the **LONGEST**? For example, TV and radio manufacturing, retail shoe store, State Labor Department, farm.

Industry 932 Armed Forces — Civilian **12-14**
 942 Armed Forces — Active duty

b. In the industry where you worked the longest as a (entry in 1a) were you —

An employee of a **PRIVATE** company, business or individual for wages, salary, or commission? **P**
 A member of the **Armed Forces**? **AF**
 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**

Class of worker **15**

1 P
 2 AF
 3 F
 4 S
 5 L
 6 I
 7 SE
 8 WP

CHECK ITEM 1 Refer to HIS-1, C1:

1 Wa/Wb box marked in C1 (Check Item 5A, page 38)
 2 Neither Wa nor Wb box marked in C1 (4) **16**

4 a. **DURING THE PAST 12 MONTHS**, that is, since (12 month date) a year ago, did you work at any time at a job or business not counting work around the house? (Include unpaid work in the family business or farm.)

1 Yes **17**
 2 No

b. How long has it been since you last worked at a job or business?

Number { 1 Weeks } If less than 1 year (4c)
 { 2 Months }
 { 3 Years } If 1 year or more (8) **18-20**

c. For whom did you work at your last job or business? Enter name of company, business, organization, or other employer.

Employer 932 Armed Forces — Civilian } (4e) **21-23**
 942 Armed Forces — Active duty

d. What kind of business or industry is this? For example, TV and radio manufacturing, retail shoe store, State Labor Department farm.

Industry

e. What kind of work were you doing? For example, electrical engineer, stock clerk, typist, farmer.

Occupation **24-26**

f. What were your most important activities or duties at that job? For example, types, keeps account books, files, sells cars, operates printing press, finishes concrete.

Duties

Complete from entries in 4c-f. If not clear, ask:

g. Were you —

An employee of a **PRIVATE** company, business or individual for wages, salary, or commission? **P**
 A member of the **Armed Forces**? **AF**
 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**

Class of worker **27**

1 P
 2 AF
 3 F
 4 S
 5 L
 6 I
 7 SE
 8 WP

Section N1 — WORK HISTORY — Continued

5. How long did you work as a (occupation in 4e) for (employer in 4c)?		Number } <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years	28-30
CHECK ITEM 2	Refer to 4e and 1a:	1 <input type="checkbox"/> Occupation in 4e is same as in 1a (8) 8 <input type="checkbox"/> All others (8a)	31
6a. Considering ALL of your employers, for how many years altogether did you do this KIND of work?		00 <input type="checkbox"/> Less than 1 year _____ Years	32-33
b. How old were you when you started doing this kind of work?		_____ Age	34-35
7a. In what kind of business or industry did you do this kind of work the LONGEST? For example, TV and radio manufacturing, retail shoe store, State Labor Department, farm.		Industry 932 <input type="checkbox"/> Armed Forces — Civilian 942 <input type="checkbox"/> Armed Forces — Active duty	36-38
b. Were you — An employee of a PRIVATE company, business or individual for wages, salary, or commission? P A member of the Armed Forces? AF 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		Class of worker 1 <input type="checkbox"/> P 2 <input type="checkbox"/> AF 3 <input type="checkbox"/> F 4 <input type="checkbox"/> S 5 <input type="checkbox"/> L 6 <input type="checkbox"/> I 7 <input type="checkbox"/> SE 8 <input type="checkbox"/> WP	39
Hand Card N1, read list if telephone interview. 8a. Which of these statements describe the reason or reasons you stopped working (entry in 4b) ago? Mark all that apply.		1 <input type="checkbox"/> Stopped working because of own illness, injury, disability or other health problem that was JOB-RELATED. 2 <input type="checkbox"/> Stopped working because of own illness, injury, disability or other health problem that was NOT JOB-RELATED 3 <input type="checkbox"/> Retired 4 <input type="checkbox"/> Child/family care 5 <input type="checkbox"/> On layoff from a job 8 <input type="checkbox"/> Some other reason — Specify ↘ 9 <input type="checkbox"/> DK	40 41 42 43 44 45 46
CHECK ITEM 3	Refer to 8a:	1 <input type="checkbox"/> Box 1 marked in 8a (8b) 8 <input type="checkbox"/> All others (Check Item 4)	47
8b. Was a worker's compensation claim filed for your illness, injury, disability, or other health problem?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (8d)	48
c. Have you received any money or other benefits from worker's compensation since you stopped working (entry in 4b) ago?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	49
d. Was a claim filed for any other income or benefits because your health problem was job-related?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	50
CHECK ITEM 4	Refer to question 4. Mark first appropriate box:	1 <input type="checkbox"/> "Armed Forces-Active Duty" in 4c (Section N7, page 56) 2 <input type="checkbox"/> "Yes" in 4a (Check Item 7) 8 <input type="checkbox"/> All others (Section N7, page 56)	51

Notes

Section N1 — WORK HISTORY — Continued

CHECK ITEM 5A	Refer to HIS-1, pages 44 and 45:	<input type="checkbox"/> Self respondent for questions 6b—g (Check Item 5B) <input type="checkbox"/> Proxy respondent for questions 6b—g (9) <input type="checkbox"/> All others (9)	52
9a. For whom were you employed during the 2 weeks outlined in red on that calendar? Enter name of company, business, organization, or other employer.	Employer	932 <input type="checkbox"/> Armed Forces — Civilian 942 <input type="checkbox"/> Armed Forces — Active duty } (9c)	53—55
b. What kind of business or industry is this? For example, TV and radio manufacturing, retail shoe store, State Labor Department, farm.	Industry		
<i>If "Active duty" in 9a, mark "AF" box without asking.</i>	Occupation	942 <input type="checkbox"/> AF (Section N8, page 59)	56—58
c. What kind of work were you doing? For example, electrical engineer, stock clerk, typist, farmer.	Duties		
d. What were your most important activities or duties at that job? For example, types, keeps account books, files, sells cars, operates printing press, finishes concrete.	Duties		
<i>Complete from entries in 9a—d. If not clear, ask:</i>	Class of worker		59
e. Were you — An employee of a PRIVATE company, business or individual for wages, salary, or commission? P A member of the Armed Forces? AF 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	1 <input type="checkbox"/> P 2 <input type="checkbox"/> AF (Section N8, page 59) 3 <input type="checkbox"/> F 4 <input type="checkbox"/> S 5 <input type="checkbox"/> L 6 <input type="checkbox"/> I 7 <input type="checkbox"/> SE 8 <input type="checkbox"/> WP		
CHECK ITEM 5B	Refer to questions 9a and c or to HIS-1, pages 44—45:	Transcribe from questions 9a and c or from 6b/c and e on HIS-1. _____ } (9f) Employer _____ } Occupation	
9f. (You told me that during the two weeks outlined in red on that calendar you were employed as a (occupation in Check Item 5B) for (employer in Check Item 5B.) How long have you worked as a (occupation in Check Item 5B) for (employer in Check Item 5B)?	Number	1 <input type="checkbox"/> Weeks 2 <input type="checkbox"/> Months 3 <input type="checkbox"/> Years	60—62
CHECK ITEM 6	Refer to Check Item 5B and question 1a:	1 <input type="checkbox"/> Occupation in Check Item 5B is same as in 1a (Check Item 7) 8 <input type="checkbox"/> All others (9g)	63
9g. Considering ALL of your employers, for how many years altogether did you do this KIND of work?	Years	00 <input type="checkbox"/> Less than 1 year _____ Years	64—65
h. How old were you when you started doing this kind of work?	Age	_____	66—67
i. In what kind of business or industry did you do this kind of work the LONGEST? For example, TV and radio manufacturing, retail shoe store, State Labor Department, farm.	Industry	932 <input type="checkbox"/> Armed Forces — Civilian 942 <input type="checkbox"/> Armed Forces — Active duty	68—70
j. Were you — An employee of a PRIVATE company, business or individual for wages, salary, or commission? P A member of the Armed Forces? AF 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	Class of worker	1 <input type="checkbox"/> P 2 <input type="checkbox"/> AF 3 <input type="checkbox"/> F 4 <input type="checkbox"/> S 5 <input type="checkbox"/> L 6 <input type="checkbox"/> I 7 <input type="checkbox"/> SE 8 <input type="checkbox"/> WP	71

Section N1 – WORK HISTORY – Continued

CHECK ITEM 7	<i>Refer to Check Item 5B.</i>	1 <input type="checkbox"/> Entry in Check Item 5B (Transcribe entries) 8 <input type="checkbox"/> All others (Transcribe entries from 4c and e)	72
		_____ } Employer _____ } Occupation	(10)
These next questions are about your job as a (occupation in Check Item 7) for (employer in Check Item 7).			73
10a.	Did your job require you to do REPEATED STRENUOUS PHYSICAL ACTIVITIES such as lifting, pushing or pulling heavy objects?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (11)	
b.	During a typical work day, how many minutes or hours altogether did you spend doing STRENUOUS PHYSICAL ACTIVITIES?	_____ } 1 <input type="checkbox"/> Minutes Number } 2 <input type="checkbox"/> Hours	74-76
11a.	Did this job require you to do REPEATED bending, twisting or reaching?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (12)	77
b.	During a typical work day, how many minutes or hours altogether did you spend bending, twisting or reaching?	_____ } 1 <input type="checkbox"/> Minutes Number } 2 <input type="checkbox"/> Hours	78-80
12a.	Did this job require you to BEND or TWIST your hands or wrists MANY TIMES AN HOUR?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (13)	81
b.	During a typical workday, how many minutes or hours altogether did you spend bending or twisting your hands or wrists?	_____ } 1 <input type="checkbox"/> Minutes Number } 2 <input type="checkbox"/> Hours	82-84
13a.	On this job, did you work with hand-held or hand-operated vibrating tools or machinery?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (14)	85
b.	During a typical work day, how many minutes or hours altogether did you spend working with hand-held or hand-operated vibrating machinery?	_____ } 1 <input type="checkbox"/> Minutes Number } 2 <input type="checkbox"/> Hours	86-88
14.	I am going to read a list of substances that some people get on their skin AT WORK. Tell me if you got any of these things on your HANDS or ARMS at your job as a (occupation in Check Item 7) for (employer in Check Item 7) DURING THE PAST 12 MONTHS –	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	89
a.	Did you get solvents or degreasers on your hands or arms?		
b.	Petroleum products other than solvents? For example, grease, oil, or fuel?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	90
c.	Soaps, detergents, or cleaning and disinfecting solutions used in performing your job?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	91
d.	Cutting oils, machine coolants, or metal working fluids?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	92
e.	Paints, varnishes, lacquers, or other coatings?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	93
f.	Glues, pastes, or other adhesives?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	94
g.	Acids or alkalies?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	95
h.	Pesticides, insecticides, herbicides, fungicides, or fumigants?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	96
i.	Foods or food products handled as part of your job duties?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	97
j.	Plants, trees or shrubs handled as part of your job duties?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	98
k.	Did you get any other chemicals or substances on your hands or arms that could irritate the skin?	1 <input type="checkbox"/> Yes – Specify ζ _____ 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	99 100-101

Section N2 — BACK PAIN

5

These next questions are about back pain.

1 a. At any time during the past 12 months, that is, since (12 month date) a year ago, did you have back pain every day for a week or more?

- 1 Yes
- 2 No (Section N3, page 43)

CHECK ITEM 8

Refer to sex and age:

- 1 SP is female under 50 (1b)
- 8 All others (2)

6

b. Did you have this back pain ONLY at the time of your monthly periods?

- 1 Yes (Section N3, page 43)
- 2 No
- 3 Don't menstruate

7

2 a. (The remaining questions are about back pain other than menstrual pain.) During the past 12 months, on about how many days altogether did you have back pain?

- 998 Menstrual pain only (Section N3, page 43)
- 365 Every day
- _____ Days

8-10

b. During the past 12 months, how many full days did you miss from work because of back pain?

- 000 None
- _____ Days

11-13

3 a. When you had this back pain, what PART of your BACK bothered you the most — the upper back, the middle back or the lower back?

- 1 Upper
- 2 Middle
- 3 Lower

14

b. During the past 12 months, did the back pain ever spread to your:

- buttocks?
- thighs?
- lower leg or foot?

- | | Yes | No | DK |
|----------------------------|----------------------------|----------------------------|----|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | |
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | |
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | |

15

16

17

4 a. Did any of the back pain you had in the past 12 months result from a SINGLE accident or injury? Some examples are slipping, falling, twisting, lifting something, or being in a car accident.

- 1 Yes
- 2 No (5)

18

b. When did the accident or injury happen?

____ / ____ / 19____
Month Date Year

19-24

c. Were you at work at your job or business when the accident or injury happened?

- 1 Yes
- 2 No (5)

25

d. Was this at your job as a (occupation in Check Item 7) for (employer in Check Item 7)?

- 1 Yes (5)
- 2 No

26

e. For whom did you work when the accident or injury happened? Enter name of company, business, organization, or other employer.

- Employer
- 932 Armed Forces — Civilian
- 942 Armed Forces — Active duty } (4g)

27-29

f. What kind of business or industry is this? For example, TV and radio manufacturing, retail shoe store, State Labor Department, farm.

Industry

g. What kind of work did you do at that job? For example, electrical engineer, stock clerk, typist, farmer.

Occupation

30-32

h. What were your most important activities or duties at that job? For example, types, keeps account books, files, sells cars, operates printing press, finishes concrete.

Duties

Complete from entries in 4e-h. If not clear, ask:

i. Were you —

- An employee of a PRIVATE company, business or individual for wages, salary, or commission? P
- A member of the Armed Forces? AF
- A FEDERAL government employee? F
- A STATE government employee? S
- A LOCAL government employee? L
- Self-employed in OWN business, professional practice, or farm? I
- Ask: Is the business incorporated? Yes I
- No SE
- Working WITHOUT PAY in family business or farm? WP

- 1 P
 - 2 AF
 - 3 F
 - 4 S
 - 5 L
 - 6 I
 - 7 SE
 - 8 WP
- (5)

33

Section N2 – BACK PAIN – Continued

5a. Was any of the back pain you had in the past 12 months brought on by REPEATED activities such as lifting, pushing, pulling, bending, twisting, or reaching?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (7)	34
b. Where did you perform the activities that brought on your back pain? Mark only one box.	1 <input type="checkbox"/> At work (6) 2 <input type="checkbox"/> At home 3 <input type="checkbox"/> Recreational site 4 <input type="checkbox"/> Other – Specify } (8)	35
6a. Was this at your job as a (occupation in Check Item 7) for (employer in Check Item 7)?	1 <input type="checkbox"/> Yes (8) 2 <input type="checkbox"/> No	36
b. For whom did you work when the accident or injury happened? Enter name of company, business, organization, or other employer.	Employer 932 <input type="checkbox"/> Armed Forces – Civilian 942 <input type="checkbox"/> Armed Forces – Active duty } (6d)	32-38
c. What kind of business or industry is this? For example, TV and radio manufacturing, retail shoe store, State Labor Department, farm.	Industry	
d. What kind of work did you do at that job? For example, electrical engineer, stock clerk, typist, farmer.	Occupation	40-42
e. What were your most important activities or duties at that job? For example, types, keeps account books, files, sells cars, operates printing press, finishes concrete.	Duties	
Complete from entries in 6b–e. If not clear, ask:		
f. Were you – An employee of a PRIVATE company, business or individual for wages, salary, or commission? P A member of the Armed Forces? AF 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	1 <input type="checkbox"/> P 2 <input type="checkbox"/> AF 3 <input type="checkbox"/> F 4 <input type="checkbox"/> S 5 <input type="checkbox"/> L 6 <input type="checkbox"/> I 7 <input type="checkbox"/> SE 8 <input type="checkbox"/> WP } (8)	43
If "Yes" in 4a, go to 8. 7. What caused your back pain?	_____ _____	44
8a. Has your back bothered you today?	1 <input type="checkbox"/> Yes (8c) 2 <input type="checkbox"/> No	45
b. How many days, weeks or months ago did you last have back pain?	_____ Number { 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago	46-48
c. For how many consecutive days, weeks or months [did your back bother you that time/has your back been bothering you]?	_____ Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	49-51
Notes		

Section N3 — HAND DISCOMFORT

Now I will ask some questions about your hands and wrists.		59
1. Are you left handed, right handed or able to use both hands equally well?	1 <input type="checkbox"/> Left handed 2 <input type="checkbox"/> Right handed 3 <input type="checkbox"/> Able to use both hands equally well	
2. Which hand do you use most at work?	1 <input type="checkbox"/> Left 2 <input type="checkbox"/> Right 3 <input type="checkbox"/> Use both hands equally	60
3. During the past 12 months (that is, since (12 month date) a year ago), have you had discomfort in your hands, wrists or fingers? Discomfort can mean pain, burning, stiffness, numbness or tingling.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Section N4, page 46)	61
4. Was this discomfort due entirely to an injury, such as a cut, sprain or broken bone?	1 <input type="checkbox"/> Yes (Section N4, page 46) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	62
5a. During the past 12 months, on about how many days altogether did you have discomfort in your hands, wrists or fingers?	000 <input type="checkbox"/> Less than 5 days (Section N4, page 46) _____ Days 365 <input type="checkbox"/> Every day (6)	63-65
b. During the past 12 months, did you have the discomfort every day for a week or more?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	66
CHECK ITEM 9	Refer to 5a and 5b: Mark first appropriate box	67
6. In which hand did you have this discomfort?	1 <input type="checkbox"/> 20 or more in 5a } (6) 2 <input type="checkbox"/> "Yes" in 5b } 8 <input type="checkbox"/> All others (Section N4, page 46)	68
7. Was your discomfort worse when you were trying to sleep or did it awaken you from sleep?	1 <input type="checkbox"/> Left 2 <input type="checkbox"/> Right 3 <input type="checkbox"/> Both	69
8. In the past 12 months, did your hands or fingers often feel clumsy, that is, did you often have difficulty picking up or holding things?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	70
9a. Has your hand(s) bothered you today?	1 <input type="checkbox"/> Yes (9c) 2 <input type="checkbox"/> No	71
b. How many days, weeks or months ago did you last have this discomfort?	_____ Number { <ul style="list-style-type: none"> 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 	72-74
c. For how many consecutive days, weeks, or months [did your hand(s) bother you that time/has your hand(s) been bothering you]?	_____ Number { <ul style="list-style-type: none"> 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years 	75-77
10a. In what year did you first notice this hand discomfort?	87 <input type="checkbox"/> 1987 } (11) 88 <input type="checkbox"/> 1988 } 89 <input type="checkbox"/> 1989 } <input type="checkbox"/> Earlier year — Specify <u> </u>	78-79
b. Counting (year in 10a), in how many different years has your hand(s) bothered you?	_____ Years	80-81
11a. During the past 12 months, were you away from work for more than one week for any reason?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (12)	82
b. When you were away from work for more than one week, did your hand discomfort increase, decrease, or stay the same?	1 <input type="checkbox"/> Increase 2 <input type="checkbox"/> Decrease 3 <input type="checkbox"/> Stay the same	83
12. During the past 12 months, did you miss at least a full day from work because of your hand discomfort?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	84

Section N3 -- HAND DISCOMFORT -- Continued

13a. Have you EVER stopped working at a job or changed jobs because of your hand discomfort?	1 <input type="checkbox"/> Yes (14) 2 <input type="checkbox"/> No	85
---	--	-----------

b. Have you ever made a major change in your work activities because of your hand discomfort?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	86
--	---	-----------

14a. How long has it been since you last saw or talked to a medical doctor, chiropractor, physical therapist or other medical person about your hand discomfort?	000 <input type="checkbox"/> Never saw medical person (15) Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	87-89
---	---	--------------

b. What did the medical person call your hand discomfort?	_____ _____	90
--	----------------	-----------

15. Even if you have mentioned it before, please tell me if you have EVER had any of the following conditions --	Yes No DK	
a. Arthritis of the hand, wrist or fingers?	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	91
b. A broken bone in your hand, wrist, or fingers?	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	92
c. A condition affecting the wrist and hand called carpal tunnel syndrome?	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	93

Notes

Section N4 -- WORK INJURIES

RT 78
3-4
5-6

Now I will ask about on-the-job injuries in the past 12 months.

Hand Card N3

By "on-the-job injury" we mean an injury at work that resulted in at least one of the following:

an injury that required you to get medical attention or treatment, other than first aid for MINOR INJURIES; OR to be unable to do some of your work activities; OR to lose consciousness; OR to transfer to another job.

1. DURING THE PAST 12 MONTHS, that is, since (12 month date) a year ago, have you had any on-the-job injuries?

- 1 Yes
2 No (Section N5, page 52)

7
8-9

2. How many times have you been injured on the job during the past 12 months?

Number of times

3. On what date did your [(most recent) injury/injury before that] happen?

Enter each date in a separate column.

____/____/19____
Month Date Year

10-15

Complete questions 4-21 as appropriate for the first injury before completing them for the next, etc.

4. At the time of your injury on (date in 3) were you working as a (occupation in Check Item 7) for (employer in Check Item 7)?

- 1 Yes (6)
2 No

16

5a. For whom did you work when the injury happened?

Enter name of company, business, organization, or other employer.

Employer
932 Armed Forces - civilian
942 Armed Forces - active duty } (5c)

17-19

b. What kind of business or industry is this? For example, TV and radio manufacturing, retail shoe store, State Labor Department, farm.

Industry

c. What kind of work did you do at that job? For example, electrical engineer, stock clerk, typist, farm.

Occupation

20-22

d. What were your most important activities or duties at that job? For example, types, keeps account books, files, sells cars, operates printing press, finishes concrete.

Duties

Complete from entries in 5a-d. If not clear, ask:

6. Were you --

- An employee of a PRIVATE company, business or individual for wages, salary, or commission? P
A member of the ARMED FORCES? AF
A FEDERAL government employee? S
A STATE government employee? S
A LOCAL government employee? L
Self-employed in OWN business, professional practice, or farm? L
ASK: Is the business incorporated?
Yes I
No SE
Working WITHOUT PAY in family business or farm? WP

Class of worker

- 1 P
2 AF
3 F
4 S
5 L
6 I
7 SE
8 WP

23

6. At the time of this injury, what part of your body was hurt? What kind of injury was it? Anything else?

Part(s) of body 24-25 Kind of Injury 26-27

7. Did you lose consciousness as a result of the injury?

- 1 Yes
2 No

28

8. What were you doing at the time of the injury?

29-30

9. How did the injury happen?

31-32

Go to 10 for this injury

Section N4 – WORK INJURIES – Continued

10. Was the activity you were doing at the time of the injury a NEW or unfamiliar job task?	1 <input type="checkbox"/> Yes (12) 2 <input type="checkbox"/> No	33	
11. Was the activity you were doing at the time of the injury part of your usual job tasks?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	34	
12. Did you see or talk to a medical doctor, nurse, chiropractor, physician's assistant, nurse practitioner or other medical person as a result of this injury?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Check Item 10)	35	
13. Where did you FIRST see or talk to a medical person about this injury?	1 <input type="checkbox"/> Work-site health unit 2 <input type="checkbox"/> Doctor's office (group practice or doctor's clinic) 3 <input type="checkbox"/> Emergency room 4 <input type="checkbox"/> Walk-in clinic 5 <input type="checkbox"/> Hospital outpatient clinic 8 <input type="checkbox"/> Other – Specify _____	36	
CHECK ITEM 10	<i>Refer to question 6:</i>	1 <input type="checkbox"/> "Eye" in 6 (14) 8 <input type="checkbox"/> All others (15)	37
14a. Were you wearing eye protection equipment over your eyes at the time of the injury?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (15)	38	
b. What type of eye protection equipment were you wearing?	1 <input type="checkbox"/> Welding goggles 2 <input type="checkbox"/> Other goggles 3 <input type="checkbox"/> Glasses with side shields 4 <input type="checkbox"/> Glasses without side shields 5 <input type="checkbox"/> Welding helmet 6 <input type="checkbox"/> Face shield 8 <input type="checkbox"/> Other	39	
15a. Did you miss more than half of the day from work on the day of the injury?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	40	
b. OTHER THAN THE DAY OF THE INJURY, how many FULL days of scheduled work did you miss as a result of the injury?	_____ Full days 000 <input type="checkbox"/> None	41-43	
c. (Not counting the (number in 15b) full days), Did you miss any (other) scheduled time from work other than the day of the injury?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (16)	44	
d. (Again, not counting the (number in 15b) full days), How many days did you miss MORE THAN HALF THE DAY from work as a result of the injury?	_____ Days 000 <input type="checkbox"/> None	45-47	
16a. Were you temporarily transferred to another job because of the injury?	1 <input type="checkbox"/> Yes (17) 2 <input type="checkbox"/> No	48	
b. Were you temporarily assigned lighter work or excused from certain duties at work other than the day of the injury?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	49	
17a. Did you report this injury to your employer?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	50	
b. Was a worker's compensation claim filed as a result of this injury?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	51	
18a. Did you change employers as a result of the injury?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (19)	52	
b. Was your salary lower, higher or the same after your change of employers?	1 <input type="checkbox"/> Lower 2 <input type="checkbox"/> Higher 3 <input type="checkbox"/> Same	53	
c. Were you as satisfied, less satisfied or more satisfied with your new employer as with your employer prior to the injury?	1 <input type="checkbox"/> As satisfied 2 <input type="checkbox"/> Less satisfied 3 <input type="checkbox"/> More satisfied } (19 for this injury)	54	

Section N4 – WORK INJURIES – Continued

19a. Did you change the kind of work you do as a result of the injury?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (<i>Check Item 11</i>)	55
<i>Mark box or ask:</i>		0 <input type="checkbox"/> Yes in 18a (19c)	56
b. Was your salary lower, higher or the same after your job change?		1 <input type="checkbox"/> Lower 2 <input type="checkbox"/> Higher 3 <input type="checkbox"/> Same	
c. Were you as satisfied, less satisfied or more satisfied with your new job as with your job prior to the injury?		1 <input type="checkbox"/> As satisfied 2 <input type="checkbox"/> Less satisfied 3 <input type="checkbox"/> More satisfied	57
CHECK ITEM 11	<i>Refer to 18a and 19a:</i>	1 <input type="checkbox"/> "Yes" in 18a OR 19a (21) 8 <input type="checkbox"/> All others (20)	58
20. Did you make a permanent change in your work activities because of this injury?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	59
21. Did you change your off-the-job activities because of this injury?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	60
CHECK ITEM 12	<i>Refer to question 2, section N4:</i>	1 <input type="checkbox"/> Additional injury (4 for next injury) 8 <input type="checkbox"/> All others (Section N5)	61

Notes

Section N5 — SKIN CONDITIONS

Now I will ask about skin conditions.			6
1a. During the past 12 months, that is, since <i>(12 month date)</i> <u>9</u> year ago have you had dermatitis, eczema, or any other red, inflamed skin rash?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No <i>(Section N6, page 54)</i>		
b. During the past 12 months, on about how many days altogether did you have a skin condition? Include days when you used treatment for the condition.	365 <input type="checkbox"/> Every day _____ Days		6-8
2. What parts of your body were affected by this skin condition? <i>Mark all that apply</i>	1 <input type="checkbox"/> Hands 2 <input type="checkbox"/> Arms 3 <input type="checkbox"/> Head, face or neck 8 <input type="checkbox"/> Other body area — <i>Specify</i> <u>7</u> 9 <input type="checkbox"/> DK		9 10 11 12 13
3. During the past 12 months, did you miss at least a full day from work because of your skin condition?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		14
4a. Did any skin condition you had in the past 12 months result from chemicals or other substances which got on your skin?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } <i>(6)</i>		15
b. What chemicals or other substances were these?	_____		16-17
c. Did you get these substances on your skin during the past 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		18
d. Were you at work at your job or business when you got these substances on your skin?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } <i>(6)</i>		19
5a. Was this at your job as a <i>(occupation in Check Item 7)</i> for <i>(employer in Check Item 7)</i> ?	1 <input type="checkbox"/> Yes <i>(6)</i> 2 <input type="checkbox"/> No		20
b. For whom did you work when you got these substances on your skin? Enter name of company, business, organization, or other employer.	Employer 932 <input type="checkbox"/> Armed Forces — Civilian 942 <input type="checkbox"/> Armed Forces — Active duty } <i>(5d)</i>		21-23
c. What kind of business or industry is this? For example, TV and radio manufacturing, retail shoe store, State Labor Department, farm.	Industry		
d. What kind of work did you do at that job? For example, electrical engineer, stock clerk, typist, farmer.	Occupation		24-26
e. What were your most important activities or duties at that job? For example, types, keeps account books, files, sells cars, operates printing press, finishes concrete.	Duties		
f. Were you — An employee of a PRIVATE company, business or individual for wages, salary, or commission? P A member of the ARMED FORCES? AF 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	Class of worker 1 <input type="checkbox"/> P 2 <input type="checkbox"/> AF 3 <input type="checkbox"/> F 4 <input type="checkbox"/> S 5 <input type="checkbox"/> L 6 <input type="checkbox"/> I 7 <input type="checkbox"/> SE 8 <input type="checkbox"/> WP		27
6a. During the past 12 months, did you use any prescription medications or other treatments prescribed by a doctor for your skin condition?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28
b. Did you use any over-the-counter or non-prescription medications or treatments for your skin condition?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		29

Section N6 – EYE, NOSE, THROAT IRRITATION – Continued

9a. Did you have these symptoms while you were at work?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (10)	67
b. When you were away from work, did these symptoms increase, decrease or stay the same?	1 <input type="checkbox"/> Increase 2 <input type="checkbox"/> Decrease 3 <input type="checkbox"/> Stay the same	68
10. During the past 2 weeks when you had these symptoms, did you also have a fever?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	69

Notes

Section N7 — CONDITIONS

I am going to read a list of medical conditions. Tell me if you have had any of these conditions even if you have mentioned them before.

1. DURING THE PAST 12 MONTHS, that is, since (12 month date) a year ago, have you had —

a. REPEATED trouble with neck, back or spine?

Yes	No	
1 <input type="checkbox"/> — Specify <input checked="" type="checkbox"/>	2 <input type="checkbox"/>	70

b. A condition affecting the wrist and hand, called carpal tunnel syndrome?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	71
----------------------------	----------------------------	----

c. A condition affecting the fingers and/or toes, called Raynaud's (Rā'nōdes) phenomenon?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	72
----------------------------	----------------------------	----

d. A condition affecting the tendons called tendonitis?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	73
----------------------------	----------------------------	----

DURING THE PAST 12 MONTHS have you had —

e. Hepatitis?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	74
----------------------------	----------------------------	----

f. Skin cancer?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	75
----------------------------	----------------------------	----

g. Lung cancer?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	76
----------------------------	----------------------------	----

h. Asthma?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	77
----------------------------	----------------------------	----

i. Chronic bronchitis?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	78
----------------------------	----------------------------	----

j. Emphysema?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	79
----------------------------	----------------------------	----

k. Any dust disease of the lungs, such as silicosis, asbestosis, brown lung, or black lung disease?

1 <input type="checkbox"/> — Specify <input checked="" type="checkbox"/>	2 <input type="checkbox"/>	80
--	----------------------------	----

2. Do you NOW have —

a. Deafness in one or both ears?

Yes	No	
1 <input type="checkbox"/>	2 <input type="checkbox"/>	81

b. Any other trouble hearing in one or both ears?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	82
----------------------------	----------------------------	----

CHECK ITEM 15

Refer to questions 1 and 2:

1 "No" or "DK" in ALL of 1 and 2 (Section N8, page 59)
 8 "Yes" in any part of 1 or 2 (Fill a column for each condition)

83

Notes

Section N7 – CONDITIONS – Continued

CONDITION 1

Name of Condition _____

3. Were you ever told by a doctor or other medical person that your (condition) was related to any job you ever had? 9
 1 Yes
 2 No

4. Was a worker's compensation claim ever filed for your (condition)? 10
 1 Yes (6)
 2 No

5. Did you ever report to your employer or to other company personnel that your (condition) was related to your job? 11
 1 Yes
 2 No

6. Did you ever tell a doctor or other medical person that your (condition) was related to any job you ever had? 12
 1 Yes
 2 No

CHECK ITEM 16 13
Refer to Check Item 7, page 39.
 1 Entries in Check Item 7 (7)
 8 All others (8)

7a. DURING THE PAST 12 MONTHS, were you told by your doctor or employer to stay home from work temporarily because of your (condition)? 14
 1 Yes
 2 No

b. DURING THE PAST 12 MONTHS, did your employer transfer you to another job, either temporarily or permanently, because of your (condition)? 15
 1 Yes (Check Item 17)
 2 No

c. DURING THE PAST 12 MONTHS, did your employer give you lighter work or excuse you from certain duties at work because of your (condition)? 16
 1 Yes
 2 No

8. Did you EVER stop working at a job or change jobs because of your (condition)? 17
 1 Yes
 2 No

CHECK ITEM 17 18
Refer to 3, 4, 5, 6:
 1 "Yes" in 3, 4, 5 OR 6 (9)
 8 All others (NC)

9a. What kind of work did you do that was related to your (condition)? For example, electrical engineer, stock clerk, typist, farmer. 19-21
 Occupation

b. What were your most important activities or duties at that job? For example, types, keeps account books, files, sells cars, operates printing press, finishes concrete. 22-24
 Duties

c. In what kind of business or industry did you work the longest as a (entry in 9a)? For example, TV and radio manufacturing, retail shoe store, State Labor Department, farm. 22-24
 Industry

d. In the industry where you worked the longest as a (entry in 9a) were you — 25
 An employee of a PRIVATE company, business or individual for wages, salary, or commission? P
 A member of the ARMED FORCES? AF
 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

Class of worker
 1 P
 2 AF
 3 F
 4 S
 5 L
 6 I
 7 SE
 8 WP

} (NC)

Notes

Section N6 – EYE, NOSE, THROAT IRRITATION

CHECK ITEM 14	Refer to HIS-1, C1:	1 <input type="checkbox"/> Wa box marked (1) 8 <input type="checkbox"/> All others (Section N7, page 56)	41
These questions are about eye, nose and throat irritation. Hand calendar			42
1a. During the past 2 weeks (outlined in red on that calendar), beginning Monday (date), and ending this past Sunday (date), have you had any episodes of itchy, irritated or watery eyes?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (4)	
b. On how many days during the past 2 weeks did you have itchy, irritated or watery eyes?		_____ Days	43-44
c. Were these symptoms due to a cold or flu, hay fever, other allergies, or something else?		1 <input type="checkbox"/> Cold or flu (4) 2 <input type="checkbox"/> Hay fever 3 <input type="checkbox"/> Other allergies 8 <input type="checkbox"/> Something else – Specify ↴ _____	45
2a. Did you have these symptoms while you were at work?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (3)	46
b. When you were away from work, did these symptoms increase, decrease, or stay the same?		1 <input type="checkbox"/> Increase 2 <input type="checkbox"/> Decrease 3 <input type="checkbox"/> Stay the same	47
3. During the past 2 weeks when you had these symptoms, did you also have a fever?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	48
4a. Do you wear contact lenses?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)	49
b. What type of contact lenses do you wear? Mark all that apply.		1 <input type="checkbox"/> Hard lens(es) (include polycron) 2 <input type="checkbox"/> Soft lens(es), daily wear 3 <input type="checkbox"/> Soft lens(es), extended wear 4 <input type="checkbox"/> Intraocular lens(es) 8 <input type="checkbox"/> Other – Specify ↴ _____ 9 <input type="checkbox"/> DK	50 51 52 53 54
5a. During the past 2 weeks, have you had any episodes of stuffy, blocked, itchy, or runny nose?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (8)	55 56
b. On how many days during the past 2 weeks did you have stuffy, blocked, itchy or runny nose?		_____ Days	57-58
c. Were these symptoms due to a cold or flu, hay fever, other allergies, or something else?		1 <input type="checkbox"/> Cold or flu (8) 2 <input type="checkbox"/> Hay fever 3 <input type="checkbox"/> Other allergies 8 <input type="checkbox"/> Something else – Specify ↴ _____	59
6a. Did you have these symptoms while you were at work?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (7)	60
b. When you were away from work, did these symptoms increase, decrease, or stay the same?		1 <input type="checkbox"/> Increase 2 <input type="checkbox"/> Decrease 3 <input type="checkbox"/> Stay the same	61
7. During the past 2 weeks when you had these symptoms, did you also have a fever?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	62
8a. During the past 2 weeks, have you had any episodes of sore or dry throat?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Section N7, page 56)	63
b. On how many days during the past 2 weeks did you have sore or dry throat?		_____ Days	64-65
c. Were these symptoms due to a cold or flu, hay fever, other allergies, or something else?		1 <input type="checkbox"/> Cold or flu (Section N7, page 56) 2 <input type="checkbox"/> Hay fever 3 <input type="checkbox"/> Other allergies 8 <input type="checkbox"/> Something else – Specify ↴ _____	66

Section N8 – CIGARETTE SMOKING

These questions are about smoking cigarettes.

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

- 1 Yes
2 No (Section O)

5

2. About how old were you when you first started smoking cigarettes fairly regularly?

- 00 Never smoked regularly
_____ Years

6-7

3. Do you smoke cigarettes now?

- 1 Yes (5)
2 No

8

Mark box or ask:

4. About how long has it been since you last smoked cigarettes fairly regularly?

- 000 Never smoked regularly (Section O)
Number { 1 Days
2 Weeks
3 Months
4 Years

9-11

5. On the average, about how many cigarettes a day [do/did] you smoke?

- 00 Less than one cigarette per day
_____ Cigarettes per day

12-13

Notes

Section 0 — ALCOHOL

Section 01 — ALCOHOL SCREENING AND ABSTAINER

3-4

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

1a. In YOUR ENTIRE LIFE, have you had at least 12 drinks of any kind of alcoholic beverage?

- 1 Yes
- 2 No (2)

5

b. In the PAST 12 MONTHS did you have at least 12 drinks of ANY kind of alcoholic beverage?

- 1 Yes (Section 03, page 67)
- 2 No

6

c. In ANY ONE YEAR of your entire life did you have at least 12 drinks of ANY kind of alcoholic beverage?

- 1 Yes (Section 04, page 73)
- 2 No (Section 02, page 63)

7

Hand Card 01, read list if telephone interview.

2a. (Please look at this list and tell me) What are your reasons for not drinking?

Anything else?

Mark all mentioned.

- 01 Don't socialize very much
- 02 Don't care for it or dislike it
- 03 Am an alcoholic
- 04 Thought I might become an alcoholic
- 05 Had problems with my drinking
- 06 Have a responsibility to my family
- 07 Family member an alcoholic or problem drinker
- 08 Medical or health reasons
- 09 Religious or moral reasons
- 10 Brought up not to drink
- 11 Makes me sick
- 12 Can't control my drinking
- 13 Costs too much or can't afford it
- 14 Dieting or too fattening
- 88 Other
- 99 DK

- 8-9
- 10-11
- 12-13
- 14-16
- 16-17
- 18-19
- 20-21
- 22-23
- 24-25
- 26-27
- 28-29
- 30-31
- 32-33
- 34-36
- 36-37
- 38-39

If only one reason in 2a, mark box without asking; otherwise, ask:

b. Of the reasons you have just told me, which of these is your MOST IMPORTANT reason for not drinking?

- 01 Don't socialize very much
- 02 Don't care for it or dislike it
- 03 Am an alcoholic
- 04 Thought I might become an alcoholic
- 05 Had problems with my drinking
- 06 Have a responsibility to my family
- 07 Family member an alcoholic or problem drinker
- 08 Medical or health reasons
- 09 Religious or moral reasons
- 10 Brought up not to drink
- 11 Makes me sick
- 12 Can't control my drinking
- 13 Costs too much or can't afford it
- 14 Dieting or too fattening
- 88 Other
- 99 DK

40-41

People have different opinions about heavy, moderate and light drinking. We would like to know how OFTEN and how MUCH you think a person must drink in order to be considered a heavy, moderate or light drinker.

3a. In your opinion, how OFTEN must a person drink in order to be considered a HEAVY drinker?

- 0000 Everyday
 - _____ Days per
 - 9999 DK (4)
- 1 Week
 - 2 Month
 - 3 Year

42-45

b. On those days, how MANY DRINKS must a person have in order to be considered a HEAVY drinker?

- _____ Drinks
- 99 DK

46-47

4a. In your opinion, how OFTEN must a person drink in order to be considered a MODERATE drinker?

- 0000 Everyday
 - _____ Days per
 - 9999 DK (5)
- 1 Week
 - 2 Month
 - 3 Year

48-51

b. On those days, how MANY DRINKS must a person have in order to be considered a MODERATE drinker?

- _____ Drinks
- 99 DK

52-53

5a. In your opinion, how OFTEN must a person drink in order to be considered a LIGHT drinker?

- 0000 Everyday
 - _____ Days per
 - 9999 DK (6)
- 1 Week
 - 2 Month
 - 3 Year

54-57

b. On those days, how MANY DRINKS must a person have in order to be considered a LIGHT drinker?

- _____ Drinks
- 99 DK

58-59

Section 01 – ALCOHOL SCREENING AND ABSTAINER – Continued

6a. When you were growing up, that is, during your first 18 years, did you live with anyone who was a problem drinker or alcoholic?

- 1 Yes
 2 No } (7)
 9 DK }

80

b. Who was this?

Anyone else?

If parent, ask: Was this your biological (natural), adoptive, step, or foster [mother/father]?

If brother/sister, ask: Was this your full, half, adoptive, step, or foster [brother/sister]?

Record up to first 5 mentioned.

Ask 6c for each person in 6b.

c. For how long did you live with (person in 6b) while (person in 6b) was a problem drinker or alcoholic?

1) _____	61-62	_____	{ 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	63-65
2) _____	66-67	_____	{ 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	68-70
3) _____	71-72	_____	{ 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	73-75
4) _____	76-77	_____	{ 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	78-80
5) _____	81-82	_____	{ 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	83-85

7a. Have any of your (other) blood relatives EVER been a problem drinker or alcoholic?

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

86

b. Who was this?

Anyone else?

Mark all mentioned.

If necessary, probe as indicated in 6b.

- 1 Biological mother
 2 Biological father
 1 Biological brother(s)
 2 Biological sister(s)
 1 Half brother(s)
 2 Half sister(s)
 1 Biological son(s)
 2 Biological daughter(s)
 1 Grandmother(s)
 2 Grandfather(s)
 1 Aunt(s)
 2 Uncle(s)
 1 Niece(s)
 2 Nephew(s)
 1 Cousin(s)
 2 Other blood relative(s)
 1 DK

87
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101
102
103

8. Have you ever been married to, or lived with someone as if you were married, who was a problem drinker or alcoholic?

- 1 Yes
 2 No

104

Notes

Section 01 — ALCOHOL SCREENING AND ABSTAINER — Continued

Refer to Table B on the Cover Page and ask for each person listed except the sample person.

If personal interview — hand Card O2 and read first alternative wording.

If telephone interview — read second alternative wording and the list of answer categories.

9a. Please look at this card and tell me which number best describes — drinking during the past year.
I am going to read a list of different drinking categories, please tell me which one best describes — drinking in the past year.

Person No. _____

- 1 Heavy
- 2 Moderate
- 3 Light
- 4 Very light or occasional
- 5 Quit drinking
- 6 Never drank
- 9 DK

b. What about — drinking?

Person No. _____

- 1 Heavy
- 2 Moderate
- 3 Light
- 4 Very light or occasional
- 5 Quit drinking
- 6 Never drank
- 9 DK

c. What about — drinking?

Person No. _____

- 1 Heavy
- 2 Moderate
- 3 Light
- 4 Very light or occasional
- 5 Quit drinking
- 6 Never drank
- 9 DK

d. What about — drinking?

Person No. _____

- 1 Heavy
- 2 Moderate
- 3 Light
- 4 Very light or occasional
- 5 Quit drinking
- 6 Never drank
- 9 DK

e. What about — drinking?

Person No. _____

- 1 Heavy
- 2 Moderate
- 3 Light
- 4 Very light or occasional
- 5 Quit drinking
- 6 Never drank
- 9 DK

f. What about — drinking?

Person No. _____

- 1 Heavy
- 2 Moderate
- 3 Light
- 4 Very light or occasional
- 5 Quit drinking
- 6 Never drank
- 9 DK

10. Tell me whether or not you have EVER had any of the following conditions even if you have mentioned them before —

- a. Hypertension or high blood pressure (excluding during pregnancy)?
- b. Hardening of the arteries?
- c. Any heart disease?
- d. Arthritis or rheumatism?
- e. An ulcer, not including skin ulcers?
- f. Diabetes?
- g. Any disease of the liver, such as yellow jaundice, hepatitis or cirrhosis?
- h. Cancer, other than skin cancer?
- i. Alcoholism?

- | | Yes | No |
|---|--------------------------|----------------------------|
| 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |

CHECK ITEM 1

Mark one box, then go to HIS-1B(AIDS).

- 1 SP alone during interview
- 2 Child(ren) present during interview
- 3 Other adult(s) present during interview
- 4 Child(ren) and other adult(s) present during interview
- 5 Telephone interview

Section 02 – LIFETIME INFREQUENT DRINKER

1. Not counting small tastes, how old were you when you started drinking alcoholic beverages?	_____ Years 99 <input type="checkbox"/> DK	33-34																
2. In the PAST 12 MONTHS about how many drinks of ANY kind of alcoholic beverage did you have?	00 <input type="checkbox"/> None _____ Drinks 99 <input type="checkbox"/> DK	35-36																
3. When did you have your last drink of any kind of alcoholic beverage?	_____ 19 _____ Month Year 9999 <input type="checkbox"/> DK	37-40																
4. What type of alcoholic beverage [do/did] you PREFER to drink – beer, wine, or liquor? <i>Mark only one box.</i>	1 <input type="checkbox"/> Beer 2 <input type="checkbox"/> Wine 3 <input type="checkbox"/> Liquor 4 <input type="checkbox"/> No preference 9 <input type="checkbox"/> DK	41																
5. When you [drink/drank] who [do/did] you USUALLY drink with – friends, relatives, people from work, other people, or by yourself? <i>Mark only one box.</i>	1 <input type="checkbox"/> Friends 2 <input type="checkbox"/> Relatives 3 <input type="checkbox"/> People from work 4 <input type="checkbox"/> Other people 5 <input type="checkbox"/> Self 9 <input type="checkbox"/> DK	42																
<i>Hand Card 01, read list if telephone interview.</i> 6a. (Please look at this list and tell me) What are your reasons for not drinking very much? Anything else? <i>Mark all mentioned.</i>	01 <input type="checkbox"/> Don't socialize very much 02 <input type="checkbox"/> Don't care for it or dislike it 03 <input type="checkbox"/> Am an alcoholic 04 <input type="checkbox"/> Thought I might become an alcoholic 05 <input type="checkbox"/> Had problems with my drinking 06 <input type="checkbox"/> Have a responsibility to my family 07 <input type="checkbox"/> Family member an alcoholic or problem drinker 08 <input type="checkbox"/> Medical or health reasons 09 <input type="checkbox"/> Religious or moral reasons 10 <input type="checkbox"/> Brought up not to drink 11 <input type="checkbox"/> Makes me sick 12 <input type="checkbox"/> Can't control my drinking 13 <input type="checkbox"/> Costs too much or can't afford it 14 <input type="checkbox"/> Dieting or too fattening 88 <input type="checkbox"/> Other 99 <input type="checkbox"/> DK	<table border="1" style="font-size: small; border-collapse: collapse;"> <tr><td>43-44</td></tr> <tr><td>45-46</td></tr> <tr><td>47-48</td></tr> <tr><td>49-50</td></tr> <tr><td>51-52</td></tr> <tr><td>53-54</td></tr> <tr><td>55-56</td></tr> <tr><td>57-58</td></tr> <tr><td>59-60</td></tr> <tr><td>61-62</td></tr> <tr><td>63-64</td></tr> <tr><td>65-66</td></tr> <tr><td>67-68</td></tr> <tr><td>69-70</td></tr> <tr><td>71-72</td></tr> <tr><td>73-74</td></tr> </table>	43-44	45-46	47-48	49-50	51-52	53-54	55-56	57-58	59-60	61-62	63-64	65-66	67-68	69-70	71-72	73-74
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59-60																		
61-62																		
63-64																		
65-66																		
67-68																		
69-70																		
71-72																		
73-74																		
<i>If only one reason in 6a, mark box without asking; otherwise, ask:</i> b. Of the reasons you have told me, which of these is your MOST IMPORTANT reason for not drinking very much?	01 <input type="checkbox"/> Don't socialize very much 02 <input type="checkbox"/> Don't care for it or dislike it 03 <input type="checkbox"/> Am an alcoholic 04 <input type="checkbox"/> Thought I might become an alcoholic 05 <input type="checkbox"/> Had problems with my drinking 06 <input type="checkbox"/> Have a responsibility to my family 07 <input type="checkbox"/> Family member an alcoholic or problem drinker 08 <input type="checkbox"/> Medical or health reasons 09 <input type="checkbox"/> Religious or moral reasons 10 <input type="checkbox"/> Brought up not to drink 11 <input type="checkbox"/> Makes me sick 12 <input type="checkbox"/> Can't control my drinking 13 <input type="checkbox"/> Costs too much or can't afford it 14 <input type="checkbox"/> Dieting or too fattening 88 <input type="checkbox"/> Other 99 <input type="checkbox"/> DK	75-76																
Notes																		

Section 02 — LIFETIME INFREQUENT DRINKER — Continued

<p>People have different opinions about heavy, moderate and light drinking. We would like to know how OFTEN and how MUCH you think a person must drink in order to be considered a heavy, moderate or light drinker.</p> <p>7a. In your opinion, how OFTEN must a person drink in order to be considered a HEAVY drinker?</p>	<p align="right">77-80</p> <p>0000 <input type="checkbox"/> Everyday _____ Days per 9999 <input type="checkbox"/> DK (8)</p> <p style="font-size: 2em;">}</p> <p style="margin-left: 20px;">1 <input type="checkbox"/> Week 2 <input type="checkbox"/> Month 3 <input type="checkbox"/> Year</p>
<p>b. On those days, how MANY DRINKS must a person have in order to be considered a HEAVY drinker?</p>	<p align="right">81-82</p> <p>_____ Drinks 99 <input type="checkbox"/> DK</p>
<p>8a. In your opinion, how OFTEN must a person drink in order to be considered a MODERATE drinker?</p>	<p align="right">83-86</p> <p>0000 <input type="checkbox"/> Everyday _____ Days per 9999 <input type="checkbox"/> DK (9)</p> <p style="font-size: 2em;">}</p> <p style="margin-left: 20px;">1 <input type="checkbox"/> Week 2 <input type="checkbox"/> Month 3 <input type="checkbox"/> Year</p>
<p>b. On those days, how MANY DRINKS must a person have in order to be considered a MODERATE drinker?</p>	<p align="right">87-88</p> <p>_____ Drinks 99 <input type="checkbox"/> DK</p>
<p>9a. In your opinion, how OFTEN must a person drink in order to be considered a LIGHT drinker?</p>	<p align="right">89-92</p> <p>0000 <input type="checkbox"/> Everyday _____ Days per 9999 <input type="checkbox"/> DK (10)</p> <p style="font-size: 2em;">}</p> <p style="margin-left: 20px;">1 <input type="checkbox"/> Week 2 <input type="checkbox"/> Month 3 <input type="checkbox"/> Year</p>
<p>b. On those days, how MANY DRINKS must a person have in order to be considered a LIGHT drinker?</p>	<p align="right">93-94</p> <p>_____ Drinks 99 <input type="checkbox"/> DK</p>
<p>10a. When you were growing up, that is, during your first 18 years, did you live with anyone who was a problem drinker or alcoholic?</p>	<p align="right">95</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (11)</p>
<p>b. Who was this? Anyone else? If parent, ask: Was this your biological (natural), adoptive, step, or foster [mother/father]? If brother/sister, ask: Was this your full, half, adoptive, step, or foster [brother/sister]? Record up to first 5 mentioned.</p>	<p align="right">96-97</p> <p>1) _____</p>
<p>c. For how long did you live with (person in 10b) while (person in 10b) was a problem drinker or alcoholic?</p>	<p align="right">98-100</p> <p>_____</p> <p style="font-size: 2em;">}</p> <p style="margin-left: 20px;">1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p>
<p>2) _____</p>	<p align="right">101-102</p> <p>_____</p> <p style="font-size: 2em;">}</p> <p style="margin-left: 20px;">1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p>
<p>3) _____</p>	<p align="right">106-107</p> <p>_____</p> <p style="font-size: 2em;">}</p> <p style="margin-left: 20px;">1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p>
<p>4) _____</p>	<p align="right">111-112</p> <p>_____</p> <p style="font-size: 2em;">}</p> <p style="margin-left: 20px;">1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p>
<p>5) _____</p>	<p align="right">116-117</p> <p>_____</p> <p style="font-size: 2em;">}</p> <p style="margin-left: 20px;">1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p>

Section O2 — LIFETIME INFREQUENT DRINKER — Continued

3-4

11 a. Have any of your (other) blood relatives EVER been problem drinkers or alcoholics?

- 1 Yes
- 2 No
- 9 DK } (12)

5

b. Who was this?

Anyone else?

Mark all mentioned.

If necessary, probe as indicated in 10b.

- 1 Biological mother
- 2 Biological father
- 1 Biological brother(s)
- 2 Biological sister(s)
- 1 Half brother(s)
- 2 Half sister(s)
- 1 Biological son(s)
- 2 Biological daughter(s)
- 1 Grandmother(s)
- 2 Grandfather(s)
- 1 Aunt(s)
- 2 Uncle(s)
- 1 Niece(s)
- 2 Nephew(s)
- 1 Cousin(s)
- 2 Other blood relative(s)
- 1 DK

- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21
- 22

12. Have you ever been married to, or lived with someone as if you were married, who was a problem drinker or alcoholic?

- 1 Yes
- 2 No

23

Refer to Table B on the Cover Page and ask for each person listed except the sample person.

If personal interview — hand Card O2 and read first alternative wording.

If telephone interview — read second alternative wording and the list of answer categories.

13a. Please look at this card and tell me which number best describes — drinking during the past year.
I am going to read a list of different drinking categories, please tell me which one best describes — drinking in the past year.

- Person No. _____
- 1 Heavy
 - 2 Moderate
 - 3 Light
 - 4 Very light or occasional
 - 5 Quit drinking
 - 6 Never drank
 - 9 DK

24-25

26

b. What about — drinking?

- Person No. _____
- 1 Heavy
 - 2 Moderate
 - 3 Light
 - 4 Very light or occasional
 - 5 Quit drinking
 - 6 Never drank
 - 9 DK

27-28

c. What about — drinking?

- Person No. _____
- 1 Heavy
 - 2 Moderate
 - 3 Light
 - 4 Very light or occasional
 - 5 Quit drinking
 - 6 Never drank
 - 9 DK

29

30-31

d. What about — drinking?

- Person No. _____
- 1 Heavy
 - 2 Moderate
 - 3 Light
 - 4 Very light or occasional
 - 5 Quit drinking
 - 6 Never drank
 - 9 DK

32

33-34

e. What about — drinking?

- Person No. _____
- 1 Heavy
 - 2 Moderate
 - 3 Light
 - 4 Very light or occasional
 - 5 Quit drinking
 - 6 Never drank
 - 9 DK

35

36-37

f. What about — drinking?

- Person No. _____
- 1 Heavy
 - 2 Moderate
 - 3 Light
 - 4 Very light or occasional
 - 5 Quit drinking
 - 6 Never drank
 - 9 DK

38

39-40

41

Section 03 — CURRENT DRINKER — Continued

RT 85

INTRO

I have asked you about beer, wine, and liquor separately.
Now I want you to think about them combined.

3-4

<p><i>Refer to questions 4b, 5b, and 6b</i> 8a. During that 2-week period, did you have more than (largest number in 4b, 5b, or 6b) drink(s) on a single day?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (9)</p>	<p>5</p>
<p>b. On how many days did you have more than (largest number in 4b, 5b, or 6b) drink(s) of beer, or wine, or liquor?</p>	<p>_____ Days 01 <input type="checkbox"/> One day only (8e)</p>	<p>6-7</p>
<p>c. What was the largest number of drinks you had on any one of those days?</p>	<p>_____ Drinks</p>	<p>8-9</p>
<p>d. On how many days during that 2-week period did you have (number in 8c) drinks?</p>	<p>_____ Days (9)</p>	<p>10-11</p>
<p>e. How many drinks did you have on that day?</p>	<p>_____ Drinks</p>	<p>12-13</p>
<p>9a. Was the amount of your drinking during that 2-week period typical of your drinking during the past 12 months?</p>	<p>1 <input type="checkbox"/> Yes (9c) 2 <input type="checkbox"/> No</p>	<p>14</p>
<p>b. Was the amount of your drinking during that 2-week period MORE OR LESS than your drinking during the past 12 months?</p>	<p>1 <input type="checkbox"/> More } (16) 2 <input type="checkbox"/> Less }</p>	<p>15</p>
<p>c. For how many years has this been typical of your drinking?</p>	<p>_____ Years } (16) 00 <input type="checkbox"/> Less than one }</p>	<p>16-17</p>
<p>Let's talk about the 2-week period ending the day you had your last drink. Please include that last day. b. During that 2-week period, on how many days did you drink any beer?</p>	<p>_____ Days 00 <input type="checkbox"/> None or never (11)</p>	<p>18-19</p>
<p>On the day(s) when you drank beer, about how many beers did you drink a day?</p>	<p>99 <input type="checkbox"/> DK _____ Beers</p>	<p>20-21</p>
<p>c. About how many ounces were in a typical can or bottle or glass of beer that you drank during that period?</p>	<p>_____ Ounces 99.99 <input type="checkbox"/> DK</p>	<p>22-26</p>
<p>1 a. During that 2-week period, on how many days did you drink any wine?</p>	<p>_____ Days 00 <input type="checkbox"/> None or never (12)</p>	<p>27-28</p>
<p>b. On the day(s) when you drank wine, about how many glasses of wine did you drink a day?</p>	<p>99 <input type="checkbox"/> DK _____ Glasses</p>	<p>29-30</p>
<p>c. About how many ounces of wine were in a typical glass that you drank during that period?</p>	<p>_____ Ounces 99.99 <input type="checkbox"/> DK</p>	<p>31-35</p>
<p>2a. During that 2-week period, on how many days did you drink any liquor, such as whiskey, rum, gin, or vodka?</p>	<p>_____ Days 00 <input type="checkbox"/> None or never (Check Item 4)</p>	<p>36-37</p>
<p>b. On the day(s) when you drank liquor, about how many drinks did you have a day?</p>	<p>99 <input type="checkbox"/> DK _____ Drinks</p>	<p>38-39</p>
<p>c. About how many ounces of liquor were in a typical drink that you had during that period?</p>	<p>_____ Ounces 99.99 <input type="checkbox"/> DK</p>	<p>40-44</p>
<p>CHECK ITEM 4</p>	<p><i>Refer to 10a, 11a, and 12a. Mark first appropriate box.</i></p>	<p>1 <input type="checkbox"/> Only one beverage type (14) 2 <input type="checkbox"/> 14 days in 10a, 11a, or 12a (14) 8 <input type="checkbox"/> Other (13)</p>

Section 03 – CURRENT DRINKER – Continued

<p>I have asked you about beer, wine and liquor separately. Now I want you to think about them combined.</p> <p>13. Still thinking about the same 2-week period, on how many days altogether did you drink alcoholic beverages, that is, beer, wine, or liquor?</p>	<p align="right">46-47</p> <p>01 <input type="checkbox"/> One day only</p> <p>_____ Days</p>
<p>14a. Was the amount of your drinking during that 2-week period typical of your drinking during the previous 12 months?</p>	<p align="right">48</p> <p>1 <input type="checkbox"/> Yes (14c)</p> <p>2 <input type="checkbox"/> No</p>
<p>b. During that 2-week period, did you drink MORE OR LESS than usual?</p>	<p align="right">49</p> <p>1 <input type="checkbox"/> More } (15)</p> <p>2 <input type="checkbox"/> Less }</p>
<p>c. For how many years has this been typical of your drinking?</p>	<p align="right">50-51</p> <p>00 <input type="checkbox"/> Less than one year</p> <p>_____ Years</p>
<p><i>Hand Card O1, read list if telephone interview.</i></p> <p>15a. (Please look at this list and tell me) What are your reasons for not drinking since (date in 3c)?</p> <p>Anything else?</p> <p><i>Mark all mentioned</i></p>	<p>01 <input type="checkbox"/> Don't socialize very much 52-53</p> <p>02 <input type="checkbox"/> Don't care for it/dislike it 54-55</p> <p>03 <input type="checkbox"/> Am an alcoholic 56-57</p> <p>04 <input type="checkbox"/> Thought I might become an alcoholic 58-59</p> <p>05 <input type="checkbox"/> Had problems with my drinking 60-61</p> <p>06 <input type="checkbox"/> Have a responsibility to my family 62-63</p> <p>07 <input type="checkbox"/> Family member an alcoholic or problem drinker 64-65</p> <p>08 <input type="checkbox"/> Medical or health reasons 66-67</p> <p>09 <input type="checkbox"/> Religious or moral reasons 68-69</p> <p>10 <input type="checkbox"/> Brought up not to drink 70-71</p> <p>11 <input type="checkbox"/> Makes me sick 72-73</p> <p>12 <input type="checkbox"/> Can't control my drinking 74-75</p> <p>13 <input type="checkbox"/> Costs too much or can't afford it 76-77</p> <p>14 <input type="checkbox"/> Dieting or too fattening 78-79</p> <p>88 <input type="checkbox"/> Other 80-</p> <p>99 <input type="checkbox"/> DK 8</p>
<p><i>If only one reason in 15a, mark box without asking ; otherwise ask:</i></p> <p>b. Of the reasons you have told me, which of these is your MOST IMPORTANT reason for not drinking since (date in 3c)?</p>	<p align="right">84-</p> <p>01 <input type="checkbox"/> Don't socialize very much</p> <p>02 <input type="checkbox"/> Don't care for it/dislike it</p> <p>03 <input type="checkbox"/> Am an alcoholic</p> <p>04 <input type="checkbox"/> Thought I might become an alcoholic</p> <p>05 <input type="checkbox"/> Had problems with my drinking</p> <p>06 <input type="checkbox"/> Have a responsibility to my family</p> <p>07 <input type="checkbox"/> Family member an alcoholic or problem drinker</p> <p>08 <input type="checkbox"/> Medical or health reasons</p> <p>09 <input type="checkbox"/> Religious or moral reasons</p> <p>10 <input type="checkbox"/> Brought up not to drink</p> <p>11 <input type="checkbox"/> Makes me sick</p> <p>12 <input type="checkbox"/> Can't control my drinking</p> <p>13 <input type="checkbox"/> Costs too much or can't afford it</p> <p>14 <input type="checkbox"/> Dieting or too fattening</p> <p>88 <input type="checkbox"/> Other</p> <p>99 <input type="checkbox"/> DK</p>
<p>c. Do you think you will probably drink again or have you stopped drinking permanently?</p>	<p align="right">86</p> <p>1 <input type="checkbox"/> Will probably drink again</p> <p>2 <input type="checkbox"/> Stopped permanently</p> <p>8 <input type="checkbox"/> Other</p> <p>9 <input type="checkbox"/> DK</p>
<p>16a. (Thinking about the 12 months before your last drink) Did you have at least one drink in every month [last year/of that year]?</p>	<p align="right">87</p> <p>1 <input type="checkbox"/> Yes (17)</p> <p>2 <input type="checkbox"/> No</p>
<p>b. In how many months did you have at least one drink?</p>	<p align="right">88-89</p> <p>_____ Months</p> <p>00 <input type="checkbox"/> None (18)</p>
<p>17a. During [that month/those months], on how many DAYS did you have 9 or more drinks of ANY alcoholic beverage?</p>	<p align="right">90-92</p> <p>_____ Days</p> <p>000 <input type="checkbox"/> None</p>
<p>b. During [that month/those months], on how many DAYS did you have 5 or more drinks of ANY alcoholic beverage? (Include the (number in 17a) days you had 9 or more drinks.)</p>	<p align="right">93-95</p> <p>_____ Days</p> <p>000 <input type="checkbox"/> None</p>

Section 03 – CURRENT DRINKER – Continued

18. Do you NOW consider yourself to be a heavy, moderate, light, very light or occasional drinker?	<input type="checkbox"/> 1 Heavy <input type="checkbox"/> 2 Moderate <input type="checkbox"/> 3 Light <input type="checkbox"/> 4 Very light or occasional <input type="checkbox"/> 5 Quit drinking	3-4 5
---	--	----------

19a. In your ENTIRE LIFE, when you drank the MOST, about how often did you drink?	<input type="checkbox"/> 0000 Everyday _____ Days per { <input type="checkbox"/> 1 Week <input type="checkbox"/> 2 Month <input type="checkbox"/> 3 Year <input type="checkbox"/> 9999 DK	6-9
--	---	-----

b. On these days, about how many drinks did you have a day?	_____ Drinks <input type="checkbox"/> 99 DK	10-11
--	--	-------

c. For how long of a period did you drink this amount?	_____ Number { <input type="checkbox"/> 1 Days <input type="checkbox"/> 2 Weeks <input type="checkbox"/> 3 Months <input type="checkbox"/> 4 Years <input type="checkbox"/> 9999 DK	12-15
---	---	-------

20. (Before you stopped drinking) What type of alcoholic beverage [do/did] you PREFER to drink – beer, wine, or liquor? <i>Mark only one box.</i>	<input type="checkbox"/> 1 Beer <input type="checkbox"/> 2 Wine <input type="checkbox"/> 3 Liquor <input type="checkbox"/> 4 No preference <input type="checkbox"/> 9 DK	16
---	--	----

21. (Before you stopped drinking) When you drink who [did/do] you USUALLY drink with – friends, relatives, people from work, other people, or by yourself? <i>Mark only one box.</i>	<input type="checkbox"/> 1 Friends <input type="checkbox"/> 2 Relatives <input type="checkbox"/> 3 People from work <input type="checkbox"/> 4 Other people <input type="checkbox"/> 5 Self <input type="checkbox"/> 9 DK	17
--	--	----

22a. In your opinion, how OFTEN must a person drink in order to be considered a HEAVY drinker?	<input type="checkbox"/> 0000 Everyday _____ Days per { <input type="checkbox"/> 1 Week <input type="checkbox"/> 2 Month <input type="checkbox"/> 3 Year <input type="checkbox"/> 9999 DK (23)	18-21
---	--	-------

b. On those days, how MANY DRINKS must a person have in order to be considered a HEAVY drinker?	_____ Drinks <input type="checkbox"/> 99 DK	22-23
--	--	-------

23a. In your opinion, how OFTEN must a person drink in order to be considered a MODERATE drinker?	<input type="checkbox"/> 0000 Everyday _____ Days per { <input type="checkbox"/> 1 Week <input type="checkbox"/> 2 Month <input type="checkbox"/> 3 Year <input type="checkbox"/> 9999 DK (24)	24-27
--	--	-------

b. On those days, how MANY DRINKS must a person have in order to be considered a MODERATE drinker?	_____ Drinks <input type="checkbox"/> 99 DK	28-29
---	--	-------

24a. In your opinion, how OFTEN must a person drink in order to be considered a LIGHT drinker?	<input type="checkbox"/> 0000 Everyday _____ Days per { <input type="checkbox"/> 1 Week <input type="checkbox"/> 2 Month <input type="checkbox"/> 3 Year <input type="checkbox"/> 9999 DK (25)	30-33
---	--	-------

b. On those days, how MANY DRINKS must a person have in order to be considered a LIGHT drinker?	_____ Drinks <input type="checkbox"/> 99 DK	34-35
--	--	-------

Section 03 — CURRENT DRINKER — Continued

Refer to Table B on the Cover Page and ask for each person listed except the sample person.
 If personal interview — hand Card O2 and read first alternative wording.
 If telephone interview — read second alternative wording and the list of answer categories.

28a. Please look at this card and tell me which number best describes — drinking during the past year.
 I am going to read a list of different drinking categories, please tell me which best describes — drinking in the past year.

- Person No. _____
- | | |
|---|--|
| 1 <input type="checkbox"/> Heavy | 5 <input type="checkbox"/> Quit drinking |
| 2 <input type="checkbox"/> Moderate | 6 <input type="checkbox"/> Never drank |
| 3 <input type="checkbox"/> Light | 9 <input type="checkbox"/> DK |
| 4 <input type="checkbox"/> Very light or occasional | |

81-82

b. What about — drinking?

- Person No. _____
- | | |
|---|--|
| 1 <input type="checkbox"/> Heavy | 5 <input type="checkbox"/> Quit drinking |
| 2 <input type="checkbox"/> Moderate | 6 <input type="checkbox"/> Never drank |
| 3 <input type="checkbox"/> Light | 9 <input type="checkbox"/> DK |
| 4 <input type="checkbox"/> Very light or occasional | |

83
84-85

c. What about — drinking?

- Person No. _____
- | | |
|---|--|
| 1 <input type="checkbox"/> Heavy | 5 <input type="checkbox"/> Quit drinking |
| 2 <input type="checkbox"/> Moderate | 6 <input type="checkbox"/> Never drank |
| 3 <input type="checkbox"/> Light | 9 <input type="checkbox"/> DK |
| 4 <input type="checkbox"/> Very light or occasional | |

86
87-88

d. What about — drinking?

- Person No. _____
- | | |
|---|--|
| 1 <input type="checkbox"/> Heavy | 5 <input type="checkbox"/> Quit drinking |
| 2 <input type="checkbox"/> Moderate | 6 <input type="checkbox"/> Never drank |
| 3 <input type="checkbox"/> Light | 9 <input type="checkbox"/> DK |
| 4 <input type="checkbox"/> Very light or occasional | |

89
90-91

e. What about — drinking?

- Person No. _____
- | | |
|---|--|
| 1 <input type="checkbox"/> Heavy | 5 <input type="checkbox"/> Quit drinking |
| 2 <input type="checkbox"/> Moderate | 6 <input type="checkbox"/> Never drank |
| 3 <input type="checkbox"/> Light | 9 <input type="checkbox"/> DK |
| 4 <input type="checkbox"/> Very light or occasional | |

92
93-94

f. What about — drinking?

- Person No. _____
- | | |
|---|--|
| 1 <input type="checkbox"/> Heavy | 5 <input type="checkbox"/> Quit drinking |
| 2 <input type="checkbox"/> Moderate | 6 <input type="checkbox"/> Never drank |
| 3 <input type="checkbox"/> Light | 9 <input type="checkbox"/> DK |
| 4 <input type="checkbox"/> Very light or occasional | |

95
96-97

29. Tell me whether or not you have EVER had any of the following conditions even if you have mentioned them before —

- | | | | |
|--|----------------------------|----------------------------|--|
| a. Hypertension or high blood pressure (excluding during pregnancy)? | Yes | No | |
| b. Hardening of the arteries? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| c. Any heart disease? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| d. Arthritis or rheumatism? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| e. An ulcer, not including skin ulcers? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| f. Diabetes? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| g. Any disease of the liver, such as yellow jaundice, hepatitis or cirrhosis? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| h. Cancer, other than skin cancer? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| i. Alcoholism? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |

98

CHECK ITEM 5

Mark one box, then read "Intro" for HIS-2, Alcohol Questionnaire.

- | |
|---|
| 1 <input type="checkbox"/> SP alone during interview |
| 2 <input type="checkbox"/> Child(ren) present during interview |
| 3 <input type="checkbox"/> Other adult(s) present during interview |
| 4 <input type="checkbox"/> Child(ren) and other adult(s) present during interview |
| 5 <input type="checkbox"/> Telephone interview |

108

INTRO: (Hand questionnaire and read to respondent) These next questions are about things that happen to people when they are drinking or after they have been drinking. We would like to know if any of these things have ever happened to you. (I can read the questions to you or you can fill out the form yourself. Which would you prefer?)

METHOD OF INTERVIEW

109

- | |
|---|
| 1 <input type="checkbox"/> Read to SP (HIS-2) |
| 2 <input type="checkbox"/> Self-administered (Instructions) |
| 3 <input type="checkbox"/> Telephone interview (HIS-2) |
| 4 <input type="checkbox"/> Refused HIS-2 (HIS-1B) |

INSTRUCTIONS — In COLUMN 1, please circle the answer that best describes the number of times each of these things has happened to you IN THE PAST 12 MONTHS. Complete column 1 for each question first. Then go back and in COLUMN 2, circle "Yes" or "No" if any of these things have or have not ever happened to you IN YOUR ENTIRE LIFE. If you need any help ask me for assistance.

Section 04 - FORMER DRINKER

1. Not counting small tastes, how old were you when you started drinking alcoholic beverages?

____ Years
99 [] DK

3-4
5-6

2. In the PAST 12 MONTHS about how many drinks of ANY kind of alcoholic beverage did you have?

00 [] None
____ Drinks
99 [] DK

7-8

3. When did you have your last drink of any kind of alcoholic beverage?

____ 19 ____
Month Year
9999 [] DK

9-12

4a. In your ENTIRE LIFE, when you drank the MOST, about how often did you drink?

0000 [] Everyday
____ Days per { 1 [] Week
2 [] Month
3 [] Year
9999 [] DK

13-16

b. On those days, about how many drinks did you have a day?

00 [] None
____ Drinks
99 [] DK

17-18

c. For how long of a period did you drink this amount?

____ { 1 [] Days
2 [] Weeks
3 [] Months
4 [] Years
9999 [] DK

19-22

5. What type of alcoholic beverage [do/did] you PREFER to drink - beer, wine, or liquor?

Mark only one box

1 [] Beer
2 [] Wine
3 [] Liquor
4 [] No preference
9 [] DK

23

6. When you [drink/drank] who [do/did] you USUALLY drink with - friends, relatives, people from work, other people, or by yourself?

Mark only one box.

1 [] Friends
2 [] Relatives
3 [] People from work
4 [] Other people
5 [] Self
9 [] DK

2

Hand Card 01, read list if telephone interview.

7a. (Please look at this list and tell me) What are your reasons for drinking less than 12 drinks in the past year?

Anything else?

Mark all mentioned.

- 01 [] Don't socialize very much
02 [] Don't care for it or dislike it
03 [] Am an alcoholic
04 [] Thought I might become an alcoholic
05 [] Had problems with my drinking
06 [] Have a responsibility to my family
07 [] Family member an alcoholic or problem drinker
08 [] Medical or health reasons
09 [] Religious or moral reasons
10 [] Brought up not to drink
11 [] Makes me sick
12 [] Can't control my drinking
13 [] Costs too much or can't afford it
14 [] Dieting or too fattening
88 [] Other
99 [] DK

25-26
27-28
29-30
31-32
33-34
35-36
37-38
39-40
41-42
43-44
45-46
47-48
49-50
51-52
53-54
55-56

If only one reason in 7a, mark box without asking; otherwise, ask:

b. Of the reasons you have told me, which of these is your MOST IMPORTANT reason for drinking less than 12 drinks in the past year?

- 01 [] Don't socialize very much
02 [] Don't care for it or dislike it
03 [] Am an alcoholic
04 [] Thought I might become an alcoholic
05 [] Had problems with my drinking
06 [] Have a responsibility to my family
07 [] Family member an alcoholic or problem drinker
08 [] Medical or health reasons
09 [] Religious or moral reasons
10 [] Brought up not to drink
11 [] Makes me sick
12 [] Can't control my drinking
13 [] Costs too much or can't afford it
14 [] Dieting or too fattening
88 [] Other
99 [] DK

57-58

Section 04 – FORMER DRINKER

<p>People have different opinions about heavy, moderate and light drinking. We would like to know how OFTEN and how MUCH you think a person must drink in order to be considered a heavy, moderate or light drinker.</p> <p>8a. In your opinion, how OFTEN must a person drink in order to be considered a HEAVY drinker?</p>	<p align="right">59-62</p> <p>0000 <input type="checkbox"/> Everyday _____ Days per { 1 <input type="checkbox"/> Week 2 <input type="checkbox"/> Month 3 <input type="checkbox"/> Year 9999 <input type="checkbox"/> DK (9)</p>										
<p>b. On those days, how MANY DRINKS must a person have in order to be considered a HEAVY drinker?</p>	<p align="right">63-64</p> <p>_____ Drinks 99 <input type="checkbox"/> DK</p>										
<p>9a. In your opinion, how OFTEN must a person drink in order to be considered a MODERATE drinker?</p>	<p align="right">65-68</p> <p>0000 <input type="checkbox"/> Everyday _____ Days per { 1 <input type="checkbox"/> Week 2 <input type="checkbox"/> Month 3 <input type="checkbox"/> Year 9999 <input type="checkbox"/> DK (10)</p>										
<p>b. On those days, how MANY DRINKS must a person have in order to be considered a MODERATE drinker?</p>	<p align="right">69-70</p> <p>_____ Drinks 99 <input type="checkbox"/> DK</p>										
<p>10a. In your opinion, how OFTEN must a person drink in order to be considered a LIGHT drinker?</p>	<p align="right">71-74</p> <p>0000 <input type="checkbox"/> Everyday _____ Days per { 1 <input type="checkbox"/> Week 2 <input type="checkbox"/> Month 3 <input type="checkbox"/> Year 9999 <input type="checkbox"/> DK (11)</p>										
<p>b. On those days, how MANY DRINKS must a person have in order to be considered a LIGHT drinker?</p>	<p align="right">75-76</p> <p>_____ Drinks 99 <input type="checkbox"/> DK</p>										
<p>11a. When you were growing up, that is, during your first 18 years, did you live with anyone who was a problem drinker or alcoholic?</p>	<p align="right">77</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (12) 3 <input type="checkbox"/> DK</p>										
<p>b. Who was this? Anyone else? If parent, ask: Was this your biological (natural), adoptive, step, or foster (mother/father)? If brother/sister, ask: Was this your full, half, adoptive, step, or foster (brother/sister)? Record up to first 5 mentioned.</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; vertical-align: top;"> <p align="right">78-79</p> <p>1) _____</p> </td> <td style="width:50%; vertical-align: top;"> <p align="right">80-82</p> <p align="center"><i>Ask 11c for each person in 11b.</i></p> <p>C. For how long did you live with (person in 11b) while (person in 11b) was a problem drinker or alcoholic?</p> <p>_____ { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p> </td> </tr> <tr> <td style="vertical-align: top;"> <p align="right">83-84</p> <p>2) _____</p> </td> <td style="vertical-align: top;"> <p align="right">85-87</p> <p>_____ { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p> </td> </tr> <tr> <td style="vertical-align: top;"> <p align="right">88-89</p> <p>3) _____</p> </td> <td style="vertical-align: top;"> <p align="right">90-92</p> <p>_____ { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p> </td> </tr> <tr> <td style="vertical-align: top;"> <p align="right">93-94</p> <p>4) _____</p> </td> <td style="vertical-align: top;"> <p align="right">95-97</p> <p>_____ { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p> </td> </tr> <tr> <td style="vertical-align: top;"> <p align="right">98-99</p> <p>5) _____</p> </td> <td style="vertical-align: top;"> <p align="right">100-102</p> <p>_____ { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p> </td> </tr> </table>	<p align="right">78-79</p> <p>1) _____</p>	<p align="right">80-82</p> <p align="center"><i>Ask 11c for each person in 11b.</i></p> <p>C. For how long did you live with (person in 11b) while (person in 11b) was a problem drinker or alcoholic?</p> <p>_____ { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p>	<p align="right">83-84</p> <p>2) _____</p>	<p align="right">85-87</p> <p>_____ { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p>	<p align="right">88-89</p> <p>3) _____</p>	<p align="right">90-92</p> <p>_____ { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p>	<p align="right">93-94</p> <p>4) _____</p>	<p align="right">95-97</p> <p>_____ { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p>	<p align="right">98-99</p> <p>5) _____</p>	<p align="right">100-102</p> <p>_____ { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p>
<p align="right">78-79</p> <p>1) _____</p>	<p align="right">80-82</p> <p align="center"><i>Ask 11c for each person in 11b.</i></p> <p>C. For how long did you live with (person in 11b) while (person in 11b) was a problem drinker or alcoholic?</p> <p>_____ { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p>										
<p align="right">83-84</p> <p>2) _____</p>	<p align="right">85-87</p> <p>_____ { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p>										
<p align="right">88-89</p> <p>3) _____</p>	<p align="right">90-92</p> <p>_____ { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p>										
<p align="right">93-94</p> <p>4) _____</p>	<p align="right">95-97</p> <p>_____ { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p>										
<p align="right">98-99</p> <p>5) _____</p>	<p align="right">100-102</p> <p>_____ { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years</p>										

Section O4 — FORMER DRINKER — Continued

12a. Have any of your (other) blood relatives EVER been problem drinkers or alcoholics?

- 1 Yes
- 2 No
- 9 DK } (13)

b. Who was this?

Anyone else?

Mark all mentioned.

If necessary, probe as indicated in 11b.

- 1 Biological mother
- 2 Biological father
- 1 Biological brother(s)
- 2 Biological sister(s)
- 1 Half brother(s)
- 2 Half sister(s)
- 1 Biological son(s)
- 2 Biological daughter(s)
- 1 Grandmother(s)
- 2 Grandfather(s)
- 1 Aunt(s)
- 2 Uncle(s)
- 1 Niece(s)
- 2 Nephew(s)
- 1 Cousin(s)
- 2 Other blood relative(s)
- 1 DK

- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21
- 22

13. Have you ever been married to, or lived with someone as if you were married, who was a problem drinker or alcoholic?

- 1 Yes
- 2 No

Refer to Table B on the Cover Page and ask for each person listed except the sample person.
 If personal interview — hand Card O2 and read first alternative wording.
 If telephone interview — read second alternative wording and the list of answer categories.

14a. Please look at this card and tell me which number best describes — drinking during the past year.

I am going to read a list of different drinking categories, please tell me which one best describes — drinking in the past year.

Person No. _____

- 1 Heavy
- 2 Moderate
- 3 Light
- 4 Very light or occasional
- 5 Quit drinking
- 6 Never drank
- 9 DK

b. What about — drinking?

Person No. _____

- 1 Heavy
- 2 Moderate
- 3 Light
- 4 Very light or occasional
- 5 Quit drinking
- 6 Never drank
- 9 DK

c. What about — drinking?

Person No. _____

- 1 Heavy
- 2 Moderate
- 3 Light
- 4 Very light or occasional
- 5 Quit drinking
- 6 Never drank
- 9 DK

d. What about — drinking?

Person No. _____

- 1 Heavy
- 2 Moderate
- 3 Light
- 4 Very light or occasional
- 5 Quit drinking
- 6 Never drank
- 9 DK

e. What about — drinking?

Person No. _____

- 1 Heavy
- 2 Moderate
- 3 Light
- 4 Very light or occasional
- 5 Quit drinking
- 6 Never drank
- 9 DK

f. What about — drinking?

Person No. _____

- 1 Heavy
- 2 Moderate
- 3 Light
- 4 Very light or occasional
- 5 Quit drinking
- 6 Never drank
- 9 DK

Section P – CHILD HEALTH

Section P1 – INTRODUCTION

The next questions will be used to study the health of the Nation's children.
(It would be best if I could ask these questions in private.)
Arrange to conduct supplement in private if possible.
If more than one child in family read: **The only child I will ask the rest of my questions about is--.**

3-4

Ask or verify for each HH member.		Person number on HIS-1	Relationship to sample child	
1. How is (Name on HIS-1) related to ---? If parent, ask: Is (Name of parent) -- biological (natural), adoptive, step, or foster [mother/father]? If brother/sister, ask: Is (Name of sibling) -- full, half, adoptive, step or foster [brother/sister]? Enter "sample child" on appropriate line. Enter "unrelated" for persons not related to the sample child.		1		5-6
		2		7-8
		3		9-10
		4		11-12
		5		13-14
		6		15-16
		7		17-18
		8		19-20
		9		21-22
		10		23-24

CHECK ITEM 1	Mark first appropriate box.	1 <input type="checkbox"/> Biological or adoptive mother in hhld (Check Item 2)	25
		2 <input type="checkbox"/> Biological father or step or foster mother in hhld. (Check Item 2)	
		3 <input type="checkbox"/> One adult relative in hhld. (Check Item 2)	
		4 <input type="checkbox"/> 2+ adult relatives in hhld. (2)	
		5 <input type="checkbox"/> No eligible respondent in household (Cover Page)	

2a. Which family member knows the most about the health related matters of ---?		25-27
		28-29

b. Is (person named in 2a) available?		30
	1 <input type="checkbox"/> Yes (Section P2)	
	2 <input type="checkbox"/> No (Arrange callback, THEN Cover Page)	

CHECK ITEM 2	Mark first appropriate box.	31
	1 <input type="checkbox"/> Person in Check Item 1 available (Section P2)	
	2 <input type="checkbox"/> Person in Check Item 1 not available (Arrange callback, THEN Cover Page)	

Notes

Section P2 — CHILD CARE

CHECK ITEM 3	<i>Mark box and enter person number of respondent.</i>	1 <input type="checkbox"/> Same as respondent in HIS-1 _____ Person number (Check Item 4) 2 <input type="checkbox"/> New respondent _____ Person number	32 33-34
---------------------	--	--	-------------

These questions will be used to study the health of the Nation's children. (It would be best if I could ask these questions in private.) I will be asking questions about ——. Arrange to conduct supplement in private if possible.

CHECK ITEM 4	<i>Refer to age of sample child</i>	1 <input type="checkbox"/> Under 2 years old (Check Item 5) 2 <input type="checkbox"/> 2 or 3 years old (2) 3 <input type="checkbox"/> 4 or 5 years old (1) 4 <input type="checkbox"/> 6+ years old (Section P3, page 83)	36
---------------------	-------------------------------------	--	----

1 a. Is — currently attending either kindergarten or first grade?	1 <input type="checkbox"/> Yes, kindergarten 2 <input type="checkbox"/> Yes, first grade 3 <input type="checkbox"/> No (2)	36
---	--	----

b. At what time of day does the [kindergarten/first grade] start?	_____ : _____ { <table style="display: inline-table; vertical-align: middle;"> <tr> <td>1 <input type="checkbox"/> A.M.</td> <td>3 <input type="checkbox"/> Noon</td> </tr> <tr> <td>2 <input type="checkbox"/> P.M.</td> <td>9 <input type="checkbox"/> DK</td> </tr> </table>	1 <input type="checkbox"/> A.M.	3 <input type="checkbox"/> Noon	2 <input type="checkbox"/> P.M.	9 <input type="checkbox"/> DK	37-41
1 <input type="checkbox"/> A.M.	3 <input type="checkbox"/> Noon					
2 <input type="checkbox"/> P.M.	9 <input type="checkbox"/> DK					

c. At what time does the [kindergarten/first grade] end?	_____ : _____ { <table style="display: inline-table; vertical-align: middle;"> <tr> <td>1 <input type="checkbox"/> A.M.</td> <td>3 <input type="checkbox"/> Noon</td> </tr> <tr> <td>2 <input type="checkbox"/> P.M.</td> <td>9 <input type="checkbox"/> DK</td> </tr> </table>	1 <input type="checkbox"/> A.M.	3 <input type="checkbox"/> Noon	2 <input type="checkbox"/> P.M.	9 <input type="checkbox"/> DK	42-46
1 <input type="checkbox"/> A.M.	3 <input type="checkbox"/> Noon					
2 <input type="checkbox"/> P.M.	9 <input type="checkbox"/> DK					

If in first grade, go to 3 d. Does the kindergarten have a day care or extended day program that — also takes part in?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Check Item 5) 9 <input type="checkbox"/> DK	47
---	---	----

e. How many hours per week does — spend in this program?	_____ Hours } (Check Item 5) 99 <input type="checkbox"/> DK	48-49
--	--	-------

2 a. During the past four weeks has — attended nursery or preschool?	1 <input type="checkbox"/> Yes, Nursery 2 <input type="checkbox"/> Yes, Preschool 3 <input type="checkbox"/> No (Check Item 5)	50
--	--	----

b. Did the [nursery school/preschool] have a day care or extended day program that — also took part in?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	51
---	---	----

c. How many hours per week did — spend in the [nursery school/preschool (with day care)]?	_____ Hours per week 99 <input type="checkbox"/> DK	52-53
---	--	-------

CHECK ITEM 5	<i>Refer to Check Item 1. Mark first appropriate box.</i>	1 <input type="checkbox"/> Biological mother respondent (3a) 2 <input type="checkbox"/> Biological/adoptive/step or foster mother in hhhd., NOT respondent (3d) 8 <input type="checkbox"/> Other (3a)	54
---------------------	---	---	----

3 a. Have you worked at a job or business for pay in the last four weeks?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (4)	55
---	---	----

b. How many hours a week do you usually work?	_____ Hours per week 999 <input type="checkbox"/> DK	56-58
---	---	-------

Mark box or ask: c. Do you only work while — is in (school level in 1a or 2a) or do you work during other hours?	0 <input type="checkbox"/> Child under 2 or "No" in 1a AND 2a (5b) 1 <input type="checkbox"/> Only while child is in school (4) 8 <input type="checkbox"/> Other hours (5b)	59
---	---	----

d. Has — (mother) worked at a job or business for pay in the last 4 weeks?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (4)	60
--	---	----

e. How many hours a week did she work?	_____ Hours per week 999 <input type="checkbox"/> DK	61-63
--	---	-------

Mark box or ask: f. Does she work only while — is in (school level in 1a or 2a) or does she work other hours?	0 <input type="checkbox"/> "No" or blank in 1a AND "No" in 2a (5b) 1 <input type="checkbox"/> Only while child is in school (4) 8 <input type="checkbox"/> Other hours (5b)	64
--	---	----

Section P2 -- CHILD CARE -- Continued

4. (Other than the [nursery school/preschool]), in the past four weeks, has -- been cared for in ANY kind of regular child care arrangement such as a day care center, playgroup, by a babysitter, relative, or some other regular arrangement?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Check Item 6)	66
Hand Card P1, read list if telephone interview. 5a. How was -- USUALLY cared for during the hours that child care was used? Mark only one box.	01 <input type="checkbox"/> Day care center 02 <input type="checkbox"/> Babysitter in child's home 03 <input type="checkbox"/> In babysitter's home 04 <input type="checkbox"/> Father cares for child 05 <input type="checkbox"/> Mother cares for child while working at home 06 <input type="checkbox"/> Mother cares for child while working outside of home 07 <input type="checkbox"/> Child cares for self 08 <input type="checkbox"/> Other relative cares for child (5c) 09 <input type="checkbox"/> Day camp (5e) 88 <input type="checkbox"/> Other -- Specify <input checked="" type="checkbox"/> _____ (5e)	66-67
Hand Card P1, read list if telephone interview. b. (Other than [kindergarten/first grade/nursery school/preschool]) How was -- usually cared for while you worked? Mark only one box.	01 <input type="checkbox"/> Day care center 02 <input type="checkbox"/> Babysitter in child's home 03 <input type="checkbox"/> In babysitter's home 04 <input type="checkbox"/> Father cares for child 05 <input type="checkbox"/> Mother cares for child while working at home 06 <input type="checkbox"/> Mother cares for child while working outside of home 07 <input type="checkbox"/> Child cares for self 08 <input type="checkbox"/> Other relative cares for child (5c) 09 <input type="checkbox"/> Day camp (5e) 88 <input type="checkbox"/> Other -- Specify <input checked="" type="checkbox"/> _____ (5e)	68-69
c. How is this person related to --?	1 <input type="checkbox"/> Sibling 8 <input type="checkbox"/> Other relative 2 <input type="checkbox"/> Grandparent 9 <input type="checkbox"/> DK	70
d. Where does this person usually care for --, in (sample child) home or somewhere else?	1 <input type="checkbox"/> At home 2 <input type="checkbox"/> Somewhere else	71
e. About how many hours per week was -- usually cared for [by/at] (arrangement)?	_____ Hours per week 99 <input type="checkbox"/> DK	72-73
6a. Besides [nursery or preschool (and)] (child care arrangements in 5a/b)], during the past four weeks, has -- been cared for in any other regular child care arrangement?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Check Item 6)	74
Hand Card P1, read list if telephone interview. b. Other than [nursery or preschool (and)] (child care arrangement in 5a/b)], how was -- usually cared for during most of the other hours that child care was used? Mark only one box.	01 <input type="checkbox"/> Day care center 02 <input type="checkbox"/> Babysitter in child's home 03 <input type="checkbox"/> In babysitter's home 04 <input type="checkbox"/> Father cares for child 05 <input type="checkbox"/> Mother cares for child while working at home 06 <input type="checkbox"/> Mother cares for child while working outside of home 07 <input type="checkbox"/> Child cares for self 08 <input type="checkbox"/> Other relative cares for child (6c) 09 <input type="checkbox"/> Day camp (6e) 88 <input type="checkbox"/> Other -- Specify <input checked="" type="checkbox"/> _____ (6e)	75-76
c. How is this person related to --?	1 <input type="checkbox"/> Sibling 8 <input type="checkbox"/> Other relative 2 <input type="checkbox"/> Grandparent 9 <input type="checkbox"/> DK	77
d. Where does this person usually care for --, in (sample child) home or somewhere else?	1 <input type="checkbox"/> At home 2 <input type="checkbox"/> Somewhere else	78
e. About how many hours per week was -- usually cared for [by/at] (arrangement)?	_____ Hours per week 99 <input type="checkbox"/> DK	79-80
7a. Were any other child care arrangements used on a regular basis?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Check Item 6)	81
b. How many additional hours a week was child care used?	_____ Hours per week 99 <input type="checkbox"/> DK	82-83

Section P2 – CHILD CARE – Continued

CHECK ITEM 6	<i>Refer to 1d, 2a, 5a/5b, 6b.</i>	1 <input type="checkbox"/> No or blank in 1d AND No in 2a AND blank in 5a/5b(11) (No nursery school or child care) 84 2 <input type="checkbox"/> Box 4, 5, 6, or 7 in 5a/5b AND blank or box 4, 5, 6, or 7 in 6b (13) (Mother, Father, self care ONLY) 8 <input type="checkbox"/> Other (8)
8. Now I would like to ask you about ("Main" child care arrangement). Including —, how many children are usually cared for together, in the same group, at the same time? Do not include children in the entire school or program.		_____ Children 99 <input type="checkbox"/> DK 85-86
9. How many adults usually supervise the children in the same group as —?		_____ Adults 99 <input type="checkbox"/> DK 87-88
10. Has the main person responsible for caring for — received education or training specifically related to young children, such as early childhood or elementary education, or child psychology?		1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } (13) 9 <input type="checkbox"/> DK }
11. Was — ever cared for in any regular child care arrangement?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Section P3, page 83) 90
12. When did — last receive care in a regular child care arrangement?		1 <input type="checkbox"/> Within last 12 months 2 <input type="checkbox"/> Prior to last 12 months (15) 91
13. How many times has — main child care arrangement been changed in the past year?		000 <input type="checkbox"/> None (15) 92-94 _____ Times
Hand Card P2, read list if telephone interview. 14a. What was the last type of care used before — changed to the type of care — is using now? Mark only one box.		01 <input type="checkbox"/> Nursery school or preschool 02 <input type="checkbox"/> Nursery school or preschool with day care 03 <input type="checkbox"/> Day care center 04 <input type="checkbox"/> Babysitter in child's home 05 <input type="checkbox"/> In babysitter's home 06 <input type="checkbox"/> Father cares for child 07 <input type="checkbox"/> Mother cares for child while working at home 08 <input type="checkbox"/> Mother cares for child while working outside of home 09 <input type="checkbox"/> Summer day camp 10 <input type="checkbox"/> Child cares for self 11 <input type="checkbox"/> Other relative cares for child (14b) 88 <input type="checkbox"/> Other — Specify: <u> </u> _____ (14d) 99 <input type="checkbox"/> DK (15) 95-96
b. How is this person related to —?		1 <input type="checkbox"/> Sibling 8 <input type="checkbox"/> Other relative 2 <input type="checkbox"/> Grandparent 9 <input type="checkbox"/> DK 97
c. Where did this person usually care for —, in (sample child) home or somewhere else?		1 <input type="checkbox"/> At home 2 <input type="checkbox"/> Somewhere else 98
d. About how many hours per week was — usually cared for [by/at] (arrangement)?		_____ Hours per week 99 <input type="checkbox"/> DK 99-100

Notes

Section P3 — RELATIONSHIPS AND MOBILITY

3-4

These next few questions are about — (biological mother).

5-6

1. How old was — (biological mother) when — was born?

_____ Age

- 88 Respondent knows nothing about biological mother (Check Item 7)
 99 DK

2. Including —, how many children has she ever had?
Do not count miscarriages or stillbirths.01 One/sample child only (Check item 7)

7-8

_____ Number

99 DK

3. Was — the first born (or) second born (or third, etc.)?

- 1 First (Check Item 7)
 2 Second
 3 Third
 4 Fourth
 5 Fifth
 6 Sixth or Later
 9 DK (Check Item 7)

9

4. How old was — (biological mother) when the first child was born?

_____ Age

99 DK

10-11

**CHECK
ITEM 7**

Refer to Q. 1, page 78

- 1 Biological mother in hhld. (8)
 8 Other (5)

12

5a. Has — ever lived with — biological mother for at least 4 consecutive months?

- 1 Yes
 2 No
 9 DK } (6)

13

b. In what month and year did — last live with her?

0000 Lived here since birth_____/ 19_____
Month Year9999 DK

14-17

6. Is she now living or deceased?

- 1 Living
 2 Deceased (Check item 11)
 9 DK (Check Item 11)

18

7. How often does — see her?

- 01 Everyday
 02 Almost every day
 03 Several times a week
 04 About once a week
 05 Two or three times a month
 06 About once a month
 07 Several times a year
 08 Once a year or less
 00 Never
 99 DK

19-20

8. Is — (biological mother) now married, widowed, divorced, separated, or has she never been married?

- 1 Married
 2 Widowed
 3 Divorced
 4 Separated
 0 Never married (Check Item 11)
 9 DK (Check Item 11)

21

9. How many times altogether has she been married?

_____ Times

9 DK

22

Notes

Section P3 — RELATIONSHIPS AND MOBILITY — Continued

CHECK ITEM 11	Refer to Q. 1, page 78.	1 <input type="checkbox"/> Biological father in household (16) 8 <input type="checkbox"/> Other (13)	44
These next few questions are about — (biological father).		0 <input type="checkbox"/> Respondent knows nothing about father (16) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (16)	45
13a. Has — ever lived with — biological father for at least 4 consecutive months?		0000 <input type="checkbox"/> Lived here since birth _____ / 19 _____ Month Year 9999 <input type="checkbox"/> DK	46-49
b. In what month and year did — last live with him?			
14. Is he now living or deceased?		1 <input type="checkbox"/> Living 2 <input type="checkbox"/> Deceased 9 <input type="checkbox"/> DK } (16)	50
15. How often does — see him?		01 <input type="checkbox"/> Everyday 02 <input type="checkbox"/> Almost every day 03 <input type="checkbox"/> Several times a week 04 <input type="checkbox"/> About once a week 05 <input type="checkbox"/> Two or three times a month 06 <input type="checkbox"/> About once a month 07 <input type="checkbox"/> Several times a year 08 <input type="checkbox"/> Once a year or less 00 <input type="checkbox"/> Never 99 <input type="checkbox"/> DK	51-52
16. In what month and year did (sample child) move to this address or has — lived here since birth?		0000 <input type="checkbox"/> Lived here since birth (Check Item 12) _____ / 19 _____ Month Year 9999 <input type="checkbox"/> DK	53-56
17. About how far from here is the home (sample child) lived in before — moved to this home — less than a mile, 1 to 50 miles, or more than 50 miles?		1 <input type="checkbox"/> Less than 1 mile 2 <input type="checkbox"/> 1-50 miles 3 <input type="checkbox"/> 50+ miles 9 <input type="checkbox"/> DK	57
18. Altogether, how many times has — ever moved?		_____ Times 99 <input type="checkbox"/> DK	58-59
CHECK ITEM 12		1 <input type="checkbox"/> Respondent is biological mother or biological father (Section P4) 8 <input type="checkbox"/> Other (19)	60
19. In what month and year did — begin living with you?		0000 <input type="checkbox"/> Since birth _____ / 19 _____ Month Year 8888 <input type="checkbox"/> Does not live with respondent 9999 <input type="checkbox"/> DK	61-64

Notes

Section P4 — BIRTH

1 a. Was --- born in a hospital or some other place?	1 <input type="checkbox"/> Hospital 2 <input type="checkbox"/> Birthing center } (1b) 3 <input type="checkbox"/> Home (2) 4 <input type="checkbox"/> In transit to hospital (1b) 8 <input type="checkbox"/> Other — Specify _____ (2) 9 <input type="checkbox"/> DK	65
b. How many nights was --- (biological mother) in the [hospital/birthing center] during this stay?	00 <input type="checkbox"/> None _____ Nights 99 <input type="checkbox"/> DK	66-67
c. How many nights was --- in the [hospital/birthing center] during this stay?	00 <input type="checkbox"/> None _____ Nights 99 <input type="checkbox"/> DK	68-69
2 a. How much did --- weigh at birth? <i>Probe for ounces if not reported.</i>	_____ Lbs. _____ Oz. (3) 9999 <input type="checkbox"/> DK	70-73
b. Did --- weigh more than 5 1/2 pounds or less?	<input type="checkbox"/> More than 5 1/2 lbs. 1 <input type="checkbox"/> Less than 5 1/2 lbs. } (3) 7 <input type="checkbox"/> DK	74
c. Did weigh --- more than 9 pounds or less?	2 <input type="checkbox"/> More than 9 lbs. 3 <input type="checkbox"/> Less than 9 lbs. 8 <input type="checkbox"/> DK	
3 a. How many months pregnant was --- (biological mother) when --- was born?	_____ Months 99 <input type="checkbox"/> DK	75-76
b. Was --- born about when expected, or was it earlier or later?	1 <input type="checkbox"/> Earlier than expected 2 <input type="checkbox"/> When expected (Check item 13) 3 <input type="checkbox"/> Later than expected 9 <input type="checkbox"/> DK (Check item 13)	77
c. About how many weeks [earlier/later] than expected was --- born?	00 <input type="checkbox"/> Less than one week _____ Weeks 99 <input type="checkbox"/> DK	78-79
CHECK ITEM 13	1 <input type="checkbox"/> Under 6 years old AND biological mother respondent (4) 8 <input type="checkbox"/> Other (Section P5, page 88)	80
4. How many weeks pregnant were you when you first thought you were pregnant with ---?	_____ Weeks 99 <input type="checkbox"/> DK	81-82
5 a. Did you see or talk to a doctor to find out if you were pregnant?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5c)	83
b. About how many weeks pregnant were you when you first found out from a doctor that you were pregnant?	1 <input type="checkbox"/> 4 weeks or less 2 <input type="checkbox"/> 5-13 weeks 3 <input type="checkbox"/> 14-27 weeks 4 <input type="checkbox"/> 28 weeks or more 9 <input type="checkbox"/> DK	84
c. Did you see or talk to a doctor about your pregnancy at any (other) time during that pregnancy?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6)	85
If "Yes" in 5a, go to 6 d. How many weeks or months pregnant were you when you first saw a doctor about your pregnancy?	1 <input type="checkbox"/> 4 weeks or less 2 <input type="checkbox"/> 5-13 weeks 3 <input type="checkbox"/> 14-27 weeks 4 <input type="checkbox"/> 28 weeks or more 9 <input type="checkbox"/> DK	86
6. Altogether, how many pounds did you either gain or lose during that pregnancy?	_____ Pounds { 1 <input type="checkbox"/> Gained { 2 <input type="checkbox"/> Lost	87-89
7 a. Did --- receive any newborn care in an intensive care unit, premature nursery, or any other type of special care unit?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (8)	90
b. How many nights did --- stay in the special care unit?	00 <input type="checkbox"/> None _____ Nights	91-92

Section P4 – BIRTH – Continued

8. Do you NOW have diabetes or sugar diabetes?	<div style="text-align: right;">93</div> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK		
9a. At any time during your pregnancy with ---, did you have ---	Sugar in the urine? (1)	High sugar in the blood? (2)	Diabetes? (3)
b. When did you FIRST notice it – was it during your pregnancy with --- or before?	1 <input type="checkbox"/> Yes (9b and c) 2 <input type="checkbox"/> No (Next column)	1 <input type="checkbox"/> Yes (9b and c) 2 <input type="checkbox"/> No (Next column)	1 <input type="checkbox"/> Yes (9b and c) 2 <input type="checkbox"/> No
Mark box or ask: c. Did you have the (condition) for at least 3 months after --- was born?	0 <input type="checkbox"/> Child und. 3 mos. 1 <input type="checkbox"/> Yes } (9a) 2 <input type="checkbox"/> No }	0 <input type="checkbox"/> Child und. 3 mos. 1 <input type="checkbox"/> Yes } (9a) 2 <input type="checkbox"/> No }	0 <input type="checkbox"/> Child und. 3 mos. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

Notes

Section P5 — CHILDHOOD CONDITIONS

RT 93
3-4
6-6
7

1 a. During the past 12 months, did — have an accident, injury, or poisoning that required medical attention?

1a. Yes
 No } (2)
 DK

b. How many accidents, injuries, or poisonings did — have in the last 12 months that required medical attention?

b. _____ Number 8-9

c. (Beginning with the most recent,) what caused the accident, injury, or poisoning? For example, was — hit by a car while riding a bike, or burned by hot liquid or did — swallow an object or pills?
Enter each in a separate column.

c. Group A (Brief description) 10-14
 (1) _____

Hand Card P3, read list if telephone interview.

d. Which of the conditions on this list OR ANY OTHER CONDITIONS resulted from the (entry in 1c)?
Mark all that apply and ask 1e.

d. 01 Broken or dislocated bones 15-16
 02 Sprain, strain, or pulled muscle 17-18
 03 Cuts, scrapes, or puncture wounds 19-20
 04 Head injury, concussion 21-22
 05 Bruise, contusion, or internal bleeding 23-24
 06 Burn, scald 25-26
 07 Poisoning from chemicals, medicines, drugs 27-28
 08 Respiratory problem such as breathing, cough, pneumonia 29-30
 88 Other 31-32
 99 Don't know type of condition } (1f) 33-34
 00 None 35-36

e. Were there ANY other conditions that resulted from this accident, injury or poisoning?
Mark any additional conditions

e. Yes (Reask 1d, THEN 1f)
 No

f. Where did this accident or injury or poisoning happen?
DO NOT READ CATEGORIES
Mark only one box.

List each accident, injury, or poisoning which resulted in at least one condition (Codes 01—88) on a condition page as group A and a short name for the accident, injury, or poisoning from 1c. Then go to 1c in next column or question 2.

f. Home (not necessarily child's) 37
 Day care location (preschool/nursery)
 School (including grounds and athletic areas)
 Street or highway
 Public building or space (other than street or school)
 Farm or agricultural area, except farm home
 Place of recreation or sports, except at school
 Other
 Don't know

RT 84
3-4
5

2. Does — now have —

a. a missing finger, hand, arm, toe, foot, or leg?
If "Yes," ask: Which is it?
Is — missing [1 or both/more than one] (body part)?
(Enter on a Condition page, Group J)

2. **a.** 1 Yes (Ask probe questions)
 2 No
 9 DK

b. permanent impairment, stiffness or any deformity of the back, foot, or leg?
If "Yes," ask: Which is it?
Is [1 or both/more than one] (body part) affected?
(Enter on a Condition page, Group J)

b. 1 Yes (Ask probe questions)
 2 No
 9 DK 6

c. permanent impairment, stiffness or any deformity of the fingers, hand, or arm?
If "Yes," ask: Which is it?
Is [1 or both/more than one] (body part) affected?
(Enter on a Condition page, Group J)

c. 1 Yes (Ask probe questions)
 2 No
 9 DK 7

Section P5 – CHILDHOOD CONDITIONS – Continued

The next questions are about other health conditions — may have EVER had.

3. Did — ever have —
GROUP B

ASK if Yes in 3.

4a. Did — have (condition) in the last 12 months?

4b. Has — had (condition) for at least 3 months in — lifetime?

Mark without asking
4c. Is it an obviously permanent condition that began less than 3 months ago?

Repeated tonsillitis or enlargement of the tonsils or adenoids?

1 Yes **8**
2 No/DK

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

Frequent or repeated ear infections?

1 Yes **9**
2 No/DK

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

Any kind of food or digestive allergy?

1 Yes **10**
2 No/DK

Yes (4b)
 No/DK (Next Yes)

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

FREQUENT or REPEATED diarrhea or colitis?

1 Yes **11**
2 No/DK

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

Any other persistent bowel trouble?
Specify

1 Yes **12**
2 No/DK

Yes (4b)
 No/DK (Next Yes)

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

Diabetes?

1 Yes **13**
2 No/DK

Yes (4b)
 No/DK (Next Yes)

Yes (Enter on Cond. Page)
 No/DK (4c)

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

Sickle cell anemia?

1 Yes **14**
2 No/DK

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

Anemia?

1 Yes **15**
2 No/DK

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

Asthma?

1 Yes **16**
2 No/DK

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

GROUP C

Mononucleosis?

1 Yes **17**
2 No/DK

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

Hepatitis?

1 Yes **18**
2 No/DK

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

Meningitis or spinal meningitis?

1 Yes **19**
2 No/DK

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

Bladder infection or urinary tract infection?

1 Yes **20**
2 No/DK

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

Rheumatic fever?

1 Yes **21**
2 No/DK

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

Pneumonia?

1 Yes **22**
2 No/DK

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

GROUP D

Hay fever?

1 Yes **23**
2 No/DK

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

Any (other) kind of respiratory allergy?

1 Yes **24**
2 No/DK

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

GROUP E

Deafness or trouble hearing with one or both ears?

If "Yes," ask: Is it one or both ears?

1 Yes, one ear
2 Yes, both ears
9 No/DK

Yes (4b)
 No/DK (Next Yes)

Yes (Enter on Cond. Page)
 No/DK (4c)

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

Blindness in one or both eyes?

If "Yes," ask: Is it one or both eyes?

1 Yes, one eye
2 Yes, both eyes
9 No/DK

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

Crossed eyes?

1 Yes **27**
2 No/DK

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

Any other trouble seeing with one or both eyes, even when wearing glasses?
Specify

1 Yes **28**
2 No/DK

Yes (4b)
 No/DK (Next Yes)

Yes (Enter on Cond. Page)
 No/DK (4c)

Yes (Enter on Cond. Page)
 No/DK (Next Yes)

Section P5 – CHILDHOOD CONDITIONS – Continued

3. Did -- ever have --	ASK if Yes in 3.		4b. Has -- had (condition) for at least 3 months in -- lifetime?	4c. Is it an obviously permanent condition that began less than 3 months ago?
	4a. Did -- have (condition) in the last 12 months?			
GROUP F				
Eczema?	1 <input type="checkbox"/> Yes 29 2 <input type="checkbox"/> No/DK	<input type="checkbox"/> Yes (4b) <input type="checkbox"/> No/DK (Next Yes)	<input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (Next Yes)	
GROUP G				
Epilepsy or repeated convulsions or seizures not associated with fever?	1 <input type="checkbox"/> Yes 30 2 <input type="checkbox"/> No/DK	<input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (Next Yes)		
Seizures associated with fever?	1 <input type="checkbox"/> Yes 31 2 <input type="checkbox"/> No/DK	<input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (Next Yes)		
Frequent or severe headaches, including migraines?	1 <input type="checkbox"/> Yes 32 2 <input type="checkbox"/> No/DK	<input type="checkbox"/> Yes (4b) <input type="checkbox"/> No/DK (Next Yes)	<input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (Next Yes)	
<i>Child under 3, go to I</i>				
GROUP H				
Stammering or stuttering?	1 <input type="checkbox"/> Yes 33 2 <input type="checkbox"/> No/DK	<input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (Next Yes)		
Any other speech defect?	1 <input type="checkbox"/> Yes 34 2 <input type="checkbox"/> No/DK	<input type="checkbox"/> Yes (4b) <input type="checkbox"/> No/DK (Next Yes)	<input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (4c)	<input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (Next Yes)
<i>Specify</i> <input type="checkbox"/>				
<i>Child under 6, go to I</i>				
Enuresis or bedwetting problem?	1 <input type="checkbox"/> Yes 35 2 <input type="checkbox"/> No/DK	<input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (Next Yes)		
GROUP I				
Arthritis or any other joint disease or joint problem?	1 <input type="checkbox"/> Yes 36 2 <input type="checkbox"/> No/DK	<input type="checkbox"/> Yes (4b) <input type="checkbox"/> No/DK (Next Yes)	<input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (4c)	<input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (Next Yes)
<i>Specify</i> <input type="checkbox"/>				
Any other condition affecting the bone, cartilage, muscle, or tendon?	1 <input type="checkbox"/> Yes 37 2 <input type="checkbox"/> No/DK	<input type="checkbox"/> Yes (4b) <input type="checkbox"/> No/DK (Next Yes)	<input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (4c)	<input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (Next Yes)
<i>Specify</i> <input type="checkbox"/>				
Cerebral palsy?	1 <input type="checkbox"/> Yes 38 2 <input type="checkbox"/> No/DK	<input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (Next Yes)		
Congenital heart disease?	1 <input type="checkbox"/> Yes 39 2 <input type="checkbox"/> No/DK	<input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (Next Yes)		
Any other heart disease or condition? --	1 <input type="checkbox"/> Yes 40 2 <input type="checkbox"/> No/DK	<input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (Next Yes)		
<i>Specify</i> <input type="checkbox"/>				
Any other conditions that required surgery in past 12 months?	41 <input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK			
<i>Specify</i> <input type="checkbox"/>				
Any other condition that lasted three months or more?	<input type="checkbox"/> Yes <input type="checkbox"/> No/DK			
<i>List below and reask.</i>				
a.	42 <input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (Next Yes)			
b.	43 <input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (Next Yes)			
c.	44 <input type="checkbox"/> Yes (Enter on Cond. Page) <input type="checkbox"/> No/DK (Next Yes)			

Section P6 — SUPPLEMENTAL CONDITION PAGE

RT 95
3-4
6-8
7-9

CHECK ITEM 14

No conditions reported (Section P7, page 96)
Enter condition/AIP name and group letter:

Condition 1

Condition/AIP: _____

Group letter: _____

The next questions are about — (condition/AIP).

000 Less than 1 month

How old was — when (condition/AIP) [happened/was first noticed]?

Age { 3 Months
4 Years
999 DK

CHECK ITEM 15

Refer to Check Item 14

1 Group E (4)
2 Group F or H (5)
8 All others (2)

If not known, ask:

2a. (Including nursery or preschool) Did — attend school at all during the past 12 months?

1 Yes
2 No (3)

b. During the past 12 months, did — (condition/AIP) cause — to miss any time from school?

1 Yes
2 No } (3)
9 DK }

c. How many days in the past 12 months did — miss all or part of the day?

_____ Days
999 DK

3a. During the past 12 months, did — (condition/AIP) cause — to stay in bed more than half of the day?

1 Yes
2 No } (3c)
9 DK }

b. How many days in the past 12 months did — stay in bed more than half of the day?

_____ Days
999 DK

c. During the past 12 months, did — (condition/AIP) limit or prevent — from doing usual childhood activities, such as playing with other children or participating in games or sports?

1 Yes
2 No
9 DK

4. During the past 12 months, about how many nights did — spend in the hospital because of (condition/AIP)?

000 None
_____ Number of nights
999 DK

5. During the past 12 months, about how many times did [—/anyone] see or talk to a medical doctor or assistant about this (condition/AIP)? (Do not count doctors seen while an overnight patient in a hospital.)

000 None
_____ Number of doctor visits
999 DK

6. During the past 12 months, did this (condition/AIP) make it necessary for — to use any medicine, other than vitamins, that a doctor prescribed OR told — to take?

1 Yes
2 No
9 DK

CHECK ITEM 16

Refer to Check Item 14

1 Group D or F or H (8)
8 All others (7)

7. During the past 12 months did — have any surgery performed, including bone settings and stitches for this (condition/AIP)?

1 Yes
2 No
9 DK

8a. In the last 12 months, how often [did this condition/the conditions resulting from the (AIP) cause — pain or discomfort or upset — all of the time, often, once in a while, or never?

1 All of the time
2 Often
3 Once in a while
0 Never (Check Item 17)

b. When this condition did bother —, was — bothered a great deal, some, or very little?

1 Great deal
2 Some
3 Very little

CHECK ITEM 17

Refer to Check Item 14

1 Group A or B or D or F (NC)
8 Other (9)

Section P6 — SUPPLEMENTAL CONDITION PAGE — Continued

<p>9a. Did the <u>(condition)</u> result from an accident, injury or poisoning?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (NC)</p>	<p>36</p>
<p>b. Did this occur within the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>37</p>
<p>c. Did you already tell me about this accident, injury or poisoning?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (9e)</p>	<p>38</p>
<p>d. Which accident, injury, or poisoning was it?</p>	<p>Condition No. _____ (NC)</p>	<p>39-40</p>
<p>e. What kind of accident or injury or poisoning was it?</p>	<p>Brief description</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>41-45</p>
<p><i>Hand Card P3, read list if telephone interview.</i></p> <p>f. Which of the conditions on this list OR ANY OTHER CONDITIONS resulted from the <u>(entry in 9e)</u>.</p> <p><i>Mark all that apply in chart and ask 9g.</i></p>	<p>01 <input type="checkbox"/> Broken or dislocated bones 02 <input type="checkbox"/> Sprain, strain, or pulled muscle 03 <input type="checkbox"/> Cuts, scrapes, or puncture wounds 04 <input type="checkbox"/> Head injury, concussion 05 <input type="checkbox"/> Bruise, contusion, or internal bleeding 06 <input type="checkbox"/> Burn, scald 07 <input type="checkbox"/> Poisoning from chemicals, medicines, drugs 08 <input type="checkbox"/> Respiratory problem, such as breathing, cough, pneumonia 88 <input type="checkbox"/> Other 99 <input type="checkbox"/> Don't know type of condition } (9h) 00 <input type="checkbox"/> None</p>	<p>46-47 48-49 50-51 52-53 54-55 56-57 58-59 60-61 62-63 64-65 66-67</p>
<p>g. Were there ANY other conditions that resulted from this accident, injury or poisoning?</p> <p><i>Mark any additional conditions.</i></p>	<p><input type="checkbox"/> Yes (Reask 9f, THEN 9h) <input type="checkbox"/> No</p>	<p>68</p>
<p>h. Where did this accident or injury or poisoning happen?</p> <p><i>DO NOT READ CATEGORIES</i></p> <p><i>Mark only one box.</i></p>	<p>1 <input type="checkbox"/> Home (not necessarily child's) 2 <input type="checkbox"/> Day care location (preschool/nursery) 3 <input type="checkbox"/> School (including grounds and athletic areas) 4 <input type="checkbox"/> Street or highway 5 <input type="checkbox"/> Public building or space (other than street or school) 6 <input type="checkbox"/> Farm or agricultural area, except farm home 7 <input type="checkbox"/> Place of recreation or sports, except at school 8 <input type="checkbox"/> Other 9 <input type="checkbox"/> Don't know</p>	<p>68</p>

Notes

Section P7 — GENERAL HEALTH STATUS

RT 96
3-4

**CHECK
ITEM 18**

Refer to age of sample child.

- 1 3+ years old (1)
2 Under 3 years old (3)

5

1. Does — wear glasses or contact lenses?

- 1 Yes
2 No

6

2. About how long has it been since — LAST saw someone for dental care?

- 1 6 months ago or less
2 Over 6 months to 12 months
3 Over 12 months to 2 years
4 Over 2 years to 5 years
5 More than 5 years
0 Never
9 DK

7

3. When riding in a car, does — wear a seat belt or restraint all or most of the time, some of the time, once in a while, or never?

- 1 All /most of time
2 Some of the time
3 Once in a while
0 Never
9 DK

8

**CHECK
ITEM 19**

Refer to age of sample child.

- 1 Under 6 years old and biological mother is respondent (4)
8 Other (6)

9

4a. Did you smoke cigarettes at all during the year before — was born?

- 1 Yes
2 No (4e)

10

b. Did you continue to smoke during the entire pregnancy?

- 1 Yes (4d)
2 No

11

c. Did you stop during the first three months of the pregnancy or later?

- 1 Before pregnancy
2 1st three months
3 Later
9 DK

12

d. About how many cigarettes a day did you usually smoke?

_____ Number
99 DK

13-14

e. Do you now smoke?

- 1 Yes (5)
2 No

15

f. How long ago did you stop?

_____ Number { 1 Days
2 Months
3 Years

16-18

5. During most of your pregnancy, would you say you were in contact with persons who smoked cigarettes such as friends, co-workers or family members — occasionally, often, always or never?

- 1 Occasionally
2 Often
3 Always
0 Never
9 DK

19

6a. Has anyone in your household smoked regularly since — was born?

- 1 Yes
2 No } (7)
9 DK

20

b. Is anyone in the household currently smoking cigarettes?

- 1 Yes (7)
2 No (6c)
9 DK (7)

21

c. How long has it been since anyone in the household smoked cigarettes?

- 1 During the last 12 months
2 More than 12 months ago

22

Section P7 – GENERAL HEALTH STATUS – Continued

7. Please tell me whether each of the following statements about — health is mostly true or mostly false. The first statement is: “(sample child) health is excellent.” Has this been mostly true or mostly false? (Record response and continue with statement b.)

	Mostly true (1)	Mostly false (2)
a. — health is excellent	1 <input type="checkbox"/>	2 <input type="checkbox"/> 23
b. — seems to resist illness very well	1 <input type="checkbox"/>	2 <input type="checkbox"/> 24
c. — seems less healthy than other children I know	1 <input type="checkbox"/>	2 <input type="checkbox"/> 25
d. When there is something going around, — usually catches it	1 <input type="checkbox"/>	2 <input type="checkbox"/> 26
e. — is somewhat clumsy	1 <input type="checkbox"/>	2 <input type="checkbox"/> 27
f. — seems accident-prone	1 <input type="checkbox"/>	2 <input type="checkbox"/> 28
g. When — is sick or injured, — usually recovers quickly	1 <input type="checkbox"/>	2 <input type="checkbox"/> 29

8a. Has — EVER been seriously ill? **30**
 1 Yes
 2 No } (Check Item 20)
 9 DK

b. Was — EVER so sick that you thought — might die? **31**
 1 Yes
 2 No
 9 DK

CHECK ITEM 20 *Refer to age of sample child.* **32**
 1 Under 1 year (10)
 2 1+ years old (9)

9a. On weeknights (If 4+ : during the school year), does — usually go to bed at about the same time each night, or does — bedtime vary a lot from night to night? **33**
 1 Has usual bedtime
 2 Bedtime varies (9c)

b. About what time does — usually go to bed? **34-38**
Round time to nearest quarter hour.
 _____ : _____ 1 a.m. } (10)
 _____ : _____ 2 p.m.
 99999 DK

c. What is the latest time that — goes to bed on weekdays? **39-43**
Round time to nearest quarter hour.
 _____ : _____ 1 a.m.
 _____ : _____ 2 p.m.
 99999 DK

10a. Does — usually sleep in one room or in different rooms? **44**
 1 One room
 2 Different rooms

b. Does — usually sleep alone in a room or share a room? **45**
 1 Alone (Section P8)
 2 Shares

c. Who usually sleeps in the room with —? **46**
Mark all that apply.
Anyone else?
 1 Brother(s) **47**
 2 Sister(s) **48**
 3 Other child(ren) **49**
 4 Father **50**
 5 Mother **51**
 8 Other adult(s) **52**
 9 DK

Section P8 – SCHOOL

**CHECK
ITEM 21**

Refer to age of sample child.

- 0 Under 5 years old (Section P9)
1 5+ years old

53

1. Has — ever attended school?

- 1 Yes
2 No (Section P9)

54

2. Is — NOW either going to school or on vacation from school?

- 1 Going to school
2 On vacation from school
0 Neither (5)

55

**3. What grade [is — in now?]
will — be in?]**

If child is between grades, enter grade promoted to.

- 21 Nursery school or preschool } (Section P9)
22 Kindergarten }
_____ Grade

56-57

4. Overall what kind of student would you say — is now? Is — one of the best in the class, above the middle, in the middle, below the middle, or near the bottom of the class?

- 1 One of the best }
2 Above the middle } (6)
3 In the middle }
4 Below the middle }
5 Near the bottom }

58

5a. Why did — stop going to school?

- 0 Never went — health reasons } (Section P9)
1 Never went — other reasons }
2 Graduated
3 Health problem
4 Dropped out
8 Other — Specify ↴

59

b. How long ago did — stop going to school?

- 1 Less than 12 months
2 12 months — less than 2 years (7)
3 2+ years (7)

60

6. During the past 12 months, that is, since (12 month date) a year ago, about how many days was — absent from school because of illness?

- 00 None
_____ Days

61-62

7a. Has — repeated any grades for any reasons?

- 1 Yes
2 No (8)

63

b. What grade or grades did — repeat?

_____ Grade(s)

64-65

66-67

c. Why did — repeat the (grades in 7b) grade(s)?

Mark all that apply.

- 1 Academic failure
2 Immature/acted too young
3 Frequently absent
4 Moved into more difficult school
8 Other — Specify ↴

68

69

70

71

72

d. Any other reasons?

- Yes (Reask 7c and d)
 No

73

8a. Has — ever been suspended, excluded, or expelled from school?

- 1 Yes
2 No (9)

74

b. How many times has this happened?

_____ Number

75-76

c. How long ago was the last time?

- Number { 1 Days
2 Weeks
3 Months
4 Years

77-79

d. Was it for health or behavior reasons?

- 1 Health
2 Behavior
8 Other
9 DK

80

9a. Not counting routine conferences, has anyone from — school ever asked someone to come in to talk about problems — was having?

- 1 Yes
2 No (Section P9)

81

b. How long ago was the last time?

- Number { 1 Days
2 Weeks
3 Months
4 Years

82-84

Section P9 — DEVELOPMENT, LEARNING, BEHAVIOR

<p>1. Has --- EVER had ---</p> <p>a. a delay in --- growth or development?</p> <p style="text-align: center;"><i>Mark box or ask:</i></p> <p>b. a learning disability?</p> <p>c. an emotional or behavioral problem that lasted 3 months or more?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>0 <input type="checkbox"/> Child under 3 (Check Item 22)</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>5</p> <p>6</p> <p>7</p>
---	---	----------------------------

CHECK ITEM 22

Refer to 1

1 1 or more "Yes" in 1 a-c (2)
8 All other (Check Item 23)

8

	Delay in Development (1)	Learning Disability (2)	Emotion/Behavior Problem (3)
<i>Ask 2a-h for each "Yes" in 1a-c.</i>	9-11	23-25	37-39
2a. How old was --- when the (condition) was first noticed?	000 <input type="checkbox"/> Since birth Age { 1 <input type="checkbox"/> Months 2 <input type="checkbox"/> Years	000 <input type="checkbox"/> Since birth Age { 1 <input type="checkbox"/> Months 2 <input type="checkbox"/> Years	000 <input type="checkbox"/> Since birth Age { 1 <input type="checkbox"/> Months 2 <input type="checkbox"/> Years
b. Has --- ever received treatment or counseling for the (condition)?	1 <input type="checkbox"/> Yes 12 2 <input type="checkbox"/> No (2e)	1 <input type="checkbox"/> Yes 26 2 <input type="checkbox"/> No (2e)	1 <input type="checkbox"/> Yes 40 2 <input type="checkbox"/> No (2e)
c. Has --- received any such treatment or counseling during the past 12 months?	1 <input type="checkbox"/> Yes 13 2 <input type="checkbox"/> No (2e)	1 <input type="checkbox"/> Yes 27 2 <input type="checkbox"/> No (2e)	1 <input type="checkbox"/> Yes 41 2 <input type="checkbox"/> No (2e)
d. During the past 12 months, about how many times did anyone see or talk to a doctor, psychologist, or counselor about this problem?	14-16 Times 999 <input type="checkbox"/> DK	28-30 Times 999 <input type="checkbox"/> DK	42-44 Times 999 <input type="checkbox"/> DK
<i>Mark box or ask:</i>	17	31	45
e. During the past 12 months, did the (condition) cause --- to miss any time from school?	0 <input type="checkbox"/> Not in school (2h) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2g)	0 <input type="checkbox"/> Not in school (2h) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2g)	0 <input type="checkbox"/> Not in school (2h) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2g)
f. On how many days in the past 12 months did --- miss part or all of the school day because of this problem?	18-20 Days 999 <input type="checkbox"/> DK	32-34 Days 999 <input type="checkbox"/> DK	46-48 Days 999 <input type="checkbox"/> DK
g. During the past 12 months, did the (condition) make it necessary for --- to attend special classes, or a special school, or get special help at school?	1 <input type="checkbox"/> Yes 21 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 35 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 49 2 <input type="checkbox"/> No
h. During the past 12 months, has --- been taking any medicine for the (condition)?	1 <input type="checkbox"/> Yes 22 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 36 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 50 2 <input type="checkbox"/> No
	<i>(Col. (2) or Section P10)</i>	<i>(Col. (3) or Section P10)</i>	<i>(Section P10)</i>

CHECK ITEM 23

Refer to age of sample child.

0 Under 3 years old (Section P10)
1 3+ years old (3)

51

<p>3a. Has --- ever seen a psychiatrist, psychologist, doctor, or counselor about any emotional, mental, or behavior problem?</p> <p>b. When was the last time --- saw this person?</p> <p>c. During the past 12 months, have you felt, or has anyone suggested, that --- needed help for any emotional, mental, or behavioral problem?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (3c)</p> <p>1 <input type="checkbox"/> More than 12 months ago 2 <input type="checkbox"/> Within past 12 months (Section P10)</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>52</p> <p>53</p> <p>54</p>
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Section P10 – HEALTH SERVICES

<p>Now I will ask about ROUTINE care, including routine checkups and immunizations when nothing is wrong.</p> <p>1. How long has it been since — last visit to a clinic, health center, hospital, doctor's office or other place for routine health care?</p>	<p>1 <input type="checkbox"/> Less than 6 months 2 <input type="checkbox"/> 6 months, less than 1 year 3 <input type="checkbox"/> 1 year, less than 2 years 4 <input type="checkbox"/> 2 years, less than 5 years 5 <input type="checkbox"/> 5 or more years 9 <input type="checkbox"/> DK 0 <input type="checkbox"/> Never (4)</p>	55
<p>2. Is there a particular clinic, health center, hospital, doctor's office or other place that — usually goes to for routine health care?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (4)</p>	56
<p>3. What kind of place is it — a clinic, a health center, a hospital, a doctor's office, or some other place?</p> <p><i>PROBE IF CLINIC:</i> Is this a private clinic, a hospital outpatient clinic, a company or school clinic, a migrant clinic, or some other kind of clinic?</p> <p><i>PROBE IF HEALTH CENTER:</i> Is this a community health center, neighborhood health center, a family health center, a rural health center, or some other kind of health center?</p> <p><i>PROBE IF HOSPITAL:</i> Is this an outpatient clinic or emergency room?</p>	<p>01 <input type="checkbox"/> Home 02 <input type="checkbox"/> Doctor's office or private clinic 03 <input type="checkbox"/> Company or school clinic 04 <input type="checkbox"/> Hospital outpatient clinic 05 <input type="checkbox"/> Migrant clinic 06 <input type="checkbox"/> Other clinic — <i>Specify</i> _____ 07 <input type="checkbox"/> Hospital emergency room 08 <input type="checkbox"/> Community, neighborhood, or family health center 09 <input type="checkbox"/> Walk-in/emergency care center 10 <input type="checkbox"/> Rural health center 11 <input type="checkbox"/> HMO/prepaid group 88 <input type="checkbox"/> Other place — <i>Specify</i> _____</p>	57-58
<p>Now I will ask about — visits for health care when — is sick or injured.</p> <p>4. Is there a particular clinic, health center, hospital, doctor's office or other place that — usually goes to when — is sick or injured?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (8)</p>	59
<p>5. Is this the same (place in 3) or is it somewhere else?</p>	<p>1 <input type="checkbox"/> Same place 2 <input type="checkbox"/> Somewhere else</p>	60
<p><i>IF "SAME PLACE" IN 5, REFER TO 3 AND MARK WITHOUT ASKING, OTHERWISE ASK:</i></p> <p>6. What kind of place is it — a clinic, a health center, a hospital, a doctor's office, or some other place?</p> <p><i>PROBE IF CLINIC:</i> Is this a private clinic, a hospital outpatient clinic, a company or school clinic, a migrant clinic, or some other kind of clinic?</p> <p><i>PROBE IF HEALTH CENTER:</i> Is this a community health center, neighborhood health center, a family health center, a rural health center, or some other kind of health center?</p> <p><i>PROBE IF HOSPITAL:</i> Is this an outpatient clinic or emergency room?</p>	<p>01 <input type="checkbox"/> Home 02 <input type="checkbox"/> Doctor's office or private clinic (9) 03 <input type="checkbox"/> Company or school clinic 04 <input type="checkbox"/> Hospital outpatient clinic 05 <input type="checkbox"/> Migrant clinic 06 <input type="checkbox"/> Other clinic — <i>Specify</i> _____ 07 <input type="checkbox"/> Hospital emergency room 08 <input type="checkbox"/> Community, neighborhood, or family health center 09 <input type="checkbox"/> Walk-in/Emergency clinic 10 <input type="checkbox"/> Rural health center 11 <input type="checkbox"/> HMO/prepaid group 88 <input type="checkbox"/> Other place — <i>Specify</i> _____</p>	61-62
<p>7a. Is there a particular medical person — usually sees at the (place in 6) when — is sick?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (9)</p>	63
<p>b. Is there someone at the (place in 6), that knows about — health history who will give you advice over the telephone?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (9)</p>	64
<p><i>Hand Card P4. Read categories if telephone interview.</i></p> <p>8. Many people do not have a particular place they usually go when they are sick. (Could you please give me the number of the statement) which is the MAIN reason — does not have a particular place — usually goes?</p> <p>1. Has two or more usual doctors or places depending on what is wrong. 2. Has not needed a doctor. 3. Previous doctor no longer available. 4. Have not been able to find the right doctor. 5. Recently moved to area. 8. Other reason (Specify).</p>	<p>1 2 3 4 5 8</p> <p style="text-align: center;">_____</p> <p style="text-align: center;"><i>Specify</i></p>	65

Section P11 — BEHAVIOR PROBLEMS INDEX

**CHECK
ITEM 24**

Refer to age of sample child.

- 1 Under 5 years old (*Cover Page*)
2 5+ years old (*Intro*)

72

INTRO

Now I am going to read some statements that describe the behavior of many children. Please tell me whether each statement has been **OFTEN** true, **SOMETIMES** true, or **NOT** true of — during the past 3 months?

The first statement is: "Has sudden changes in mood or feelings." Has that been **OFTEN** true, **SOMETIMES** true, or **NOT** true of — in the past 3 months.

Record response and continue with statement 2.

Read list repeating categories and/or time reference as needed.

	Often true (a)	Sometimes true (b)	Not true (c)	
1. Has sudden changes in mood or feelings.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	73
2. Feels or complains that no one loves —.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	74
3. Is rather high strung, tense, or nervous.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	75
4. Cheats or tells lies.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	76
5. Is too fearful or anxious.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	77
6. Argues too much.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	78
7. Has difficulty concentrating, cannot pay attention for long.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	79
8. Is easily confused, seems to be in a fog.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	80
9. Bullies, or is cruel or mean to others.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	81
10. Is disobedient at home.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	82
11. Is disobedient at school.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	83
12. Does not seem to feel sorry after — misbehaves.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	84
13. Has trouble getting along with other children.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	85
14. Has trouble getting along with teachers.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	86
15. Is impulsive, or acts without thinking.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	87
16. Feels worthless or inferior.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	88
17. Is not liked by other children.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	89
18. Has a lot of difficulty getting — mind off certain thoughts, has obsessions.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	90
19. Is restless or overly active, cannot sit still.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	91
20. Is stubborn, sullen, or irritable.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	92
21. Has a very strong temper and loses it easily.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	93
22. Is unhappy, sad or depressed.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	94
23. Is withdrawn, does not get involved with others.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	95
<i>If child is 12+ years old, go to 29.</i>				96
24. Breaks things on purpose, deliberately destroys — own or others' things.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
25. Clings to adults.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97
26. Cries too much.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	98
27. Demands a lot of attention.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	99
28. Is too dependent on others.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	100
<i>If child is under 12 years, go to Cover Page</i>				101
29. Feels others are out to get —.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	

Section P11 – BEHAVIOR PROBLEMS INDEX – Continued

	Often true (a)	Sometimes true (b)	Not true (c)	
30. Hangs around with kids who get into trouble.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	102
31. Is secretive, keeps things to [himself/herself].	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	103
32. Worries too much.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	104

Notes

FORM HIS-3
(9-2-87)U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS**NOTICE** — Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).**ALCOHOL QUESTIONNAIRE**

1. RO	2. Sample	3. Control number			4. Person number	5. Interviewer's name	Code
		PSU	Segment	Serial			

INSTRUCTIONS — Please circle "Yes" or "No" if any of these things have or have not ever happened to you IN YOUR ENTIRE LIFE. If you need any help ask me for assistance.RT 90
3-4**IN YOUR ENTIRE LIFE HAVE you ever . . .**

1. Had a strong desire or urge to drink?	1 Yes 2 No	5
2. Started drinking even though you hadn't intended to?	1 Yes 2 No	6
3. Ended up drinking much more than you intended to?	1 Yes 2 No	7
4. Found it difficult to stop drinking once you had started?	1 Yes 2 No	8
5. Driven a car after having had too much to drink?	1 Yes 2 No	9
6. Been sick or vomited after drinking, or the morning after?	1 Yes 2 No	10
7. Done things when drinking that could have caused you to be hurt?	1 Yes 2 No	11
8. Felt the effects of alcohol sooner than you used to?	1 Yes 2 No	12
9. Kept on drinking for a longer period of time than you intended to?	1 Yes 2 No	13
10. Found that the same amount of alcohol had less effect than before?	1 Yes 2 No	14
11. Felt depressed, irritable, or nervous after drinking, or the morning after?	1 Yes 2 No	15
12. Felt powerless over your drinking?	1 Yes 2 No	16
13. Sought help from family, friends, professionals or self-help groups about your drinking?	1 Yes 2 No	17
14. Had a spouse or someone you lived with threaten to leave you because of your drinking?	1 Yes 2 No	18
15. Gone on benders or binges that lasted two or more days?	1 Yes 2 No	19
16. Tried to cut down or stop drinking and found you couldn't do it?	1 Yes 2 No	20
17. Found yourself sweating heavily or shaking after drinking, or the morning after?	1 Yes 2 No	21
18. Given up or cut down on activities or interests like sports or associations with friends, in order to drink?	1 Yes 2 No	22
19. Been unable to remember some of the things you did while drinking?	1 Yes 2 No	23
20. Needed a drink so badly you couldn't think of anything else?	1 Yes 2 No	24
21. Found that you had to drink more than you once did to get the same effect?	1 Yes 2 No	25

Continue on reverse

ALCOHOL QUESTIONNAIRE — Continued

INSTRUCTIONS — Please circle "Yes" or "No" if any of these things have or have not ever happened to you IN YOUR ENTIRE LIFE. If you need any help ask me for assistance.

IN YOUR ENTIRE LIFE have you ever . . .

22. Stayed away from work or gone to work late because of drinking or a hangover?	1Yes 2No	26
23. Spent money on drinks that was needed for essentials like food, or bills?	1Yes 2No	27
24. Lost ties with or drifted apart from a family member or friend because of your drinking?	1Yes 2No	28
25. Gotten drunk instead of doing the things you were supposed to do?	1Yes 2No	29
26. Had a doctor suggest that you cut down or stop drinking alcohol?	1Yes 2No	30
27. Continued to drink alcohol even though it was a threat to your health?	1Yes 2No	31
28. Lost a job, or nearly lost one, because of drinking?	1Yes 2No	32
29. Had family, friends or co-workers suggest that you stop or cut down on your drinking?	1Yes 2No	33
30. Done things when drinking that could have caused someone else to be hurt?	1Yes 2No	34
31. Felt uneasy if alcohol was not around in case you wanted a drink?	1Yes 2No	35
32. Spent a lot of time drinking, or getting over the effects of drinking?	1Yes 2No	36
33. Been so hungover that it interfered with doing things you were supposed to do?	1Yes 2No	37
34. Kept drinking even though it caused you emotional problems?	1Yes 2No	38
35. Had your chances for promotion, raises, or better jobs hurt by your drinking?	1Yes 2No	39
36. Heard or seen things that weren't really there after drinking, or the morning after?	1Yes 2No	40
37. Taken a drink to keep yourself from shaking or feeling sick either after drinking, or the morning after?	1Yes 2No	41
38. Kept drinking even though it caused you problems at home, work, or school?	1Yes 2No	42
39. Attended a meeting of Alcoholics Anonymous (AA) because of your drinking?	1Yes 2No	43
40. Been arrested or had trouble with the police because of your drinking?	1Yes 2No	44
41. Wanted to cut down or stop your drinking and found you couldn't do it?	1Yes 2No	45

FORM HS-3 (9-2-87)

FD-203
HIS-2
(5-2-87)U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

NOTICE — Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

ALCOHOL QUESTIONNAIRE

1. RO	2. Sample	3. Control number PSU Segment Serial	4. Person number	5. Interviewer's name	Code
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RT 89

3-4

INSTRUCTIONS — In COLUMN 1, please circle the answer that best describes the number of times each of these things has happened to you IN THE PAST 12 MONTHS. Complete column 1 for each question first. Then go back and in COLUMN 2, circle "Yes" or "No" if any of these things have or have not ever happened to you IN YOUR ENTIRE LIFE. If you need any help ask me for assistance.

COLUMN 1
IN THE PAST 12 MONTHS how many times have you ...

COLUMN 2
In your ENTIRE LIFE have you ever ...

1. Had a strong desire or urge to drink?	0	1	2-3	4 or more	5	1Yes	2No	6
2. Started drinking even though you hadn't intended to?	0	1	2-3	4 or more	7	1Yes	2No	8
3. Ended up drinking much more than you intended to?	0	1	2-3	4 or more	9	1Yes	2No	10
4. Found it difficult to stop drinking once you had started?	0	1	2-3	4 or more	11	1Yes	2No	12
5. Driven a car after having had too much to drink?	0	1	2-3	4 or more	13	1Yes	2No	14
6. Been sick or vomited after drinking, or the morning after?	0	1	2-3	4 or more	15	1Yes	2No	16
7. Done things when drinking that could have caused you to be hurt?	0	1	2-3	4 or more	17	1Yes	2No	18
8. Felt the effects of alcohol sooner than you used to?	0	1	2-3	4 or more	19	1Yes	2No	20
9. Kept on drinking for a longer period of time than you intended to?	0	1	2-3	4 or more	21	1Yes	2No	22
10. Found that the same amount of alcohol had less effect than before?	0	1	2-3	4 or more	23	1Yes	2No	24
11. Felt depressed, irritable, or nervous after drinking, or the morning after?	0	1	2-3	4 or more	25	1Yes	2No	26
12. Felt powerless over your drinking?	0	1	2-3	4 or more	27	1Yes	2No	28
13. Sought help from family, friends, professionals or self-help groups about your drinking?	0	1	2-3	4 or more	29	1Yes	2No	30
14. Had a spouse or someone you lived with threaten to leave you because of your drinking?	0	1	2-3	4 or more	31	1Yes	2No	32
15. Gone on benders or binges that lasted two or more days?	0	1	2-3	4 or more	33	1Yes	2No	34
16. Tried to cut down or stop drinking and found you couldn't do it?	0	1	2-3	4 or more	35	1Yes	2No	36
17. Found yourself sweating heavily or shaking after drinking, or the morning after?	0	1	2-3	4 or more	37	1Yes	2No	38
18. Given up or cut down on activities or interests like sports or associations with friends, in order to drink?	0	1	2-3	4 or more	39	1Yes	2No	40
19. Been unable to remember some of the things you did while drinking?	0	1	2-3	4 or more	41	1Yes	2No	42
20. Needed a drink so badly you couldn't think of anything else?	0	1	2-3	4 or more	43	1Yes	2No	44
21. Found that you had to drink more than you once did to get the same effect?	0	1	2-3	4 or more	45	1Yes	2No	46

Continue on reverse

ALCOHOL QUESTIONNAIRE – Continued

	COLUMN 1					COLUMN 2		
	IN THE PAST 12 MONTHS how many times have you ...					In your ENTIRE LIFE have you ever...		
	0	1	2-3	4 or more	[]	1Yes	2No	[]
22. Stayed away from work or gone to work late because of drinking or a hangover?	0	1	2-3	4 or more	47			48
23. Spent money on drinks that was needed for essentials like food, or bills?	0	1	2-3	4 or more	49			50
24. Lost ties with or drifted apart from a family member or friend because of your drinking?	0	1	2-3	4 or more	51			52
25. Gotten drunk instead of doing the things you were supposed to do?	0	1	2-3	4 or more	53			54
26. Had a doctor suggest that you cut down or stop drinking alcohol?	0	1	2-3	4 or more	55			56
27. Continued to drink alcohol even though it was a threat to your health?	0	1	2-3	4 or more	57			58
28. Lost a job, or nearly lost one, because of drinking?	0	1	2-3	4 or more	59			60
29. Had family, friends or co-workers suggest that you stop or cut down on your drinking?	0	1	2-3	4 or more	61			62
30. Done things when drinking that could have caused someone else to be hurt?	0	1	2-3	4 or more	63			64
31. Felt uneasy if alcohol was not around in case you wanted a drink?	0	1	2-3	4 or more	65			66
32. Spent a lot of time drinking, or getting over the effects of drinking?	0	1	2-3	4 or more	67			68
33. Been so hungover that it interfered with doing things you were supposed to do?	0	1	2-3	4 or more	69			70
34. Kept drinking even though it caused you emotional problems?	0	1	2-3	4 or more	71			72
35. Had your chances for promotion, raises, or better jobs hurt by your drinking?	0	1	2-3	4 or more	73			74
36. Heard or seen things that weren't really there after drinking, or the morning after?	0	1	2-3	4 or more	75			76
37. Taken a drink to keep yourself from shaking or feeling sick either after drinking, or the morning after?	0	1	2-3	4 or more	77			78
38. Kept drinking even though it caused you problems at home, work, or school?	0	1	2-3	4 or more	79			80
39. Attended a meeting of Alcoholics Anonymous (AA) because of your drinking?	0	1	2-3	4 or more	81			82
40. Been arrested or had trouble with the police because of your drinking?	0	1	2-3	4 or more	83			84
41. Wanted to cut down or stop your drinking and found you couldn't do it?	0	1	2-3	4 or more	85			86

FORM HIS-4A (1988)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR THE
U.S. PUBLIC HEALTH SERVICE

NATIONAL HEALTH INTERVIEW SURVEY

AIDS KNOWLEDGE AND ATTITUDES

NOTICE - Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

1. Book <u>RT 98</u> of <u>3-7</u> books		2. R.O. number <u>9-10</u>	3. Sample <u>11-13</u>
4. Control number PSU <u>14-16</u> Segment <u>17-23</u> Serial <u>24-25</u>		5. Beginning time <u>28-29</u> <u>30</u>	
		1 a.m.	
		2 p.m.	

6. NUMBER OF FAMILY MEMBERS 18 + YEARS OLD
(Record number of nondeleted family members 18 + years old.)

_____ 31-32

Space 33-36

7. FINAL STATUS

- No person 18 + in this family (Household Page)
- Interview (Complete Item 63, Page 18)
- Complete interview (all appropriate questions completed)
- Partial interview (some but not all appropriate questions completed) - Explain z

Noninterview (Complete Item 63, Page 18)

- Refusal (Explain in Notes)
- SP temporarily absent
- SP mentally or physically incapable
- Other - Explain z

37

8. Ending time <u>38-41</u> <u>42</u>	9. Interview mode <u>43</u>	11. Interviewer identification <u>44-46</u>
1 a.m.	<input type="checkbox"/> Personal	Name _____ Code _____
2 p.m.	<input type="checkbox"/> Telephone	

TRANSCRIPTION FROM COMPLETED HIS-1

12. Sex of SP (Page 2 or 51, question 3) <u>47</u>	13. Education of SP (Page 42 or 43, question 2a) <u>48-49</u>	14. Main race of SP (Page 42 or 43, question 3a/b) <u>51</u>
<input type="checkbox"/> M <input type="checkbox"/> F	00 <input type="checkbox"/> Never attended or kindergarten Elem: 1 2 3 4 5 6 7 8 High: 9 10 11 12 College: 1 2 3 4 5 6 + Finish grade/year (Question 2b) <u>50</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	1 2 3 4 5 - Specify <u>z</u>

15. Marital status (Page 46 or 47, question 7) <u>52</u>	16. Family income (Page 46, question 8b) <u>53-54</u>	17. <u>55-56</u>	18. <u>57-58</u>	19. Booklet type <u>59</u>
<input type="checkbox"/> Married - spouse in HH <input type="checkbox"/> Married - spouse not in HH <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Never married	00 <input type="checkbox"/> A 07 <input type="checkbox"/> H 14 <input type="checkbox"/> O 21 <input type="checkbox"/> V 01 <input type="checkbox"/> B 08 <input type="checkbox"/> I 15 <input type="checkbox"/> P 22 <input type="checkbox"/> W 02 <input type="checkbox"/> C 09 <input type="checkbox"/> J 16 <input type="checkbox"/> Q 23 <input type="checkbox"/> X 03 <input type="checkbox"/> D 10 <input type="checkbox"/> K 17 <input type="checkbox"/> R 24 <input type="checkbox"/> Y 04 <input type="checkbox"/> E 11 <input type="checkbox"/> L 18 <input type="checkbox"/> S 25 <input type="checkbox"/> Z 05 <input type="checkbox"/> F 12 <input type="checkbox"/> M 19 <input type="checkbox"/> T 26 <input type="checkbox"/> ZZ 06 <input type="checkbox"/> G 13 <input type="checkbox"/> N 20 <input type="checkbox"/> U (Transcribe from 8a if 8b blank) 27 <input type="checkbox"/> \$20,000 or more 28 <input type="checkbox"/> Less than \$20,000	Sample Person Number _____	Sample Person Age _____	1 x AIDS Knowledge and Attitudes Version 1

Introduction: These next questions are to determine what people know about AIDS, also called Acquired Immunodeficiency Syndrome.

1. In the PAST MONTH, have you . . .

a. seen any Public Service Announcements about AIDS on television?

1 Yes 2 No 9 DK 60

b. heard any Public Service Announcements about AIDS on the radio?

1 Yes 2 No 9 DK 61

**CHECK
ITEM** 1

Refer to Q. 1a,b

"Yes" in 1a and/or 1b (2)
 Other (3)

2. Were any of those Public Service Announcements called "America Responds to AIDS"?

1 Yes 62
2 No
9 DK

3. In the PAST MONTH, have you read any brochures or pamphlets about AIDS? Do not include articles in magazines or newspapers.

1 Yes (5) 63
2 No
9 DK

4. Have you EVER read any brochures or pamphlets about AIDS? Again, do not include articles in magazines or newspapers.

1 Yes (5) 64
2 No }
9 DK } (Check Item 2)

<p>5. Where did you get the pamphlets or brochures? Anywhere else? (MARK ALL THAT APPLY)</p>	<p>1 <input type="checkbox"/> Clinic, other than work clinic 65 1 <input type="checkbox"/> Doctor's office/HMO 66 1 <input type="checkbox"/> Drug store 67 1 <input type="checkbox"/> Public Health Department 68 1 <input type="checkbox"/> Received it in the mail without asking for it 69 1 <input type="checkbox"/> Red Cross/with Red Cross blood donation 70 1 <input type="checkbox"/> With other blood donation 71 1 <input type="checkbox"/> School 72 1 <input type="checkbox"/> Sent/phoned for it myself, requested it 73 1 <input type="checkbox"/> "The Government" - Federal, state or local 74 1 <input type="checkbox"/> Work, other than clinic or nurse 75 1 <input type="checkbox"/> Work, nurse or clinic 76 1 <input type="checkbox"/> Other (SPECIFY) 77</p>	
<p>CHECK ITEM 2</p>	<p>Refer to assignment</p>	<p><input type="checkbox"/> May, June, July ¹⁹⁸⁸ (6) <input type="checkbox"/> Other (17)</p>
<p>6. The Government is mailing a brochure with basic information about AIDS to each household in the country.</p> <p>, HOLD COPY UP The brochure looked like this. /</p> <p>The brochure is 8½ by 11 inches, white with blue and black printing, and has a picture of Dr. C. Everett Koop, the Surgeon General of the United States on the cover, with the title, "Understanding AIDS" printed at the top..</p> <p>Was this brochure received at this household?</p>	<p style="text-align: right;">78</p> <p>1 <input type="checkbox"/> Yes (7) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't Know } (17)</p>	
<p>7. How much of the brochure did you read; would you say all or almost all of it, about half, less than half, or none of it?</p>	<p>1 <input type="checkbox"/> All/Almost all 79 2 <input type="checkbox"/> About half 3 <input type="checkbox"/> Less than half 4 <input type="checkbox"/> None 9 <input type="checkbox"/> DK</p>	

8. When you read it, did you read it carefully or did you just skim through it?	1 <input type="checkbox"/> Read carefully 80 2 <input type="checkbox"/> Skimmed through 8 <input type="checkbox"/> Other (SPECIFY) 9 <input type="checkbox"/> DK _____
9. Did the brochure give you any new information or answer any questions you had about AIDS?	1 <input type="checkbox"/> Yes 81 2 <input type="checkbox"/> No
(IF ONE-PERSON HOUSEHOLD, MARK BOX 3 AND SKIP TO Q. 11)	
10. Did you discuss the brochure with anyone else in the family?	1 <input type="checkbox"/> Yes 82 2 <input type="checkbox"/> No 3 <input type="checkbox"/> One-person
11. Do you have any children aged 10 through 17?	1 <input type="checkbox"/> Yes 83 2 <input type="checkbox"/> No (21)
12. How many do you have?	_____ 84-85
13. Did [this child/any of your children aged 10 through 17] read the brochure?	1 <input type="checkbox"/> Yes 86 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
14. Was the brochure discussed with [this child/any of your children aged 10 through 17]?	1 <input type="checkbox"/> Yes (16) 87 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
15. Have you ever discussed AIDS with [this child/any of your children aged 10 through 17]?	1 <input type="checkbox"/> Yes 88 2 <input type="checkbox"/> No
16. [Has this child/Have any or all of your children aged 10 through 17] had instruction at school about AIDS?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (21) 89
17. Do you have any children aged 10 through 17?	1 <input type="checkbox"/> Yes 90 2 <input type="checkbox"/> No (21)
18. How many do you have?	_____ 91-92

19. Have you ever discussed AIDS with [this child/any of your children aged 10 through 17]?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 93																																																								
20. [Has this child/Have any or all of your children aged 10 through 17] had instruction at school about AIDS?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 94																																																								
21. How much would you say you know about AIDS --- a lot, some, a little, or nothing?	1 <input type="checkbox"/> A lot 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> A little 4 <input type="checkbox"/> Nothing 95																																																								
22. To the best of your knowledge, is there a difference between having the AIDS virus and having the disease AIDS?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 8 <input type="checkbox"/> Other (SPECIFY) 9 <input type="checkbox"/> DK 96																																																								
HAND CARD A																																																									
23. After I read each statement, tell me whether you think the statement is definitely true, probably true, probably false, definitely false, or you don't know if it is true or false.	<table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 10%;">Def. True</th> <th style="width: 10%;">Prob. True</th> <th style="width: 10%;">Prob. False</th> <th style="width: 10%;">Def. False</th> <th style="width: 10%;">DK</th> <th style="width: 10%;"></th> </tr> </thead> <tbody> <tr> <td>a. AIDS can reduce the body's natural protection against disease.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="text-align: right;">97</td> </tr> <tr> <td>b. AIDS is especially common in older people.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="text-align: right;">98</td> </tr> <tr> <td>c. AIDS can damage the brain.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="text-align: right;">99</td> </tr> <tr> <td>d. AIDS usually leads to heart disease.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="text-align: right;">100</td> </tr> <tr> <td>e. AIDS is an infectious disease caused by a virus.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="text-align: right;">101</td> </tr> <tr> <td>f. Teenagers cannot get AIDS.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="text-align: right;">102</td> </tr> <tr> <td>g. AIDS leads to death.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td style="text-align: right;">103</td> </tr> </tbody> </table>		Def. True	Prob. True	Prob. False	Def. False	DK		a. AIDS can reduce the body's natural protection against disease.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	97	b. AIDS is especially common in older people.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	98	c. AIDS can damage the brain.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	99	d. AIDS usually leads to heart disease.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	100	e. AIDS is an infectious disease caused by a virus.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	101	f. Teenagers cannot get AIDS.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	102	g. AIDS leads to death.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	103
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23. (Continued)

Tell me whether you think each of these statements is definitely true, probably true, probably false, definitely false, or you don't know if it is true or false.

h. A person can be infected with the AIDS virus and not have the disease AIDS.

Def. True	Prob. True	Prob. False	Def. False	DK
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/> 104

i. Looking at a person is enough to tell if he or she has the AIDS virus.

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/> 105
----------------------------	----------------------------	----------------------------	----------------------------	--------------------------------

j. ANY person with the AIDS virus can pass it on to someone else through sexual intercourse.

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/> 106
----------------------------	----------------------------	----------------------------	----------------------------	--------------------------------

k. A person who has the AIDS virus can look and feel well and healthy.

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/> 107
----------------------------	----------------------------	----------------------------	----------------------------	--------------------------------

l. A pregnant woman who has the AIDS virus can give the AIDS virus to her baby.

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/> 108
----------------------------	----------------------------	----------------------------	----------------------------	--------------------------------

m. There is a vaccine available to the public that protects a person from getting the AIDS virus.

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/> 109
----------------------------	----------------------------	----------------------------	----------------------------	--------------------------------

n. There is no cure for AIDS at present.

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/> 110
----------------------------	----------------------------	----------------------------	----------------------------	--------------------------------

HAND CARD B

24. After I read each statement, tell me if you think it is very likely, somewhat likely, somewhat unlikely, very unlikely, definitely not possible, or if you don't know how likely it is that a person will get AIDS or the AIDS virus infection that way.

How likely do you think it is that a person will get AIDS or the AIDS virus infection from ---

- a. living near a home or hospital for AIDS patients.
- b. working near someone with the AIDS virus.
- c. eating in a restaurant where the cook has the AIDS virus.
- d. kissing - with exchange of saliva - a person who has the AIDS virus.
- e. shaking hands, touching, or kissing on the cheek someone who has the AIDS virus.
- f. sharing plates, forks, or glasses with someone who has the AIDS virus.
- g. using public toilets.
- h. sharing needles for drug use with someone who has the AIDS virus.
- i. being coughed on or sneezed on by someone who has the AIDS virus.
- j. attending school with a child who has the AIDS virus.
- k. mosquitoes or other insects.

	Very likely	Somewhat likely	Somewhat unlikely	Very unlikely	Definitely not possible	DK	
a.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	111
b.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	112
c.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	113
d.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	114
e.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	115
f.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	116
g.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	117
h.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	118
i.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	119
j.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	120
k.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>	121

25. Have you ever donated blood?	1 <input type="checkbox"/> Yes (26) 122 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } (27)																																													
26. Have you donated blood --- a. since March, 1985? b. in the past 12 months?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;"></th> <th style="width: 33%; text-align: center;">Yes</th> <th style="width: 33%; text-align: center;">No</th> <th style="width: 33%; text-align: center;">DK</th> <th style="width: 33%;"></th> </tr> </thead> <tbody> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/> (27)</td> <td>9 <input type="checkbox"/> (27)</td> <td></td> <td style="text-align: right;">123</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td></td> <td style="text-align: right;">124</td> </tr> </tbody> </table>		Yes	No	DK		1 <input type="checkbox"/>	2 <input type="checkbox"/> (27)	9 <input type="checkbox"/> (27)		123	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>		124																														
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1 <input type="checkbox"/>	2 <input type="checkbox"/> (27)	9 <input type="checkbox"/> (27)		123																																										
1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>		124																																										
27. Have you ever heard of a blood test that can detect the AIDS virus infection?	1 <input type="checkbox"/> Yes (28) 125 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } (44a, Page 12)																																													
<p>The next questions are about the blood test for the AIDS virus infection. No question will ask what the results are of any tests you may have had.</p> 28. To the best of your knowledge, are blood donations routinely tested now for the AIDS virus infection?	1 <input type="checkbox"/> Yes 126 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK																																													
29a. Have you ever received counseling or had a talk with a health professional about taking the AIDS virus test?	1 <input type="checkbox"/> Yes (29b) 127 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } (31)																																													
29b. Was the discussion --- 1. with a private doctor? 2. at a family planning clinic? 3. on an AIDS hotline? 4. at a prenatal clinic? 5. at an STD or sexually transmitted disease clinic? 6. at an AIDS/HIV counseling and testing site? 7. with some other health professional? 8. with some other counselor?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;"></th> <th style="width: 33%; text-align: center;">Yes</th> <th style="width: 33%; text-align: center;">No</th> <th style="width: 33%; text-align: center;">DK</th> <th style="width: 33%;"></th> </tr> </thead> <tbody> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td></td> <td style="text-align: right;">128</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td></td> <td style="text-align: right;">129</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td></td> <td style="text-align: right;">130</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td></td> <td style="text-align: right;">131</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td></td> <td style="text-align: right;">132</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td></td> <td style="text-align: right;">133</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td></td> <td style="text-align: right;">134</td> </tr> <tr> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td></td> <td style="text-align: right;">135</td> </tr> </tbody> </table>		Yes	No	DK		1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>		128	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>		129	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>		130	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>		131	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>		132	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>		133	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>		134	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>		135
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30. During that discussion, did you receive information about how to avoid getting or passing on the AIDS virus?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	136																																																			
31. Have you ever been advised by a health professional NOT to have the blood test for the AIDS virus infection?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	137																																																			
32. Have you ever been advised by friends or relatives NOT to have the blood test for the AIDS virus infection?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	138																																																			
33. Have you had your blood tested for the AIDS virus infection?	1 <input type="checkbox"/> Yes (34a) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (41)	139																																																			
34a. Have you had your blood tested for the AIDS virus infection more than once?	1 <input type="checkbox"/> Yes (35a) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	140																																																			
34b. Was your blood tested <u>in the past twelve months</u> ?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (36)	141																																																			
35a. How many times have you had your blood tested for the AIDS virus infection? 35b. How many times <u>in the past 12 months</u> have you had your blood tested for the AIDS virus infection?	<table border="0"> <tr> <td>Total times (35a.)</td> <td>Number times in past 12 Months (35b.)</td> <td>142-143</td> </tr> <tr> <td></td> <td></td> <td>144-145</td> </tr> <tr> <td>XXXX</td> <td>00 <input type="checkbox"/> None in past twelve months</td> <td></td> </tr> <tr> <td>XXXX</td> <td>01 <input type="checkbox"/> One time</td> <td></td> </tr> <tr> <td>02 <input type="checkbox"/></td> <td>02 <input type="checkbox"/> Two times</td> <td></td> </tr> <tr> <td>03 <input type="checkbox"/></td> <td>03 <input type="checkbox"/> Three times</td> <td></td> </tr> <tr> <td>04 <input type="checkbox"/></td> <td>04 <input type="checkbox"/> Four times</td> <td></td> </tr> <tr> <td>05 <input type="checkbox"/></td> <td>05 <input type="checkbox"/> Five times</td> <td></td> </tr> <tr> <td>06 <input type="checkbox"/></td> <td>06 <input type="checkbox"/> Six times</td> <td></td> </tr> <tr> <td>07 <input type="checkbox"/></td> <td>07 <input type="checkbox"/> Seven times</td> <td></td> </tr> <tr> <td>08 <input type="checkbox"/></td> <td>08 <input type="checkbox"/> Eight times</td> <td></td> </tr> <tr> <td>09 <input type="checkbox"/></td> <td>09 <input type="checkbox"/> Nine times</td> <td></td> </tr> <tr> <td>10 <input type="checkbox"/></td> <td>10 <input type="checkbox"/> Ten times</td> <td></td> </tr> <tr> <td>11 <input type="checkbox"/></td> <td>11 <input type="checkbox"/> Eleven times</td> <td></td> </tr> <tr> <td>12 <input type="checkbox"/></td> <td>12 <input type="checkbox"/> Twelve times</td> <td></td> </tr> <tr> <td>13 <input type="checkbox"/></td> <td>13 <input type="checkbox"/> More than twelve times</td> <td></td> </tr> <tr> <td>99 <input type="checkbox"/></td> <td>99 <input type="checkbox"/> DK</td> <td></td> </tr> </table>	Total times (35a.)	Number times in past 12 Months (35b.)	142-143			144-145	XXXX	00 <input type="checkbox"/> None in past twelve months		XXXX	01 <input type="checkbox"/> One time		02 <input type="checkbox"/>	02 <input type="checkbox"/> Two times		03 <input type="checkbox"/>	03 <input type="checkbox"/> Three times		04 <input type="checkbox"/>	04 <input type="checkbox"/> Four times		05 <input type="checkbox"/>	05 <input type="checkbox"/> Five times		06 <input type="checkbox"/>	06 <input type="checkbox"/> Six times		07 <input type="checkbox"/>	07 <input type="checkbox"/> Seven times		08 <input type="checkbox"/>	08 <input type="checkbox"/> Eight times		09 <input type="checkbox"/>	09 <input type="checkbox"/> Nine times		10 <input type="checkbox"/>	10 <input type="checkbox"/> Ten times		11 <input type="checkbox"/>	11 <input type="checkbox"/> Eleven times		12 <input type="checkbox"/>	12 <input type="checkbox"/> Twelve times		13 <input type="checkbox"/>	13 <input type="checkbox"/> More than twelve times		99 <input type="checkbox"/>	99 <input type="checkbox"/> DK		
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36. ,Was the test --- / Were <u>any</u> of the blood tests, including those you had <u>before</u> the past twelve months ----.		
	a. part of a blood donation?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 146
	b. part of a blood transfusion?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 147
	c. voluntarily sought from a source such as your doctor, clinic, or HMO?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 148
	d. part of some other activity that requires a blood sample and includes automatic AIDS testing, such as testing for the military or immigration?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 149
CHECK ITEM	3 Refer to Q. 36d	<input type="checkbox"/> "Yes" in Q. 36d (37) <input type="checkbox"/> Other (38)
37. Where did you have your blood tested for AIDS virus infection? Anywhere else? (MARK ALL THAT APPLY).		1 <input type="checkbox"/> STD clinic 150 1 <input type="checkbox"/> Family planning clinic 151 1 <input type="checkbox"/> Prenatal clinic 152 1 <input type="checkbox"/> Drug treatment facility 153 1 <input type="checkbox"/> Tuberculosis clinic 154 1 <input type="checkbox"/> Work clinic/health station 155 1 <input type="checkbox"/> AIDS counseling/testing site 156 1 <input type="checkbox"/> Military induction 157 1 <input type="checkbox"/> Immigration site 158 1 <input type="checkbox"/> Other (SPECIFY) 159 1 <input type="checkbox"/> DK 160
38. Did you get the results of ,your test?/ any of your tests?.		1 <input type="checkbox"/> Yes (39) 161 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (40)
39. When you received your test results, did you receive counseling or talk with a health professional about how to lower your chances of becoming infected with the AIDS virus or how to avoid passing it to another person?		1 <input type="checkbox"/> Yes (41) 162 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK

40. Were you referred to a health professional to get counseling about the AIDS virus infection?	1 <input type="checkbox"/> Yes 163 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
41. Do you expect to have a blood test for the AIDS virus infection in the next 12 months?	1 <input type="checkbox"/> Yes (42) 164 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } (44)
42. Will you have the blood test --- a. as part of a blood donation? b. voluntarily from a source such as your doctor, clinic, or HMO? c. as part of some other activity that requires a blood sample and includes automatic AIDS testing, such as testing for the military or immigration?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 165 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 166 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 167
CHECK ITEM 4	Refer to Q. 42b <input type="checkbox"/> "Yes" In question 42b (43) <input type="checkbox"/> Other (44)
43. Where would you go to have a blood test for the AIDS virus infection? (MARK FIRST MENTION)	168-169 00 <input type="checkbox"/> Nowhere, wouldn't take the test 01 <input type="checkbox"/> AIDS clinic 02 <input type="checkbox"/> Company or industry clinic 03 <input type="checkbox"/> Doctor/HMO 04 <input type="checkbox"/> Hospital/emergency room/OP clinic 05 <input type="checkbox"/> Other clinic 06 <input type="checkbox"/> Public Health Department 07 <input type="checkbox"/> Red Cross/blood bank 08 <input type="checkbox"/> Other (SPECIFY) <hr/> 99 <input type="checkbox"/> DK

44a. Did you have a blood transfusion at any time between 1977 and 1985?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	170																																										
44b. Do you think the present supply of blood is safe for transfusions?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	171																																										
HAND CARD C																																												
45. Here are some methods people use to keep from getting the AIDS virus through sexual activity. After I read each one, tell me whether you think it is very effective, somewhat effective, not at all effective, or if you don't know how effective it is in preventing getting the AIDS virus through sexual activity. How effective is --- a. Using a diaphragm? b. Using a condom? c. Using a spermicidal jelly, foam or cream? d. Having a vasectomy? e. Two people who do not have the AIDS virus having sex <u>only</u> with each other?	<table border="0" style="width: 100%; text-align: center;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;">Very effective</td> <td style="width: 15%;">Somewhat effective</td> <td style="width: 15%;">Not at all effective</td> <td style="width: 15%;">DK how effective</td> <td style="width: 15%;">DK method</td> <td style="width: 10%;"></td> </tr> <tr> <td>a. Using a diaphragm?</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td>172</td> </tr> <tr> <td>b. Using a condom?</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td>173</td> </tr> <tr> <td>c. Using a spermicidal jelly, foam or cream?</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td>174</td> </tr> <tr> <td>d. Having a vasectomy?</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td>175</td> </tr> <tr> <td>e. Two people who do not have the AIDS virus having sex <u>only</u> with each other?</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td>176</td> </tr> </table>		Very effective	Somewhat effective	Not at all effective	DK how effective	DK method		a. Using a diaphragm?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	172	b. Using a condom?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	173	c. Using a spermicidal jelly, foam or cream?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	174	d. Having a vasectomy?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	175	e. Two people who do not have the AIDS virus having sex <u>only</u> with each other?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	176	172
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46. What are your chances of <u>having</u> the AIDS virus; would you say high, medium, low, or none?	1 <input type="checkbox"/> High (Check Item 6) 2 <input type="checkbox"/> Medium 3 <input type="checkbox"/> Low 4 <input type="checkbox"/> None 7 <input type="checkbox"/> Refused 9 <input type="checkbox"/> DK	177																																										

<p>47. What are your chances of <u>getting</u> the AIDS virus; would you say high, medium, low, or none?</p>	<p>1 <input type="checkbox"/> High 178 2 <input type="checkbox"/> Medium 3 <input type="checkbox"/> Low 4 <input type="checkbox"/> None 7 <input type="checkbox"/> Refused (Check Item 6) 9 <input type="checkbox"/> DK</p>	
<p>48. People have different meanings when they say a "high", "medium", or "low" chance.</p> <p>If "no chance" is zero-out-of-one hundred, what would you say <u>High/Medium/Low</u> is? What number of times-out-of-one hundred?</p>	<p style="text-align: right;">179-181</p> <p>000 <input type="checkbox"/> Less than 1 out of a 100 _____ out of a 100 999 <input type="checkbox"/> DK</p>	
<p>CHECK ITEM 5</p>	<p>Refer to Q. 47</p>	<p><input type="checkbox"/> "High" OR "Medium" IN <u>Q. 47</u> (49) <input type="checkbox"/> Other (Check Item 6)</p>
<p>49. Do you say your chance of getting AIDS is <u>(high/medium)</u> because you ---</p> <p>a. Have had a blood transfusion? b. Have had sexual contact with someone who might have the virus? c. Some other reason? (SPECIFY)</p> <p>_____</p> <p>_____</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 182 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 183 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 184</p>	

CHECK ITEM 6	Refer to age and sex of S.P.	<input type="checkbox"/> Female 18-45 (50 Intro, then 50a) <input type="checkbox"/> Other (50 Intro, then 50c)			
50. In the past twelve months, have you received services or care at ---		Yes	No	DK	
a. a prenatal health clinic?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	185
b. a maternal and infant health clinic?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	186
c. a family planning clinic?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	187
d. a hospital, as an inpatient?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	188
e. a hospital emergency room?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	189
f. a tuberculosis clinic?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	190
g. a drug treatment facility or clinic?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	191
h. an STD (sexually transmitted disease) clinic?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	192
i. an alcohol treatment facility or clinic?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	193
j. an AIDS counseling and testing clinic?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	194
k. a community health clinic?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	195
l. a public health clinic?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	196
51. In the past twelve months, have you ---		Yes	No	DK	
a. been in the Job Corps?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	197
b. had a physical examination to join the military?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	198
c. been in prison?		1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	199
52. Have you ever discussed AIDS with a friend or relative?		1 <input type="checkbox"/> Yes (53) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (54)			200

<p>53. When was the last time you discussed AIDS with a friend or relative?</p>	<p>1 <input type="checkbox"/> Today 201-203</p> <p>2 <input type="checkbox"/> Days ago</p> <p>3 <input type="checkbox"/> Weeks ago</p> <p>Number 4 <input type="checkbox"/> Months ago</p> <p>5 <input type="checkbox"/> Years ago</p> <p>9 <input type="checkbox"/> DK</p>
<p>54. Have you ever personally known anyone with AIDS or the AIDS virus?</p>	<p>1 <input type="checkbox"/> Yes (55) 204</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK if someone } (57)</p> <p style="padding-left: 100px;">has/had AIDS</p> <p style="padding-left: 100px;">AIDS virus</p>
<p>(IF MORE THAN ONE PERSON VOLUNTEERED IN Q. 54, ASK Q. 55 and Q. 56 ABOUT THE PERSON KNOWN BEST)</p>	
<p>55. How long has it been since you saw this person?</p>	<p>1 <input type="checkbox"/> Within the past two weeks 205</p> <p>2 <input type="checkbox"/> Two weeks to less than one month</p> <p>3 <input type="checkbox"/> One month to less than 3 months</p> <p>4 <input type="checkbox"/> 3 months to less than 6 months</p> <p>5 <input type="checkbox"/> 6 months or more</p> <p>9 <input type="checkbox"/> DK</p>
<p>56. How well do you know this person? Would you say ---</p>	<p>1 <input type="checkbox"/> Very well, it is a close relationship 206</p> <p>2 <input type="checkbox"/> Fairly well, but it is not a close relationship ?</p> <p>3 <input type="checkbox"/> Not very well, it is only an acquaintance or casual relationship?</p> <p style="text-align: center;">or</p> <p>4 <input type="checkbox"/> You don't really know them personally, such as a friend of a friend?</p> <p>8 <input type="checkbox"/> Other (SPECIFY)</p> <p>_____</p> <p>_____</p> <p>_____</p>

HAND CARD D

57. (I am going to read a list of statements. After I have read them all,) Please tell me if any of these statements is true for you.

Do not tell me which statement or statements are true for you, just if any of them are.

- a. You have hemophilia and have received clotting factor concentrates since 1977.
- b. You are a native of Haiti, Central or East Africa who has entered the United States since 1977.
- c. You are a man who has had sex with another man at some time since 1977, even one time.
- d. You have taken illegal drugs by needle at any time since 1977.
- e. Since 1977, you are or have been the sex partner of any person who would answer "yes" to any of the items (I have read./above on this card.)
- f. You have had sex for money or drugs at any time since 1977.

207

- 1 Yes to at least one statement
- 2 No to all statements

58. The U.S. Public Health Service has said that AIDS is one of the major health problems in the country but exactly how many people it affects is not known. The Surgeon General has proposed that a study be conducted and blood samples be taken to help find out how widespread the problem is.

If you were selected in this national sample of people to have their blood tested with assurances of privacy of test results, would you have the test?

- 1 Yes (60a)
- 2 No
- 8 Other response (SPECIFY)

- 9 DK

208

<p>59. Why wouldn't you take part in the test? Any other reason? (MARK ALL THAT APPLY)</p>	<table> <tr> <td>1 <input type="checkbox"/> Don't want to know if I have AIDS</td> <td rowspan="2">} (60b)</td> <td><input type="checkbox"/> 209</td> </tr> <tr> <td>1 <input type="checkbox"/> Don't want any counseling about AIDS</td> <td><input type="checkbox"/> 210</td> </tr> <tr> <td>1 <input type="checkbox"/> Fear I'll get AIDS</td> <td rowspan="5">} (61)</td> <td><input type="checkbox"/> 211</td> </tr> <tr> <td>1 <input type="checkbox"/> Don't like to give blood</td> <td><input type="checkbox"/> 212</td> </tr> <tr> <td>1 <input type="checkbox"/> Don't trust Government programs</td> <td><input type="checkbox"/> 213</td> </tr> <tr> <td>1 <input type="checkbox"/> It is a waste of money</td> <td><input type="checkbox"/> 214</td> </tr> <tr> <td>1 <input type="checkbox"/> Don't believe AIDS can really be cured anyway</td> <td><input type="checkbox"/> 215</td> </tr> <tr> <td>1 <input type="checkbox"/> Other (SPECIFY)</td> <td></td> <td><input type="checkbox"/> 216</td> </tr> <tr> <td>1 <input type="checkbox"/> DK</td> <td></td> <td><input type="checkbox"/> 217</td> </tr> </table>	1 <input type="checkbox"/> Don't want to know if I have AIDS	} (60b)	<input type="checkbox"/> 209	1 <input type="checkbox"/> Don't want any counseling about AIDS	<input type="checkbox"/> 210	1 <input type="checkbox"/> Fear I'll get AIDS	} (61)	<input type="checkbox"/> 211	1 <input type="checkbox"/> Don't like to give blood	<input type="checkbox"/> 212	1 <input type="checkbox"/> Don't trust Government programs	<input type="checkbox"/> 213	1 <input type="checkbox"/> It is a waste of money	<input type="checkbox"/> 214	1 <input type="checkbox"/> Don't believe AIDS can really be cured anyway	<input type="checkbox"/> 215	1 <input type="checkbox"/> Other (SPECIFY)		<input type="checkbox"/> 216	1 <input type="checkbox"/> DK		<input type="checkbox"/> 217
1 <input type="checkbox"/> Don't want to know if I have AIDS	} (60b)	<input type="checkbox"/> 209																					
1 <input type="checkbox"/> Don't want any counseling about AIDS		<input type="checkbox"/> 210																					
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1 <input type="checkbox"/> Don't believe AIDS can really be cured anyway		<input type="checkbox"/> 215																					
1 <input type="checkbox"/> Other (SPECIFY)		<input type="checkbox"/> 216																					
1 <input type="checkbox"/> DK		<input type="checkbox"/> 217																					
<p>60a. If it were <u>not</u> possible to provide you with the results of the test, would you still take part in the study?</p>	<table> <tr> <td>1 <input type="checkbox"/> Yes</td> <td rowspan="3">} (61)</td> <td><input type="checkbox"/> 218</td> </tr> <tr> <td>2 <input type="checkbox"/> No</td> <td></td> </tr> <tr> <td>9 <input type="checkbox"/> DK</td> <td></td> </tr> </table>	1 <input type="checkbox"/> Yes	} (61)	<input type="checkbox"/> 218	2 <input type="checkbox"/> No		9 <input type="checkbox"/> DK																
1 <input type="checkbox"/> Yes	} (61)	<input type="checkbox"/> 218																					
2 <input type="checkbox"/> No																							
9 <input type="checkbox"/> DK																							
<p>60b. If the results of the test were <u>not</u> provided to you, <u>then</u> would you take part in the study?</p>	<table> <tr> <td>1 <input type="checkbox"/> Yes</td> <td><input type="checkbox"/> 219</td> </tr> <tr> <td>2 <input type="checkbox"/> No</td> <td></td> </tr> <tr> <td>9 <input type="checkbox"/> DK</td> <td></td> </tr> </table>	1 <input type="checkbox"/> Yes	<input type="checkbox"/> 219	2 <input type="checkbox"/> No		9 <input type="checkbox"/> DK																	
1 <input type="checkbox"/> Yes	<input type="checkbox"/> 219																						
2 <input type="checkbox"/> No																							
9 <input type="checkbox"/> DK																							
<p>61. When Federal Public Health officials give <u>information</u> about AIDS, do you believe what they say or are you doubtful about the information they give?</p>	<table> <tr> <td>1 <input type="checkbox"/> Believe them</td> <td><input type="checkbox"/> 220</td> </tr> <tr> <td>2 <input type="checkbox"/> Doubtful</td> <td></td> </tr> <tr> <td>9 <input type="checkbox"/> DK</td> <td></td> </tr> </table>	1 <input type="checkbox"/> Believe them	<input type="checkbox"/> 220	2 <input type="checkbox"/> Doubtful		9 <input type="checkbox"/> DK																	
1 <input type="checkbox"/> Believe them	<input type="checkbox"/> 220																						
2 <input type="checkbox"/> Doubtful																							
9 <input type="checkbox"/> DK																							
<p>62. When they give <u>advice</u> about <u>how to help keep from getting AIDS</u>, do you believe their advice or are you doubtful about what they say?</p>	<table> <tr> <td>1 <input type="checkbox"/> Believe their advice</td> <td><input type="checkbox"/> 221</td> </tr> <tr> <td>2 <input type="checkbox"/> Doubtful</td> <td></td> </tr> <tr> <td>9 <input type="checkbox"/> DK</td> <td></td> </tr> </table>	1 <input type="checkbox"/> Believe their advice	<input type="checkbox"/> 221	2 <input type="checkbox"/> Doubtful		9 <input type="checkbox"/> DK																	
1 <input type="checkbox"/> Believe their advice	<input type="checkbox"/> 221																						
2 <input type="checkbox"/> Doubtful																							
9 <input type="checkbox"/> DK																							

63. Date AIDS Supplement Final Status _____ / _____ / 19 _____

222-227

INTERVIEWER TRANSCRIPTION FROM HIS-1

64. Hispanic Origin (Item 4a/b, Page 41, HIS-1)

228

HIS-1 Item 4a 1 Yes
2 No

229

HIS 1 Item 4b 1 Puerto Rican
2 Cuban
3 Mexican/Mexicano
4 Mexican American
5 Chicano
6 Other Latin American
7 Other Spanish

65. Questionnaire Version

1

230

66. Exact Address (Item 6a, Cover Page, HIS-1)

RT 99

28-93

94-114
115-116
117-142
143-151

City State County ZIP Code

67. Mailing Address (Item 6b, Cover Page, HIS-1)

Same as 6a

152

153-208

209-229
230-231
232-257
258-266

City State County ZIP Code

68. Telephone Number (Item 11, Cover Page, HIS-1)

267

1 Yes, telephone (RECORD NUMBER BELOW)
2 No telephone
3 Phone, but no number listed or number refused
9 DK or Refused

_____/_____/_____
A.C. Exch. Number

268-277

CARD R

RACE

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

HS-501 (1988) (10-30-87)

CARD O

ORIGIN

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

Card R
Card O

(Cut along broken line.)

HS-501 (1988) (10-30-87)

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

HS-501 (1988) (10-30-87)

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

Card I
Card J

(Cut along broken line.)

HS-501 (1988) (10-30-87)

CARD N1

- 1 Stopped working because of own illness, injury, disability or health problem that was **JOB-RELATED**
- 2 Stopped working because of own illness, injury, disability or other health problem that was **NOT JOB-RELATED**
- 3 Retired
- 4 Child/family care
- 5 On layoff from a job
- 8 Some other reason (Specify)

HS-501 (1988) (10-30-87)

CARD N2

- 0 Less than one month
- 1 1 month, less than 3 months
- 2 3 months, less than 6 months
- 3 6 months, less than 12 months
- 4 1 year, less than 5 years
- 5 5 or more years

Card N1
Card N2

(Cut along broken line.)

HS-501 (1988) (10-30-87)

CARD N3

TO GET MEDICAL ATTENTION OR TREATMENT
OTHER THAN FIRST AID FOR MINOR INJURIES
OR
TO BE UNABLE TO DO SOME WORK ACTIVITIES
OR
TO LOSE CONSCIOUSNESS
OR
TO TRANSFER TO ANOTHER JOB

HS-501 (1988) (10-30-87)

CARD O1

- 01 Don't socialize very much
- 02 Don't care for it or dislike it
- 03 Am an alcoholic
- 04 Thought I might become an alcoholic
- 05 Had problems with my drinking
- 06 Have a responsibility to my family
- 07 Family member an alcoholic or problem drinker
- 08 Medical or health reasons
- 09 Religious or moral reasons
- 10 Brought up not to drink
- 11 Makes me sick
- 12 Can't control my drinking
- 13 Costs too much or can't afford it
- 14 Dieting or too fattening
- 88 Other

Card N3
Card O1

(Cut along broken line.)

HS-501 (1988) (10-30-87)

CARD O2

- 1 Heavy**
- 2 Moderate**
- 3 Light**
- 4 Very light or occasional**
- 5 Quit drinking**
- 6 Never drank**

HS-501 (1988) (10-30-88)

CARD P1

- 01 Day care center**
- 02 Babysitter in child's home**
- 03 In babysitter's home**
- 04 Father cares for child**
- 05 Mother cares for child while working at home**
- 06 Mother cares for child while working outside of home**
- 07 Child cares for self**
- 08 Other relative cares for child**
- 09 Day camp**
- 88 Other (Specify)**

HS-501 (1988) (10-30-87)

Card O2

Card P1

(Cut along broken line.)

CARD P2

- 01 Nursery school or preschool**
- 02 Nursery school or preschool with day care**
- 03 Day care center**
- 04 Babysitter in child's home**
- 05 In babysitter's home**
- 06 Father cares for child**
- 07 Mother cares for child while working at home**
- 08 Mother cares for child while working outside of home**
- 09 Summer day camp**
- 10 Child cares for self**
- 11 Other relative cares for child**
- 88 Other (Specify)**

FORM HS-501 (1988) (10-30-87)

CARD P3

- 01 Broken or dislocated bones**
- 02 Sprain, strain or pulled muscle**
- 03 Cuts, scrapes, or puncture wounds**
- 04 Head injury, concussion**
- 05 Bruise, contusion, or internal bleeding**
- 06 Burn, scald**
- 07 Poisoning from chemicals, medicines, drugs**
- 08 Respiratory problem, such as breathing, cough, pneumonia**
- 88 Other**
- 99 Don't know type of condition**
- 00 None**

HS-501 (1988) (10-30-87)

Card P2

Card P3

(Cut along broken line.)

CARD P4

- 1 Has two or more usual doctors or places depending on what is wrong**
- 2 Has not needed a doctor**
- 3 Previous doctor no longer available**
- 4 Have not been able to find the right doctor**
- 5 Recently moved to area**
- 8 Other reason *(Specify)***

HS-501(1888)(10-30-87)

The 1989 NHIS was conducted with a full sample. The interviewed sample included 116,929 household members in 45,711 sample households. In addition to the basic health and demographic questionnaire, the 1989 survey included questions on the following special health topics: health insurance—which also included a special survey of California residents, adult immunization, mental health, dental health, orofacial pain, diabetes and diabetes risk factors, digestive disorders, and AIDS.

The health insurance questions asked about Medicare, Medicaid, public assistance programs, types of health insurance plans, plan coverage, who pays for the insurance, reasons for not having health insurance, and health care benefits from the Armed Forces or Veterans' Administration such as CHAMPUS or CHAMP-VA. The questions also asked about service-related disability, lay off or loss of job and subsequent loss of health insurance coverage, and health insurance coverage during job loss.

A special health insurance survey of California residents was conducted in conjunction with the 1989 NHIS. This survey was in collaboration with the State of California and the University of California, Los Angeles. In addition to the health insurance questions included in the NHIS Current Health Topics Questionnaire, questions were asked about usual source of care, barriers to needed care, income and employment status, characteristics of the place of employment, and opinions about various proposals for reducing the size of the uninsured population. The survey was in the field for three quarters of the year and included about 4,200 out of the 5,600 households in the California sample. NCHS produced special weights for the California population that will take into account the 18 percent of the population not covered by the sample. The survey was also conducted in Spanish. A Spanish translation of the questionnaire was prepared and used in the field; however, it is not included in this report. The health insurance data collected in the special California survey has not been released on a public-use data tape.

Immunization questions were asked of family members 18 years of age and over. The questions inquired about vaccinations to prevent influenza, pneumonia, and tetanus.

The questions on mental health inquired about mental and emotional disorders such as schizophrenia, paranoid disorder, manic depression, major depression, senility,

alcohol abuse disorder, drug abuse disorder, and mental retardation. For each disorder reported, questions were asked about whether the disorder(s) prevented or limited the person's work, job, or school attendance.

Dental health questions obtained information about the number of visits in the past 2 weeks, reasons for not visiting the dentist in last 12 months, loss of natural teeth, dentures, dental sealants, use of mouthwash, use of fluoride, and missed work or school because of someone's dental problem.

The diabetes questionnaire asked adult diabetics for information about diagnosis, use of insulin and diabetes pills, diet, doctor visits, and sources of information. The questionnaire also asked an adult in the family who was nondiabetic about diabetes risk factors; urinary, foot, and eye problems; smoking; and family history of diabetes.

The current health topic questionnaire on orofacial pain included questions about toothaches, mouth sores, or burning sensations in the mouth in the past 6 months; pain in jaw joint or face in the past 6 months; visits to the dentist, doctor, or health professional for the pain in the past 6 months; and what was done for the pain during the past 6 months.

The questionnaire on digestive disorders asked about gallbladder trouble, ulcers, diverticulitis, and irritable bowel syndrome. In addition, questions asked about onset of condition, diagnosis abdominal pain, cause of pain, doctor visits, diagnostic tests, and questions on normative bowel functions.

The questions relating to AIDS were separate from the other 1989 current health topic questions. The interview was conducted using CAPI. The 1989 questions on AIDS were similar to those in 1987 and 1988. The series of questions asked in 1988 about the special brochure that was mailed to each household was excluded. As in the previous 2 years, the questions about AIDS pertained to AIDS knowledge and attitudes and were asked of persons in the family 18 years of age and over. Included were questions about pamphlets or brochures read or seen about AIDS, discussion of AIDS with their children, knowledge of AIDS, blood donation, blood testing for AIDS, the AIDS virus and sexual activity, the risk of getting the AIDS virus, whether person knew anyone with AIDS, and willingness to participate in sample of persons having blood tested for AIDS.

FORM **HIS-1A (1989)**
(8-15-88)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR THE
U.S. PUBLIC HEALTH SERVICE

**NATIONAL HEALTH INTERVIEW
SURVEY**

1989 CURRENT HEALTH TOPICS

NOTICE — Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m). Public reporting burden for this collection of information is estimated to vary from 20 to 75 minutes per response, with an average of 41 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer, Room 721-H, Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201; ATTN: PRA, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503.

RT 88
3-7
8

1. Book _____ of
_____ books

2. R.O. Number 9-10 3. Sample 11-13

4. Control number
PSU 14-16 Segment 17-23 Serial 24-25

5. Beginning time 26-29 30
1 a.m.
2 p.m.

ADULT FAMILY ROSTER

6. Are there any nondeleted persons 18+ years old in this family? 1 Yes (List by age, oldest to youngest) 31
2 No (Section M)

SP	32 Line No.	33-34 Person No.	35-36 Age	37 Sex	Name
	1			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
	2			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
	3			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
	4			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
	5			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
	6			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
	7			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
	8			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
	9			1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	

Refer to the sample person selection label and circle as applicable. THEN circle Person Number in item 6 and mark the "SP" box on the HIS-1 for the selected sample person. THEN go to Section M.

7. FINAL STATUS

a. Household respondent

Section	Mark as appropriate (1)	Complete interview (2)	Partial interview (Explain in notes) (3)	Noninterview	
				Refusal (Explain in notes) (4)	Other (Explain in notes) (5)
M. Health Insurance	9 <input type="checkbox"/> Not required	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/> 38
N. Immunization	0 <input type="checkbox"/> No person 18+ in this family	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/> 39
O. Mental Health		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/> 40
P. Dental		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/> 41
Q1. Diabetes Screening	0 <input type="checkbox"/> No person 18+ in this family	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/> 42

b. Household diabetic(s)

Section Q2 (page 32)
(Diabetes Followup) 43

- 0 No diabetics
7 Q1 Noninterview

Interview

- 1 Complete interview (all persons with diabetes interviewed)
2 Partial interview (some but not all persons with diabetes interviewed) (Explain in notes)

Noninterview

- 3 Refusal } (Explain in notes)
8 Other }

c. Sample person

1. Section R (page 48)
(Orofacial Pain) 44

- 0 No person 18+ in this family
Interview

- 1 Complete interview (all appropriate questions completed)
2 Partial interview (some but not all appropriate questions completed) (Explain in notes)

Noninterview

- 3 Refusal (Explain in notes)
4 SP temporarily absent
5 SP mentally or physically incapable
8 Other (Explain in notes)

2. Section S (page 50)
(Digestive Disorders) 45

- 0 No person 18+ in this family
Interview

- 1 Complete interview (all appropriate sections completed)
2 Partial interview (some but not all appropriate sections completed) (Explain in notes)

Noninterview

- 3 Refusal (Explain in notes)
4 SP temporarily absent
5 SP mentally or physically incapable
8 Other (Explain in notes)

3. Section T (page 58)
(Diabetes Risk Factors) 46

- 9 Not required
0 No person 18+ in this family
7 Q1 Noninterview

Interview

- 1 Complete interview (all appropriate questions completed)
2 Partial interview (some but not all appropriate questions completed) (Explain in notes)

Noninterview

- 3 Refusal (Explain in notes)
4 SP temporarily absent
5 SP mentally or physically incapable
8 Other (Explain in notes)

8. Ending time

- 1 a.m. 47-50 51
2 p.m.

9. Interviewer identification

Name

Code

52-53

Notes

Section M — HEALTH INSURANCE

PERSON 1

CHECK ITEM 1

Refer to letter indicated on Sample Selection label.

- 1 Letter M (1)
2 Letter T (Section N)

5

Medicare is a Social Security health insurance program for disabled persons and for persons 65 years old and over. People covered by Medicare have a card that looks like this. Show Medicare Card.

1a. Is anyone in this family, that is (read names), now covered by Medicare? Yes No (4) DK (4)

b. Is — now covered?

1b. 1 Covered 9 DK
2 Not covered

6

Ask for each person with "Covered" or "DK" in 1b.

2. May I please see the Social Security Medicare card(s) for — (and —) to determine the type of coverage and to record the Health Insurance Claim Number. Providing the Health Insurance Claim Number is voluntary and collected under the authority of the Public Health Service Act. There will be no effect on — benefits and no information will be given to any other government or non-government agency.

Read if necessary: The Public Health Service Act is Title 42, United States Code, Section 242k.

Transcribe the number, then mark the appropriate box(es).

2. H. I. C. Number 7-17
_____() ()
1 Hospital
2 Medical
3 Card N. A.

18

Ask for each person with "Card NA" in 2.

3a. Is — now covered by the part of Social Security Medicare which pays for hospital bills?

3a. 1 Yes 9 DK
2 No

19

b. Is — now covered by that part of Medicare which pays for doctor's bills? This is the Medicare plan for which — or some agency must pay a certain amount each month.

b. 1 Yes 9 DK
2 No

20

4a. (Not counting Medicare) is anyone in the family now covered by a health insurance plan which pays any part of hospital, doctor, or dental bills? Do NOT include plans that pay for ONLY ONE type of service, such as nursing home care or accidents.

Yes No (8) DK (8)

b. It's important that we have the complete and accurate name of your health insurance plan. What is the COMPLETE name of the plan?

Record in Table H.I. If "DK", probe: Do you have something with the plan name on it?

c. Is anyone in the family now covered by any OTHER health insurance plan? Again, do NOT include plans that pay for ONLY ONE service.

Yes (Reask 4b and c) No DK

TABLE H.I.

{Now I am going to ask some questions about the plan(s) you just told me about.}

Read if necessary: Health Maintenance Organizations, or HMO's, sometimes called Individual Practice Associations, or IPA's, are plans whose members are required to use only those health care providers who work for the HMO or IPA. Also, members do not have to submit claims for costs of medical care services.

PLAN 1 NAME

21-22

31

5a. Is this (name) plan a Health Maintenance Organization or HMO?

Yes	No	DK
1	2	9

23

6a. Does this (name) plan pay any part of hospital expenses?

Yes	No	DK
1	2	9

26

b. Does this plan pay any part of doctor's or surgeon's bills for operations?

Yes	No	DK
1	2	9

27

c. Does it pay for any DENTAL services other than oral surgery?

Yes	No	DK
1	2	9

28

d. Does it pay for any prescription drugs other than those administered during a hospital stay?

Yes	No	DK
1	2	9

29

e. Does it pay for any mental health, alcoholism, or drug abuse services?

Yes	No	DK
1	2	9

30

7. Is — covered under this (name) plan?

1 Covered .. } (NP)
2 Not covered }
9 DK

b. Was this plan obtained through an employer or union?

Yes	No	DK
1	2 (6a)	9 (6a)

24

c. Is it now carried through an employer or union?

Yes	No	DK
1	2	9

25

PLAN 2 NAME

32-33

42

5a. Is this (name) plan a Health Maintenance Organization or HMO?

Yes	No	DK
1	2	9

34

6a. Does this (name) plan pay any part of hospital expenses?

Yes	No	DK
1	2	9

37

b. Does this plan pay any part of doctor's or surgeon's bills for operations?

Yes	No	DK
1	2	9

38

c. Does it pay for any DENTAL services other than oral surgery?

Yes	No	DK
1	2	9

39

d. Does it pay for any prescription drugs other than those administered during a hospital stay?

Yes	No	DK
1	2	9

40

e. Does it pay for any mental health, alcoholism, or drug abuse services?

Yes	No	DK
1	2	9

41

7. Is — covered under this (name) plan?

1 Covered .. } (NP)
2 Not covered }
9 DK

Section M – HEALTH INSURANCE – Continued

PERSON 1

PLAN 3 NAME

43–44

53

	Yes	No	DK	
5a. Is this (name) plan a Health Maintenance Organization or HMO?	1	2	9	45
	1	2 (6a)	9 (6a)	46
b. Was this plan obtained through an employer or union?	1	2	9	47

	Yes	No	DK	
6a. Does this (name) plan pay any part of hospital expenses?	1	2	9	48
b. Does this plan pay any part of doctor's or surgeon's bills for operations?	1	2	9	49
c. Does it pay for any DENTAL services other than oral surgery?	1	2	9	50
d. Does it pay for any prescription drugs other than those administered during a hospital stay?	1	2	9	51
e. Does it pay for any mental health, alcoholism, or drug abuse services?	1	2	9	52

7. Is — covered under this (name) plan?

7.

- 1 Covered .. } (NP)
 2 Not covered }
 9 DK

PLAN 4 NAME

54–55

64

	Yes	No	DK	
5a. Is this (name) plan a Health Maintenance Organization or HMO?	1	2	9	56
	1	2 (6a)	9 (6a)	57
b. Was this plan obtained through an employer or union?	1	2	9	58

	Yes	No	DK	
6a. Does this (name) plan pay any part of hospital expenses?	1	2	9	59
b. Does this plan pay any part of doctor's or surgeon's bills for operations?	1	2	9	60
c. Does it pay for any DENTAL services other than oral surgery?	1	2	9	61
d. Does it pay for any prescription drugs other than those administered during a hospital stay?	1	2	9	62
e. Does it pay for any mental health, alcoholism, or drug abuse services?	1	2	9	63

7. Is — covered under this (name) plan?

7.

- 1 Covered .. } (NP)
 2 Not covered }
 9 DK

PLAN 5 NAME

65–66

75

	Yes	No	DK	
5a. Is this (name) plan a Health Maintenance Organization or HMO?	1	2	9	67
	1	2 (6a)	9 (6a)	68
b. Was this plan obtained through an employer or union?	1	2	9	69

	Yes	No	DK	
6a. Does this (name) plan pay any part of hospital expenses?	1	2	9	70
b. Does this plan pay any part of doctor's or surgeon's bills for operations?	1	2	9	71
c. Does it pay for any DENTAL services other than oral surgery?	1	2	9	72
d. Does it pay for any prescription drugs other than those administered during a hospital stay?	1	2	9	73
e. Does it pay for any mental health, alcoholism, or drug abuse services?	1	2	9	74

7. Is — covered under this (name) plan?

7.

- 1 Covered .. } (NP)
 2 Not covered }
 9 DK

8a. [In addition to the plan(s) you just mentioned] Is anyone in the family now covered by an insurance plan that pays for ONLY ONE type of health care service, such as nursing home care, eye care, or prescriptions?

- Yes No (Check Item 2) DK (Check Item 2)

b. Is — covered by this type of plan?

8b.

- 1 Covered 9 DK
 2 Not covered

76

Ask for each person "Covered" in 8b:

c. What type of service does — plan pay for?

c.

- | | |
|--|----|
| 1 <input type="checkbox"/> Prescriptions | 77 |
| 2 <input type="checkbox"/> Eyecare | 78 |
| 3 <input type="checkbox"/> Cancer treatment | 79 |
| 4 <input type="checkbox"/> Catastrophic | 80 |
| 5 <input type="checkbox"/> Nursing home care | 81 |
| 6 <input type="checkbox"/> Accidents | 82 |
| 7 <input type="checkbox"/> Dental care | 83 |
| 8 <input type="checkbox"/> Other — Specify ↴ | 84 |

d. Is — now covered by any OTHER insurance plan that pays for ONLY ONE service?

d.

- Yes (Reask 8c–d)
 No (NP with "Covered" in 8b)

Section M — HEALTH INSURANCE — Continued		PERSON 1	
CHECK ITEM 2	Review 1b and 7 for each person and determine if "Covered" by either Medicare and/or insurance, or "Not covered."	CK 2	<input type="checkbox"/> Covered } <input type="checkbox"/> Not covered under 65 } (NP) <input type="checkbox"/> Not covered 65 and over } <input type="checkbox"/> DK }
			85
<p>Ask for each person "Not covered" in Check Item 2.</p> <p>If "Not covered 65 and over," in Check Item 2, include "or Medicare."</p> <p>9a. (Many people do not carry health insurance for various reasons.) Hand Card M. Which of those statements describes why — is not covered by any health insurance (or Medicare)? Any other reason? Circle all reasons given.</p> <p>Mark box if only one reason.</p> <p>If "Not covered 65 and over," in Check Item 2, include "or Medicare."</p> <p>b. What is the MAIN reason — is not covered by any health insurance (or Medicare)?</p>		9a.	1 2 3 4 5 6 7 8 <input checked="" type="checkbox"/> _____ (Specify)
		b.	<input type="checkbox"/> Only one reason 1 2 3 4 5 6 7 8 <input checked="" type="checkbox"/> _____ (Specify)
			88-89 90-91 92-93
<p>Ask only if persons under age 20 in family; otherwise skip to 11.</p> <p>10a. Does anyone in the family now receive assistance through the "Aid to Families with Dependent Children" program, sometimes called "AFDC" or "ADC"? <input type="checkbox"/> Yes <input type="checkbox"/> No (11) <input type="checkbox"/> DK (11)</p> <p>b. Does — now receive AFDC or ADC?</p>		10b.	<input type="checkbox"/> Yes <input type="checkbox"/> DK <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> No
			94
<p>11a. Does anyone in the family now receive the "Supplemental Security Income" or "SSI" check? <input type="checkbox"/> Yes <input type="checkbox"/> No (12) <input type="checkbox"/> DK (12)</p> <p>b. Does — now receive this check?</p>		11b.	<input type="checkbox"/> Yes <input type="checkbox"/> DK <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> No
			95
<p>12a. There is a program called Medicaid that pays for health care for persons in need. (In this State it is also called (name).) During the past 12 months, has anyone in this family received health care which has been or will be paid for by Medicaid (or (name))? <input type="checkbox"/> Yes <input type="checkbox"/> No (13) <input type="checkbox"/> DK (13)</p> <p>b. Has — received this care in the past 12 months?</p>		12b.	<input type="checkbox"/> Yes <input type="checkbox"/> DK <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> No
			96
<p>13a. Does anyone in the family now have a Medicaid (or (name)) card? <input type="checkbox"/> Yes <input type="checkbox"/> No (14) <input type="checkbox"/> DK (14)</p> <p>b. Does — now have this card?</p> <p>Ask for each person with "Yes" in 13b.</p> <p>c. May I please see — (and —) card(s)? Mark appropriate box(es) in person's column.</p>		13b.	<input type="checkbox"/> Yes <input type="checkbox"/> DK <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> No
		c.	<input type="checkbox"/> Medicaid card seen <input checked="" type="checkbox"/> 1 <input type="checkbox"/> Current 2 <input type="checkbox"/> Expired 3 <input type="checkbox"/> No card seen 4 <input type="checkbox"/> Other card seen <input checked="" type="checkbox"/> _____ (Specify)
			98
<p>14a. Is anyone in the family now covered by any other public assistance program that pays for health care? <input type="checkbox"/> Yes <input type="checkbox"/> No (15) <input type="checkbox"/> DK (15)</p> <p>b. Is — now covered?</p>		14b.	<input type="checkbox"/> Yes <input type="checkbox"/> DK <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> No
			99
<p>15. Is anyone in this family now covered by health care benefits from the Armed Forces or Veterans' Administration? <input type="checkbox"/> Yes <input type="checkbox"/> No (Check Item 3) <input type="checkbox"/> DK (Check Item 3)</p>			
<p>16a. Does anyone in the family now receive military retirement payments from any branch of the Armed Forces or a pension from the Veterans' Administration? Do not include VA disability compensation. <input type="checkbox"/> Yes <input type="checkbox"/> No (17) <input type="checkbox"/> DK (17)</p> <p>b. Does — now receive military retirement or a VA pension?</p> <p>Ask for each person with "Yes" in 16b.</p> <p>c. Which does — receive — the Armed Forces retirement, the VA pension, or both?</p>		16b.	<input type="checkbox"/> Yes <input type="checkbox"/> DK <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> No
		c.	<input type="checkbox"/> Armed Forces <input type="checkbox"/> VA <input type="checkbox"/> Both
			100 101

Section M — HEALTH INSURANCE — Continued

PERSON 1

<p>17a. Is anyone in the family now covered by CHAMPUS, which is a program of medical care for dependents of military personnel? <input type="checkbox"/> Yes <input type="checkbox"/> No (17c) <input type="checkbox"/> DK (17c)</p> <p>b. Is --- now covered by CHAMPUS?</p> <p>c. Is anyone in the family now covered by CHAMP-VA, which is medical insurance for dependents or survivors of disabled veterans? <input type="checkbox"/> Yes <input type="checkbox"/> No (18) <input type="checkbox"/> DK (18)</p> <p>d. Is --- now covered by CHAMP-VA?</p>	<p>17b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 5 2 <input type="checkbox"/> No</p> <p>d. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 6 2 <input type="checkbox"/> No</p>
<p>18a. Is anyone in the family now covered by any other program that provides health care for military dependents or survivors of military persons? <input type="checkbox"/> Yes <input type="checkbox"/> No (Check Item 3) <input type="checkbox"/> DK (Check Item 3)</p> <p>b. Is --- now covered?</p>	<p>18b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 7 2 <input type="checkbox"/> No</p>
<p>CHECK ITEM 3 Refer to "AF" box above person's column in HIS-1.</p>	<p>CK 3 1 <input type="checkbox"/> AF box marked (19) 8 8 <input type="checkbox"/> Other (NP)</p>
<p>19a. Does --- have a disability related to --- service in the Armed Forces of the United States?</p> <p>b. Does --- now receive compensation for this disability from the Veterans' Administration?</p> <p>c. Has --- ever applied for a service-connected disability rating from the Veterans' Administration?</p> <p>d. Was it approved or denied?</p>	<p>19a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP) 9</p> <p>b. 1 <input type="checkbox"/> Yes (NP) 2 <input type="checkbox"/> No 10</p> <p>c. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK (NP) 11 2 <input type="checkbox"/> No (NP)</p> <p>d. 1 <input type="checkbox"/> Approved 3 <input type="checkbox"/> Pending 12 2 <input type="checkbox"/> Denied 9 <input type="checkbox"/> DK</p>
<p>20a. During the past 12 months, that is since (12-month date) a year ago, have (read names of related HH members 18 or over) been laid off from a job or lost a job? <input type="checkbox"/> Yes <input type="checkbox"/> No (Section N) <input type="checkbox"/> DK (Section N)</p> <p>b. Who was this? Mark "Laid off/lost job" box in person's column.</p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 20b and c) <input type="checkbox"/> No Ask 20d, e, and f for each person with "Laid off/lost job" in 20b.</p> <p>d. How many times has --- been laid off or lost a job during the past 12 months?</p> <p>e. In what month and year was --- laid off or did --- lose a job ([the last time/the time before that])?</p> <p>f. For ANYTIME during [that/those] job layoff(s) or job loss(es), did --- receive unemployment insurance benefits?</p>	<p>20b. 1 <input type="checkbox"/> Laid off/lost job 13</p> <p>d. _____ Times 14</p> <p>e. Mo. Yr. 19 Time 1 15-18 Mo. Yr. 19 Time 2 19-22 Mo. Yr. 19 Time 3 23-26</p> <p>f. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 27 2 <input type="checkbox"/> No</p>
<p>21a. Because of (names of persons in 20b) job layoff(s) or job loss(es), did anyone in the family lose any health insurance coverage that had been carried through [that/those] job(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No (Section N) <input type="checkbox"/> DK (Section N)</p> <p>b. Who was this? Mark "Lost coverage" box in person's column.</p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 21b and c) <input type="checkbox"/> No</p>	<p>21b. 1 <input type="checkbox"/> Lost coverage 28</p>
<p>CHECK ITEM 4 Refer to 21b and mark appropriate box.</p>	<p>CK 4 1 <input type="checkbox"/> Lost coverage (22) 29 2 <input type="checkbox"/> Did not lose coverage (NP)</p>
<p>22a. Was --- covered by some OTHER health insurance plan at any time during [that/those] job layoffs(s) or job loss(es)? Do not count military insurance or health programs such as Medicaid or AFDC.</p> <p>b. Was --- covered by another plan for the entire time (names of persons in 20b) [was/were] off work?</p> <p>c. For how long was --- not covered by any kind of health insurance plan?</p>	<p>22a. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK (23) 30 2 <input type="checkbox"/> No (23)</p> <p>b. 1 <input type="checkbox"/> Yes (23) 9 <input type="checkbox"/> DK (23) 31 2 <input type="checkbox"/> No</p> <p>c. 00 <input type="checkbox"/> Less than 1 month 32-33 _____ Months</p>
<p>23a. At ANYTIME during [that/those] job layoff(s) or job loss(es), was --- covered by a military program or by a health program such as Medicaid or AFDC?</p> <p>b. For how long was --- covered by this kind of program?</p>	<p>23a. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK (NP) 34 2 <input type="checkbox"/> No (NP)</p> <p>b. 00 <input type="checkbox"/> Less than 1 month 35-36 _____ Months</p>

Section N – IMMUNIZATION

PERSON 1

3-4

**CHECK
ITEM 1**

Refer to ages of all family members.

- 1 Persons 18 and over in family (1)
- 2 No person 18 and over (Section O)

5

The following questions are about immunizations to prevent influenza, pneumonia, and tetanus. In this family, they refer to (read names of all persons 18+).

1a. During the past 12 months, that is, since (12-month date) a year ago, have any adults in the family received a flu shot?

Read if necessary: This vaccination is usually given in the fall and protects against influenza for about one year. Yes No (2) DK (2)

b. Who was this?

Mark "Influenza immunization" box in person's column.

1b.

1 Influenza immunization

6

c. Anyone else?

Yes (Reask 1b and c) No

2a. Have any adults in the family ever received a pneumonia vaccination?

Read if necessary: This shot first became available in 1979, and is given only once in a person's lifetime. Yes No (3) DK (3)

b. Who was this?

Mark "Pneumonia vaccination" box in person's column.

2b.

1 Pneumonia vaccination

7

c. Anyone else?

Yes (Reask 2b and c) No

Ask for each person with "Pneumonia vaccination" in 2b.

d. Did -- receive the pneumonia shot within the past 12 months?

d.

- 1 Yes
- 2 No
- 9 DK

8

3a. During the past 5 years, have any adults in the family had a tetanus shot?

Read if necessary: Tetanus is sometimes called lockjaw. Yes No (Section O) DK (Section O)

b. Who was this?

Mark "Tetanus immunization" box in person's column.

3b.

1 Tetanus immunization

9

c. Anyone else?

Yes (Reask 3b and c) No

Ask for each person with "Tetanus immunization" in 3b.

d. About how long ago did -- have the LAST tetanus shot?

d.

- 1 Less than 1 year
- 2 1 year, but less than 3 years
- 3 3 or more years ago
- 9 DK

10

Notes

Section O — MENTAL HEALTH

PERSON 1

3-4

5-6

7-8

Enter person number(s) of respondent(s).

Person number(s) of respondent(s)

These questions are about mental and emotional disorders.

1a. DURING THE PAST 12 MONTHS, did anyone in the family have —

If "Yes," ask 1b and c.

b. Who is this?

Mark box in appropriate person's column.

c. DURING THE PAST 12 MONTHS, did anyone else have —

A. Schizophrenia (skit-suh-free'-nee-uh)?

Yes No

A. 1 Schizophrenia

9

B. Paranoid or delusional disorder, other than schizophrenia?

Yes No

B. 1 Paranoid disorder

10

C. Manic episodes or manic depression, also called bipolar disorder?

Yes (Specify) No

C. 1 Manic episodes
1 Manic depression

11

12

D. Major depression?

Read if necessary: A depressed mood and loss of interest in almost all activities FOR AT LEAST TWO WEEKS.

Yes No

D. 1 Major depression

13

E. Anti-social personality, obsessive-compulsive personality, or any other SEVERE personality disorder?

Yes No

E. 1 Personality disorder

14

F. Alzheimer's (alltz' hi-merz) disease or another type of senile disorder?

Yes No

F. 1 Senility

15

G. Alcohol abuse disorder?

Yes No

G. 1 Alcohol abuse

16

H. Drug abuse disorder?

Yes No

H. 1 Drug abuse

17

I. Does anyone in the family NOW have mental retardation?

Yes No

I. 1 Mental retardation

18

2a. DURING THE PAST 12 MONTHS, did anyone in the family have any OTHER mental or emotional disorders? Include ONLY those disorders which SERIOUSLY interfere with a person's ability to work or attend school, or to manage their day-to-day activities.

Yes No (Check Item 1)

b. Who is this? Anyone else? Mark box in appropriate person's column.

2b. 1 Other

19

Ask for each person with "Other" in 2b:

c. What would you call the disorder — has?

c. _____

20-22

CHECK ITEM 1

Refer to 1A-F and 2b/c.

CK 1

1 One or more entries in 1A-F or 2b/c (Check Item 2)
8 All others (NP or Section P)

23

CHECK ITEM 2

Enter disorder(s) from 1A-F and 2c. DO NOT RECORD G, H, OR I.

CK 2

Notes

Section O — MENTAL HEALTH — Continued		PERSON 1	
CHECK ITEM 3	Refer to Age.	CK 3	<input type="checkbox"/> Under 5 (8) <input type="checkbox"/> 5—17 (4) <input type="checkbox"/> 70 or over (5) <input type="checkbox"/> All others (3)
<p>Ask questions 3-8 about ALL disorders reported in 1 and 2.</p> <p>3a. Does — — (disorder(s) in questions 1 and 2) NOW entirely prevent — — from working at a paid job or business?</p>		3a.	<input type="checkbox"/> Yes (3d) <input type="checkbox"/> No <input type="checkbox"/> Doesn't work — Other reasons <input type="checkbox"/> DK
<p>b. Because of [this disorder/any of these disorders], is — — limited in the kind or amount of work — — can do?</p>		b.	<input type="checkbox"/> Yes (3d) <input type="checkbox"/> No <input type="checkbox"/> DK
<p>Mark "Doesn't work" if marked in 3a; otherwise ask:</p> <p>c. Because of [this disorder/any of these disorders], does — — have trouble finding or keeping a job or doing job tasks?</p>		c.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't work } (Check Item 4) <input type="checkbox"/> DK
<p>d. For how long has — — [been unable to work/ been limited in work/ had trouble with work] because of [this disorder/any of these disorders]?</p>		d.	<input type="checkbox"/> less than 3 months <input type="checkbox"/> 3 months, less than 1 year <input type="checkbox"/> 1 year, less than 5 years <input type="checkbox"/> 5 years or more <input type="checkbox"/> DK
CHECK ITEM 4	Refer to Age AND HIS-1, C1.	CK 4	<input type="checkbox"/> 18—24 AND neither Wa/Wb box marked (4) <input type="checkbox"/> All others (Check Item 5)
<p>4a. Does — — (disorder(s) in questions 1 and 2) NOW entirely prevent — — from attending regular school (or college)?</p>		4a.	<input type="checkbox"/> Yes (4c) <input type="checkbox"/> No <input type="checkbox"/> Not in school — Other reasons (Ck. Item 5) <input type="checkbox"/> DK
<p>b. Because of [this disorder/any of these disorders], does — — have trouble with school attendance or school work?</p>		b.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not in school — Other reasons } (Check Item 5) <input type="checkbox"/> DK
<p>c. For how long has — — [been unable to attend school/had trouble with school] because of [this disorder/any of these disorders]?</p>		c.	<input type="checkbox"/> less than 3 months <input type="checkbox"/> 3 months, less than 1 year <input type="checkbox"/> 1 year, less than 5 years <input type="checkbox"/> 5 years or more <input type="checkbox"/> DK
CHECK ITEM 5	Refer to age, then questions 3d and 4c and mark first appropriate box.	CK 5	<input type="checkbox"/> Under age 10 (7) <input type="checkbox"/> Entry in 3d or 4c (5) <input type="checkbox"/> All others (6)
<p>5a. ON — — OWN AND WITHOUT HELP, does — — appropriately take care of — — own personal care needs, such as eating, dressing, bathing, and going to the toilet?</p>		5a.	<input type="checkbox"/> Yes (6) <input type="checkbox"/> No <input type="checkbox"/> DK (6)
<p>b. Is this because of [— — (disorder)] any of these mental disorders?</p>		b.	<input type="checkbox"/> Yes <input type="checkbox"/> No } (6) <input type="checkbox"/> DK
<p>c. For how long has — — had trouble taking care of any of these needs?</p>		c.	<input type="checkbox"/> less than 3 months <input type="checkbox"/> 3 months, less than 1 year <input type="checkbox"/> 1 year, less than 5 years <input type="checkbox"/> 5 years or more <input type="checkbox"/> DK
Notes			

Section O — MENTAL HEALTH — Continued		PERSON 1
6a. ON — — OWN AND WITHOUT HELP, does — — adequately handle routine matters such as — (1) Managing money?	6a. (1)	<input type="checkbox"/> Yes (2) <input type="checkbox"/> No <input type="checkbox"/> Doesn't do <div style="text-align: right;">37</div>
b. Is this because of [— — (disorder)]any of these mental disorders? (ON — — OWN AND WITHOUT HELP, does — — adequately handle) (2) Doing everyday household chores?	b. (2)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Yes (3) <input type="checkbox"/> No <input type="checkbox"/> Doesn't do <div style="text-align: right;">38</div>
b. Is this because of [— — (disorder)]any of these mental disorders? (ON — — OWN AND WITHOUT HELP, does — — adequately handle) (3) Shopping?	b. (3)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Yes (4) <input type="checkbox"/> No <input type="checkbox"/> Doesn't do <div style="text-align: right;">39</div>
b. Is this because of [— — (disorder)]any of these mental disorders? (ON — — OWN AND WITHOUT HELP, does — — adequately handle) (4) Getting around outside the home?	b. (4)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Yes (6c) <input type="checkbox"/> No <input type="checkbox"/> Doesn't do <div style="text-align: right;">40</div>
b. Is this because of [— — (disorder)]any of these mental disorders? (ON — — OWN AND WITHOUT HELP, does — — adequately handle) (4) Getting around outside the home?	b. (4)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Yes (6c) <input type="checkbox"/> No <input type="checkbox"/> Doesn't do <div style="text-align: right;">41</div>
b. Is this because of [— — (disorder)]any of these mental disorders? (ON — — OWN AND WITHOUT HELP, does — — adequately handle) (4) Getting around outside the home?	b. (4)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Yes (6c) <input type="checkbox"/> No <input type="checkbox"/> Doesn't do <div style="text-align: right;">42</div>
b. Is this because of [— — (disorder)]any of these mental disorders? (ON — — OWN AND WITHOUT HELP, does — — adequately handle) (4) Getting around outside the home?	b. (4)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Yes (6c) <input type="checkbox"/> No <input type="checkbox"/> Doesn't do <div style="text-align: right;">43</div>
b. Is this because of [— — (disorder)]any of these mental disorders? (ON — — OWN AND WITHOUT HELP, does — — adequately handle) (4) Getting around outside the home?	b. (4)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Yes (6c) <input type="checkbox"/> No <input type="checkbox"/> Doesn't do <div style="text-align: right;">44</div>
6c. For how long has — — had trouble taking care of any of these things?	c.	<input type="checkbox"/> Less than 3 months <input type="checkbox"/> 3 months, less than 1 year <input type="checkbox"/> 1 year, less than 5 years <input type="checkbox"/> 5 years or more <input type="checkbox"/> DK <div style="text-align: right;">45</div>

Notes

Section O — MENTAL HEALTH — Continued

PERSON 1

Hand Card O1. Read answer categories if telephone interview.

7. Because of — — (disorder(s) in questions 1 and 2), how much difficulty does — — NOW have —

a. Forming friendships?

7a.

- 1 No difficulty
- 2 Some difficulty
- 3 A lot of difficulty
- 4 Completely unable
- 9 DK

46

b. Keeping friendships?

b.

- 1 No difficulty
- 2 Some difficulty
- 3 A lot of difficulty
- 4 Completely unable
- 9 DK

47

c. Concentrating long enough to complete tasks?

c.

- 1 No difficulty
- 2 Some difficulty
- 3 A lot of difficulty
- 4 Completely unable
- 9 DK

48

d. Coping with day-to-day stresses?

d.

- 1 No difficulty
- 2 Some difficulty
- 3 A lot of difficulty
- 4 Completely unable
- 9 DK

49

If all "No difficulty" and/or "DK" in 7a-d, skip to 8; otherwise ask:

e. For how long has — — had any of these difficulties?

e.

- 1 Less than 3 months
- 2 3 months, less than 1 year
- 3 1 year, less than 5 years
- 4 5 years or more
- 9 DK

50

8a. When did — — LAST see or talk to a MENTAL HEALTH PROFESSIONAL about — — (disorder(s) in questions 1 and 2)? Include psychiatrists, psychologists, social workers, psychiatric nurses, and any other type of mental health professional.

8a.

- 1 Less than 2 weeks
- 2 2 weeks, less than 1 month
- 3 1 month, less than 3 months
- 4 3 months, less than 1 year
- 5 1 year, less than 5 years
- 6 5 years or more
- 7 Never (8c)
- 9 DK

51

b. What type of mental health professional was last seen?

b.

Mental health professional

52-53

c. (Besides mental health professionals) When did — — LAST see or talk to a doctor or other health professional about — — (disorder(s) in questions 1 and 2)?

c.

- 1 Less than 2 weeks
- 2 2 weeks, less than 1 month
- 3 1 month, less than 3 months
- 4 3 months, less than 1 year
- 5 1 year, less than 5 years
- 6 5 years or more
- 7 Never
- 9 DK

54

**CHECK
ITEM 7**

Refer to 8a and c.

**CK
7**

- 1 Never in 8a AND c (12)
- 8 Other (9)

55

Notes

Section O — MENTAL HEALTH — Continued

PERSON 1

Ask 9 for the first 4 disorders recorded in Check Item 2.

► **FIRST DISORDER IN CHECK ITEM 2:** _____

9a. When did a doctor or other health professional **FIRST** give a diagnosis of (*first disorder in Check Item 2*) for — — ?

- 9a.**
- 1 Less than 1 year
 - 2 1 yr., less than 5 yrs. } (9b)
 - 3 5 years or more
 - 4 Never (9d)
 - 9 DK

56

57

b. Did the doctor call the (*first disorder in Check Item 2*) by a more technical or specific name?

- b.**
- 1 Yes
 - 2 No } (Next disorder or 10)
 - 9 DK

58

c. What did he or she call it?

c.

(Next disorder or 10)

59-61

d. Has a **DOCTOR OR OTHER HEALTH PROFESSIONAL** ever given this disorder a technical or specific name?

- d.**
- 1 Yes
 - 2 No } (Next disorder or 10)
 - 9 DK

62

e. What did he or she call it?

e.

63-65

f. When did a doctor first call this disorder (*entry in 9e*)?

- f.**
- 1 Less than 1 year
 - 2 1 yr., less than 5 yrs. } (Next disorder or 10)
 - 3 5 years or more
 - 9 DK

66

► **SECOND DISORDER IN CHECK ITEM 2:** _____

9a. When did a doctor or other health professional **FIRST** give a diagnosis of (*second disorder in Check Item 2*) for — — ?

- 9a.**
- 1 Less than 1 year
 - 2 1 yr., less than 5 yrs. } (9b)
 - 3 5 years or more
 - 4 Never (9d)
 - 9 DK

67

68

b. Did the doctor call the (*second disorder in Check Item 2*) by a more technical or specific name?

- b.**
- 1 Yes
 - 2 No } (Next disorder or 10)
 - 9 DK

69

c. What did he or she call it?

c.

(Next disorder or 10)

70-72

d. Has a **DOCTOR OR OTHER HEALTH PROFESSIONAL** ever given this disorder a technical or specific name?

- d.**
- 1 Yes
 - 2 No } (Next disorder or 10)
 - 9 DK

73

e. What did he or she call it?

e.

74-76

f. When did a doctor first call this disorder (*entry in 9e*)?

- f.**
- 1 Less than 1 year
 - 2 1 yr., less than 5 yrs. } (Next disorder or 10)
 - 3 5 years or more
 - 9 DK

77

Section O — MENTAL HEALTH — Continued

PERSON 1

<p>▶ THIRD DISORDER IN CHECK ITEM 2: _____</p>			
<p>9a. When did a doctor or other health professional FIRST give a diagnosis of <u>(third disorder in Check Item 2)</u> for — — ?</p> <p>_____</p> <p>b. Did the doctor call the <u>(third disorder in Check Item 2)</u> by a more technical or specific name?</p> <p>_____</p> <p>c. What did he or she call it?</p> <p>_____</p> <p>_____</p> <p>d. Has a DOCTOR OR OTHER HEALTH PROFESSIONAL ever given this disorder a technical or specific name?</p> <p>_____</p> <p>e. What did he or she call it?</p> <p>_____</p> <p>_____</p> <p>f. When did a doctor first call this disorder <u>(entry in 9e)</u>?</p> <p>_____</p>	<p>9a.</p> <p>1 <input type="checkbox"/> Less than 1 year 2 <input type="checkbox"/> 1 yr., less than 5 yrs. } (9b) 3 <input type="checkbox"/> 5 years or more 4 <input type="checkbox"/> Never (9d) 9 <input type="checkbox"/> DK</p> <p>b.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next disorder or 10) 9 <input type="checkbox"/> DK</p> <p>c.</p> <p>_____ (Next disorder or 10) _____</p> <p>d.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next disorder or 10) 9 <input type="checkbox"/> DK</p> <p>e.</p> <p>_____</p> <p>_____</p> <p>f.</p> <p>1 <input type="checkbox"/> Less than 1 year 2 <input type="checkbox"/> 1 yr., less than 5 yrs. } (Next disorder or 10) 3 <input type="checkbox"/> 5 years or more 9 <input type="checkbox"/> DK</p>	78	79
		80	
		81-83	
		84	
		85-87	
		88	
<p>▶ FOURTH DISORDER IN CHECK ITEM 2: _____</p>			
<p>9a. When did a doctor or other health professional FIRST give a diagnosis of <u>(fourth disorder in Check Item 2)</u> for — — ?</p> <p>_____</p> <p>b. Did the doctor call the <u>(fourth disorder in Check Item 2)</u> by a more technical or specific name?</p> <p>_____</p> <p>c. What did he or she call it?</p> <p>_____</p> <p>_____</p> <p>d. Has a DOCTOR OR OTHER HEALTH PROFESSIONAL ever given this disorder a technical or specific name?</p> <p>_____</p> <p>e. What did he or she call it?</p> <p>_____</p> <p>_____</p> <p>f. When did a doctor first call this disorder <u>(entry in 9e)</u>?</p> <p>_____</p>	<p>9a.</p> <p>1 <input type="checkbox"/> Less than 1 year 2 <input type="checkbox"/> 1 yr., less than 5 yrs. } (9b) 3 <input type="checkbox"/> 5 years or more 4 <input type="checkbox"/> Never (9d) 9 <input type="checkbox"/> DK</p> <p>b.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next disorder or 10) 9 <input type="checkbox"/> DK</p> <p>c.</p> <p>_____ (Next disorder or 10) _____</p> <p>d.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next disorder or 10) 9 <input type="checkbox"/> DK</p> <p>e.</p> <p>_____</p> <p>_____</p> <p>f.</p> <p>1 <input type="checkbox"/> Less than 1 year 2 <input type="checkbox"/> 1 yr., less than 5 yrs. } (Next disorder or 10) 3 <input type="checkbox"/> 5 years or more 9 <input type="checkbox"/> DK</p>	89	90
		91	
		92-94	
		95	
		96-98	
		99	

Section O — MENTAL HEALTH — Continued		PERSON 1
10a. Does — — NOW take any prescription medication for — — <i>(disorder(s) in Check Item 2)?</i>		10a. 1 <input type="checkbox"/> Yes (10c) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <div style="text-align: right; border: 1px solid black; width: 20px; float: right;">100</div>
b. DURING THE PAST 12 MONTHS, did — — take any prescription medication for [this disorder/any of these disorders]?		b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (12) 9 <input type="checkbox"/> DK } <div style="text-align: right; border: 1px solid black; width: 20px; float: right;">101</div>
c. How many DIFFERENT medications [does — — take/did — — take during the past 12 months] for [this disorder/any of these disorders]?		c. _____ Medication(s) Number 9 <input type="checkbox"/> DK <div style="text-align: right; border: 1px solid black; width: 20px; float: right;">102</div>
11a. [May I see/Would you please bring to the telephone] the container(s) for the medication(s) you just told me about?		11a. 1 <input type="checkbox"/> Container available 2 <input type="checkbox"/> No container available <div style="text-align: right; border: 1px solid black; width: 20px; float: right;">103</div>
<i>Record from container label. If no container available and for telephone, ask 11b—d as appropriate. If DK, show Card O2, asking "Is it any of these?" before marking "DK".</i>		
▶ FIRST MEDICATION b. What is the name of the first medication?		b. _____ _____ <div style="text-align: right; border: 1px solid black; width: 20px; float: right;">104–106</div> 999 <input type="checkbox"/> DK
▶ SECOND MEDICATION c. What is the name of the second medication?		c. _____ _____ <div style="text-align: right; border: 1px solid black; width: 20px; float: right;">107–109</div> 999 <input type="checkbox"/> DK
▶ THIRD MEDICATION d. What is the name of the third medication?		d. _____ _____ <div style="text-align: right; border: 1px solid black; width: 20px; float: right;">110–112</div> 999 <input type="checkbox"/> DK
12a. Does — — NOW receive a disability payment through any government program because of — — <i>(disorder(s) in Check Item 2)?</i>		12a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Check Item 1 for NP 9 <input type="checkbox"/> DK } or Section P) <div style="text-align: right; border: 1px solid black; width: 20px; float: right;">113</div>
b. Is this payment through Social Security Disability Insurance, called "SSDI"; through Supplemental Security Income, called SSI"; through the Veteran's Administration; or through some other program? <i>Mark all that apply.</i>		b. 1 <input type="checkbox"/> SSDI } (Check Item 2 <input type="checkbox"/> SSI } 1 for NP or 3 <input type="checkbox"/> VA } Section P) 4 <input type="checkbox"/> Other } <div style="text-align: right; border: 1px solid black; width: 20px; float: right;">114</div> <div style="text-align: right; border: 1px solid black; width: 20px; float: right;">115</div> <div style="text-align: right; border: 1px solid black; width: 20px; float: right;">116</div> <div style="text-align: right; border: 1px solid black; width: 20px; float: right;">117</div>

Notes

Section P — DENTAL

PERSON 1

Hand calendar.

These next questions are about dental care received during the 2 weeks [outlined in red on that calendar/beginning Monday (date) and ending this past Sunday (date)].

1a. DURING THOSE 2 WEEKS did anyone in the family go to a dentist? Include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists. Yes No (2) DK (2)

b. Who was this?
Mark "Dental visits" box in person's column.

c. During those 2 weeks, did anyone else in the family go to a dentist? Yes (Reask 1b and c) No

Ask for each person with "Dental visit" in 1b.

d. During those 2 weeks, how many times did — go to a dentist?

1b. 1 Dental visit

5

6-7

d. 2-week dental visits

Mark box if under 2.

2a. During the past 12 months (that is, since (12-month date) a year ago), about how many visits did — make to a dentist? (Include the (number in 1d) visits) you already told me about.)

Mark "2-week dental visit" box in person's column if visit(s) reported in 1d.

b. ABOUT how long has it been since — LAST went to a dentist?

2a. 998 Under 2 (NP)

8-10

_____ 12-month dental visits
000 None

- b.**
- 1 Past 2 weeks not reported (Mark 1b, ask 1c)
 - 2 2-week dental visit
 - 3 Over 2 weeks, less than 6 months
 - 4 6 months, less than 1 year
 - 5 1 year, less than 2 years
 - 6 2 years, less than 5 years
 - 7 5 years or more
 - 0 Never
- } (NP)
} (3)

11

3. What are the reasons — has [not visited the dentist in over 12 months/never gone to the dentist]?
Do not read categories. Circle all that apply.

- 01 Afraid
- 02 Nervous
- 03 Needles
- 04 Cost
- 05 Don't know dentist
- 06 Dentist too far
- 07 Can't get there
- 08 No problems
- 09 No teeth
- 10 Not important
- 11 Didn't think of it
- 88 Other (Specify)
- 99 Don't know

- 3.**
- 01
 - 02
 - 03
 - 04
 - 05
 - 06
 - 07
 - 08
 - 09
 - 10
 - 11
 - 88
 - 99

12-13
14-15
16-17
18-19
20-21
22-23
24-25
26-27
28-29
30-31
32-33
34-35
36-37

(Specify)

4a. Is there anyone in the family who has lost ALL of his or her upper (permanent) natural teeth? Yes No (4e)

b. Who is this?
Mark "No uppers" box in person's column.

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

Ask for each person with "No uppers" in 4b.

d. Does — have an upper denture or plate?

4b. 1 No uppers

38

d. 1 Yes 2 No

39

e. Is there anyone in the family who has lost ALL of his or her lower (permanent) natural teeth? Yes No (5)

f. Who is this?
Mark "No lowers" box in person's column.

g. Anyone else? Yes (Reask 4f and g) No

Ask for each person with "No lowers" in 4f.

h. Does — have a lower denture or plate?

h. 1 Yes 2 No

40

41

Section P – DENTAL – Continued		PERSON 1	
CHECK ITEM 1	Refer to 4b AND 4f.	1 <input type="checkbox"/> All family members have lost all teeth: upper and lower (Check Item 2)	42
		8 <input type="checkbox"/> Other (5)	
5a. Dental SEALANTS are special plastic coatings that are painted on the tops of the back teeth to prevent tooth decay. They are DIFFERENT from fillings, caps, crowns, and fluoride treatments. Has anyone in the family EVER had dental SEALANTS painted on their teeth?			
<input type="checkbox"/> Yes <input type="checkbox"/> No (6) <input type="checkbox"/> DK (6)			
b. Who is this? Mark "Dental sealants" box in person's column.		5b.	1 <input type="checkbox"/> Dental sealants
c. Anyone else?			
<input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No			
6a. In the past two weeks has anyone in the family used a mouthwash or mouthrinse at home?			
<input type="checkbox"/> Yes <input type="checkbox"/> No (Check Item 2) <input type="checkbox"/> DK (Check Item 2)			
b. Who is this? Mark "Mouthrinse" box in person's column.		6b.	1 <input type="checkbox"/> Mouthrinse
c. Anyone else?			
<input type="checkbox"/> Yes (Reask 6b and c) <input type="checkbox"/> No			
Ask for each person with "Mouthrinse" in 6b.			45-46
d. What brand did -- use most often during the past 2 weeks? Do not read answer categories. Circle ONE brand.		d.	1 2 3 4 8 9
1. $\left\{ \begin{array}{l} \text{ACT} \\ \text{Fluorigard} \\ \text{Koly nos} \\ \text{Listermint} \\ \text{Reach} \\ \text{StanCare} \end{array} \right.$			
2. Prescription fluoride rinse 3. PLAX 4. Scope, Listerine, Lavior 8. Other (Specify) 9. Don't know			(Specify)
Ask or verify.		e.	1 <input type="checkbox"/> Yes
e. Does this mouthrinse contain fluoride?			2 <input type="checkbox"/> No
			9 <input type="checkbox"/> DK
CHECK ITEM 2	Refer to age.	CK 2	1 <input type="checkbox"/> Under 2 (8)
			2 <input type="checkbox"/> 2-17 (7)
			3 <input type="checkbox"/> 18 and over (NP)
7. {Some schools have fluoride MOUTHRINSE programs.}		7.	1 <input type="checkbox"/> Yes
Does -- now take part in a fluoride MOUTHRINSE program at school?			2 <input type="checkbox"/> No
			9 <input type="checkbox"/> DK
{Doctors or dentists may prescribe or provide tablets, drops, or supplements with fluoride in them. (Sometimes these are given at school.)}		8.	1 <input type="checkbox"/> Yes
8. Does -- now take vitamins with FLUORIDE in them or any other kind of FLUORIDE tablets, drops, or supplements?			2 <input type="checkbox"/> No
			9 <input type="checkbox"/> DK
Notes			

Section P — DENTAL — Continued		PERSON 1	
<p>These next questions refer to the 2 weeks [outlined on that calendar/beginning Monday (date) and ending Sunday (date)].</p>			
<p>9a. During that 2 week period, did anyone in the family miss any time from work or school because of a dental problem or dental visit? <input type="checkbox"/> Yes <input type="checkbox"/> No (10) <input type="checkbox"/> DK (10)</p>			
<p>b. Who was this? <i>Mark "Missed time" box in person's column.</i></p>		9b.	<p>1 <input type="checkbox"/> Missed time</p>
<p>c. Anyone else? <input type="checkbox"/> Yes (Reask 9b and c) <input type="checkbox"/> No <input type="checkbox"/> DK</p>			51
<p><i>Ask for each person with "Missed time" in 9b.</i></p>			
<p>d. How much time did — miss because of a dental problem or dental visit?</p>		d.	<p>51 <input type="checkbox"/> Less than 1 hour 52 <input type="checkbox"/> 1 hour, less than 3 hours 53 <input type="checkbox"/> 3 hours, less than 5 hours 54 <input type="checkbox"/> 5 hours, less than 7 hours 55 <input type="checkbox"/> 7 or more hours OR _____ Days</p>
52-53			
<p>10a. During that two week period did anyone in the family miss any time from work or school to assist a relative or friend with a dental problem or dental visit? <input type="checkbox"/> Yes <input type="checkbox"/> No (11) <input type="checkbox"/> DK (11)</p>			
<p>b. Who was this? <i>Mark "Missed time" box in person's column.</i></p>		10b.	<p>1 <input type="checkbox"/> Missed time</p>
<p>c. Anyone else? <input type="checkbox"/> Yes (Reask 10b and c) <input type="checkbox"/> No <input type="checkbox"/> DK</p>			54
<p><i>Ask for each person with "Missed time" marked in 10b.</i></p>			
<p>d. How much time did — miss because — was assisting a relative or friend with a dental problem or visit?</p>		d.	<p>51 <input type="checkbox"/> Less than 1 hour 52 <input type="checkbox"/> 1 hour, less than 3 hours 53 <input type="checkbox"/> 3 hours, less than 5 hours 54 <input type="checkbox"/> 5 hours, less than 7 hours 55 <input type="checkbox"/> 7 or more hours OR _____ Days</p>
55-56			
<p>11a. (Not counting the time missed from work or school) Was there any (other) time during those 2 weeks that anyone in the family cut down on normal activities for MORE THAN HALF OF THE DAY because of a dental problem or dental visit? <input type="checkbox"/> Yes <input type="checkbox"/> No (Check Item 3) <input type="checkbox"/> DK (Check Item 3)</p>			
<p>b. Who was this? <i>Mark "Cut down" box in person's column.</i></p>		11b.	<p>1 <input type="checkbox"/> Cut down</p>
<p>c. Anyone else? <input type="checkbox"/> Yes (Reask 11b and c) <input type="checkbox"/> No <input type="checkbox"/> DK</p>			57
<p><i>Ask for each person with "Cut down" in 11b.</i></p>			
<p>d. During that period, how many (other) days did — cut down for MORE THAN HALF OF THE DAY because of a dental problem or dental visit?</p>		d.	<p>00 <input type="checkbox"/> None _____ Days</p>
58-59			
CHECK ITEM 3	<p>a. Mark first appropriate box.</p>	CK 3a.	<p>0 <input type="checkbox"/> Under 17 1 <input type="checkbox"/> Present for all questions 2 <input type="checkbox"/> Present for some questions 3 <input type="checkbox"/> Not present</p>
	<p>b. Enter person number(s) of respondent(s) to "Dental" section.</p>	b.	<p>_____ Days Person number(s) of respondent(s)</p>
60-62			
<p>Notes</p>			

Section Q — DIABETES		PERSON 1	RT 71 3-4
Section Q1 — DIABETES SCREENING			5
CHECK ITEM 1	Refer to ages of all family members. 1 <input type="checkbox"/> Persons aged 18 and over in family (1) 2 <input type="checkbox"/> No persons aged 18 and over in family (Section R)		
1a. Has any adult in this family, that is (read names of persons 18 and over) EVER been told by a doctor that they had diabetes? Do not include pre, potential, or borderline diabetes.	<input type="checkbox"/> Yes <input type="checkbox"/> No (Section R)		
b. Who is this? Mark "Diabetes" box in appropriate person's column.		1b.	6
c. Has any other adult in this household been told they have diabetes? Do not include pre, potential, or borderline diabetes.	<input type="checkbox"/> Yes (Reask 1b and c) <input type="checkbox"/> No		
Section Q2 — DIABETES FOLLOWUP QUESTIONS			7
CHECK ITEM 2	Refer to 1b above.	CK 2	
		0 <input type="checkbox"/> Under 18 (NP) 1 <input type="checkbox"/> "Diabetes" box marked in 1b (Check Item 3) 8 <input type="checkbox"/> All others (NP)	
CHECK ITEM 3	Status of diabetic.	CK 3	8
		1 <input type="checkbox"/> Available (1) 2 <input type="checkbox"/> Callback required (Hhld page of HIS-1, THEN NP) 3 <input type="checkbox"/> Noninterview (Cover page of HIS-1A, THEN NP)	
(Earlier I was told you had diabetes.) 1. How old were you when you got diabetes? Do not include pre, potential, or borderline diabetes.		1.	9-10
		00 <input type="checkbox"/> Don't have diabetes (NP) 98 <input type="checkbox"/> Have pre, potential, or borderline diabetes (NP) _____ Years old 99 <input type="checkbox"/> DK	
2. Are you NOW a diabetic?		2.	11
		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)	
3a. When you first learned that you might have diabetes, were you sick or feeling diabetic symptoms, OR was the diabetes discovered by chance?		3a.	12
		1 <input type="checkbox"/> Sick/symptoms 2 <input type="checkbox"/> By chance (3c) 9 <input type="checkbox"/> DK	
b. Were you at your doctor's office, a patient in the hospital, or somewhere else?		b.	13
		1 <input type="checkbox"/> Doctor's office 2 <input type="checkbox"/> Patient in hospital 3 <input type="checkbox"/> Somewhere else 9 <input type="checkbox"/> DK	(4)
c. Was the diabetes discovered while getting a routine physical, a screening test for diabetes, or while being treated for something else?		c.	14
		1 <input type="checkbox"/> Routine physical 2 <input type="checkbox"/> Screening test for diabetes 3 <input type="checkbox"/> Treated for something else 8 <input type="checkbox"/> Other 9 <input type="checkbox"/> DK	
4a. When your diabetes was first diagnosed, did you have a blood test, a urine test, or both?		4a.	15
		1 <input type="checkbox"/> Blood 2 <input type="checkbox"/> Urine (5) 3 <input type="checkbox"/> Both 9 <input type="checkbox"/> DK (5)	
b. Was the blood test an oral glucose tolerance test?		b.	16
		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	
Ask if female; otherwise, go to 6. 5a. Were you pregnant when you were first told that you had diabetes?		5a.	17
		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6)	
b. Other than during pregnancy, did a doctor EVER tell you that you had diabetes?		b.	18
		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)	
Notes			

Section Q2 — DIABETES FOLLOWUP QUESTIONS — Continued

PERSON 1

<p>6a. Are you NOW taking insulin?</p>	<p>6a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6a) 19</p>
<p>b. For how long have you been taking insulin?</p>	<p>b. 000 <input type="checkbox"/> Less than 1 month 20-22 _____ } 1 <input type="checkbox"/> Months 999 <input type="checkbox"/> DK } 2 <input type="checkbox"/> Years</p>
<p>c. Currently, about how often do you use insulin?</p>	<p>c. _____ } 1 <input type="checkbox"/> Day Times per } 2 <input type="checkbox"/> Week 23-25 998 <input type="checkbox"/> Use insulin pump 999 <input type="checkbox"/> DK</p>
<p>d. On an average day, about how many units of insulin do you take?</p>	<p>d. _____ Units per day 26-28 999 <input type="checkbox"/> DK</p>
<p><i>Mark without asking if known.</i> e. Have you EVER used an insulin pump?</p>	<p>e. 1 <input type="checkbox"/> Yes 29 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
<p>f. Are you NOW taking diabetes pills to lower your blood sugar? <i>Read if necessary: These are sometimes called oral agents or oral hypoglycemic agents.</i></p>	<p>f. 1 <input type="checkbox"/> Yes 30 2 <input type="checkbox"/> No } (7) 9 <input type="checkbox"/> DK }</p>
<p>g. For how long have you been taking them?</p>	<p>g. 000 <input type="checkbox"/> Less than 1 month 31-33 _____ } 1 <input type="checkbox"/> Months 999 <input type="checkbox"/> DK } 2 <input type="checkbox"/> Years</p>
<p>h. About how often do you take them?</p>	<p>h. _____ } 1 <input type="checkbox"/> Day Times per } 2 <input type="checkbox"/> Week 34-36 999 <input type="checkbox"/> DK</p>
<p>7a. Has a doctor or other health professional ever given you a diet or instructions on what foods you should eat as a diabetic?</p>	<p>7a. 1 <input type="checkbox"/> Yes 37 2 <input type="checkbox"/> No } (9) 9 <input type="checkbox"/> DK }</p>
<p>b. In the past 12 months, have you tried to follow the diet or instructions?</p>	<p>b. 1 <input type="checkbox"/> Yes 38 2 <input type="checkbox"/> No (9)</p>
<p><i>Hand Card Q1. Read categories if telephone interview.</i> c. In the past 12 months, about how often have you been able to follow the diet or instructions?</p>	<p>c. 1 <input type="checkbox"/> Always (9) 39 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 } (8b) 9 <input type="checkbox"/> DK }</p>

Notes

Section Q2 — DIABETES FOLLOWUP QUESTIONS — Continued		PERSON 1
8a. Is it difficult for you to stay on your diet —		40
(1) When you eat in restaurants?	8a. (1)	0 <input type="checkbox"/> Not applicable 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(2) When you go to parties or social events?	(2)	0 <input type="checkbox"/> Not applicable 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(3) When you are busy with other activities?	(3)	0 <input type="checkbox"/> Not applicable 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(4) When you go on a trip?	(4)	0 <input type="checkbox"/> Not applicable 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(5) When you are feeling upset or angry?	(5)	0 <input type="checkbox"/> Not applicable 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(6) When you are feeling sad, depressed, or blue?	(6)	0 <input type="checkbox"/> Not applicable 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(7) When you are feeling bored?	(7)	0 <input type="checkbox"/> Not applicable 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
b. Do you (also) find it difficult to stay on your diet —		47
(1) Because foods you should eat do not taste good?	b. (1)	0 <input type="checkbox"/> Not applicable 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(2) Because you crave foods not on your diet?	(2)	0 <input type="checkbox"/> Not applicable 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(3) Because you have to prepare food separately for yourself?	(3)	0 <input type="checkbox"/> Not applicable 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(4) Because of lack of help or support from your family or friends?	(4)	0 <input type="checkbox"/> Not applicable 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(5) Because you are unsure about what foods you should eat?	(5)	0 <input type="checkbox"/> Not applicable 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
9. How important do you think what you eat or drink is in controlling your diabetes? Is it very important, somewhat important, or not important?	9.	1 <input type="checkbox"/> Very important 2 <input type="checkbox"/> Somewhat important 3 <input type="checkbox"/> Not important 9 <input type="checkbox"/> DK

Section Q2 -- DIABETES FOLLOWUP QUESTIONS -- Continued

PERSON 1

<p>10a. Is there ONE doctor you usually see for your diabetes?</p> <p>b. How many times have you seen this doctor in the past 12 months?</p> <p>c. Which of the following did you see in the past 12 months for any reason --</p> <p>(1) A cardiologist or heart doctor?</p> <p>(2) An ophthalmologist, that is, a medical doctor who specializes in eye care?</p> <p><i>Ask if female; otherwise go to (4).</i></p> <p>(3) An obstetrician or gynecologist?</p> <p>(4) A podiatrist or foot doctor?</p> <p>(5) A psychologist or psychiatrist?</p> <p>(6) A dietitian or nutritionist?</p> <p>(7) Any other medical doctor? -- <i>Specify</i></p>	<p>10a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (10c) 53</p> <p>b. _____ Times 54-55 99 <input type="checkbox"/> DK</p> <p>c. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 56</p> <p>(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 57</p> <p>(3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 58</p> <p>(4) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 59</p> <p>(5) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 60</p> <p>(6) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 61</p> <p>(7) 1 <input type="checkbox"/> Yes -- <i>Specify</i> 62 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
<p>The next few questions are about glucose or sugar in your urine and blood.</p> <p>11a. About how many times in the past 6 months has a health professional checked your URINE for glucose or sugar? Do not count times when an overnight patient in the hospital.</p> <p>b. On your own, about HOW OFTEN do you check your urine for glucose or sugar? Include times when checked by a family member or friend.</p> <p><i>If "None" in 11a and "Never" in 11b, skip to 11d. Hand Card Q1. Read list if telephone interview.</i></p> <p>c. Based on ALL your urine tests during the past 6 months, how often would you say you have had glucose or sugar in your urine?</p> <p>d. Have you been tested for ketones in the past 6 months?</p> <p>e. Were any of these tests positive?</p>	<p>11a. 00 <input type="checkbox"/> None 63-64 _____ Times 99 <input type="checkbox"/> DK</p> <p>b. 000 <input type="checkbox"/> Never 65-67 _____ 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</p> <p>c. 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 68</p> <p>d. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (12) 9 <input type="checkbox"/> DK 69</p> <p>e. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 70</p>
<p>12a. About how many times in the past 6 months has a health professional checked your BLOOD for glucose or sugar? Do not count times when an overnight patient in a hospital.</p> <p>b. On your own, about HOW OFTEN do you check your blood for glucose or sugar? Include times when checked by a family member or friend.</p> <p><i>If "None" in 12a and "Never" in 12b, skip to 13.. Hand Card Q1. Read list if telephone interview.</i></p> <p>c. 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?</p>	<p>12a. 00 <input type="checkbox"/> None 71-72 _____ Times 99 <input type="checkbox"/> DK</p> <p>b. 000 <input type="checkbox"/> Never 73-75 _____ 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</p> <p>c. 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 76</p>

Section Q2 — DIABETES FOLLOWUP QUESTIONS — Continued		PERSON 1
13a. Have you ever heard of glycosylated hemoglobin (gī-ko'sil-āted he"mo-glo'bin) or hemoglobin "A one C"?	13a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (14a) 77
b. About how many times in the past 6 months has a doctor, nurse, or other health professional checked you for glycosylated hemoglobin or hemoglobin "A one C"?	b.	00 <input type="checkbox"/> None _____ Times 99 <input type="checkbox"/> DK 78-79
14a. About how many times in the past 6 months has a health professional checked your feet for any sores or irritations?	14a.	00 <input type="checkbox"/> None _____ Times 99 <input type="checkbox"/> DK 80-81
b. About how often do you check your feet for sores or irritations?	b.	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 82-84
15. During the past 6 months have you had any sores or irritations on your feet or ankles that did not heal normally?	15.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 85
16. When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light.	16.	1 <input type="checkbox"/> Less than 1 month } (18) 2 <input type="checkbox"/> 1 to 12 months } 3 <input type="checkbox"/> 13 to 24 months (17b) 4 <input type="checkbox"/> More than 2 years 5 <input type="checkbox"/> Never 9 <input type="checkbox"/> DK 86
17a. Have you had ANY kind of eye exam by a doctor within the past two years?	17a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (18) 9 <input type="checkbox"/> DK 87
b. Have you had ANY kind of eye exam by a doctor within the past 12 months?	b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 88
18a. Have you EVER been told that diabetes has affected the back of your eyes, that is, the retina?	18a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (20) 9 <input type="checkbox"/> DK 89
b. How old were you when the doctor first told you this?	b.	_____ Years old 99 <input type="checkbox"/> DK 90-91
19a. Have you ever had laser or photocoagulation treatment for this problem? Do not include treatments for cataracts.	19a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (20) 9 <input type="checkbox"/> DK 92
b. Did you receive this treatment within the past 12 months?	b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (20) 9 <input type="checkbox"/> DK 93
c. Was this the first time you had this treatment?	c.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 94
20. Have you ever had photographs taken of the retina or inside of your eyes?	20.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 95
21. Do you have serious trouble seeing with one or both eyes even when wearing glasses?	21.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 96

Section Q2 – DIABETES FOLLOWUP QUESTIONS – Continued

PERSON 1

<p>22a. About how many times in the past 12 months has a doctor or other health professional checked your blood pressure? Do not count times when an overnight patient in a hospital.</p> <p>b. Has a doctor EVER told you that you had high blood pressure or hypertension?</p> <p>c. Are you doing any of the following [for your/to prevent] high blood pressure –</p> <p>(1) Taking prescribed medication?</p> <p>(2) Losing weight or controlling weight?</p> <p>(3) Cutting down on salt or sodium?</p> <p>(4) Getting physical activity or exercise?</p> <p>d. The last time you had your blood pressure checked, were you told it was high, borderline, low, normal, or were you not told?</p>	<p>22a. 000 <input type="checkbox"/> None _____ Times 999 <input type="checkbox"/> DK</p> <p>b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>c. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>(3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>(4) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>d. 1 <input type="checkbox"/> High 2 <input type="checkbox"/> Borderline 3 <input type="checkbox"/> Low 4 <input type="checkbox"/> Normal 5 <input type="checkbox"/> Not told 6 <input type="checkbox"/> Never checked 9 <input type="checkbox"/> DK</p>
<p>23. Has a doctor EVER told you that you had –</p> <p>a. Glaucoma?</p> <p>b. Are you NOW taking any medication for it?</p> <p>c. Angina?</p> <p>d. Are you NOW taking any medication for it?</p> <p>e. Any other heart trouble?</p> <p>f. Are you NOW taking any medication for it?</p> <p>g. A stroke?</p> <p>h. Cataracts?</p> <p>i. Protein or albumin in your urine?</p> <p>j. Periodontal or gum disease?</p>	<p>23a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (23c)</p> <p>b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>c. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (23e)</p> <p>d. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>e. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (23g)</p> <p>f. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>g. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>h. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>i. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>j. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
<p>24. Has a doctor EVER told you that you had –</p> <p>a. Kidney disease? Do not include kidney stones or bladder infection.</p> <p>b. Polycystic kidney disease?</p>	<p>24a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (25)</p> <p>b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
<p>25. About how many different times in the past 12 months have you had a bladder or urinary tract infection?</p>	<p>25. 00 <input type="checkbox"/> None _____ Times 99 <input type="checkbox"/> DK</p>
<p>26. Have you ever had symptoms of a bladder infection that lasted more than 3 months, such as frequent urination and pain in your bladder?</p>	<p>26. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (29)</p>

Section Q2 — DIABETES FOLLOWUP QUESTIONS — Continued		PERSON 1	
27. When you had these symptoms, were you told that you had painful bladder syndrome or interstitial cystitis (in 'ter-stish'al sis-ti'tis)?	27.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (29)	29
28. How old were you when you were first told that you had painful bladder syndrome or interstitial cystitis? (In 'ter-stish'al sis-ti'tis)	28.	_____ Years old 99 <input type="checkbox"/> DK	30-31
29. When you urinate — a. Do you USUALLY have trouble starting?	29a.	0 <input type="checkbox"/> NA/Dialysis (31) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	32
b. Do you USUALLY feel like you have not completely emptied your bladder?	b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	33
30a. Do you USUALLY have to get up at night to go to the bathroom to urinate? Exclude nights when you drink a lot of liquids.	30a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (31)	34
b. About how many times each night do you have to get up?	b.	_____ Times 00 <input type="checkbox"/> Less than once a night	35-36
31. Have you ever had an amputation of your toe, foot, leg, or part of a leg? <i>If "Yes," ask: Which? Mark all that apply.</i>	31.	1 <input type="checkbox"/> Yes, toe 2 <input type="checkbox"/> Yes, foot 3 <input type="checkbox"/> Yes, leg or part of leg 4 <input type="checkbox"/> No	37 38
32. During the past THREE months have you had — a. Numbness or loss of feeling in your hands or feet other than from your hands or feet falling asleep?	32a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	39
b. A painful sensation or tingling in your hands or feet? Do not include normal foot aches from standing or walking for long periods.	b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	40
c. Decreased ability to feel hot or cold in things you touch?	c.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	41
33a. Do you NOW smoke cigarettes?	33a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (34)	42
b. About how many cigarettes do you smoke per day?	b.	00 <input type="checkbox"/> Less than one per day _____ Per day 98 <input type="checkbox"/> Don't smoke regularly	43-44
34a. Have you tried to lose weight in the past year?	34a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	45
b. Is your weight now more, less, or about the same as a year ago?	b.	1 <input type="checkbox"/> More 2 <input type="checkbox"/> Less 3 <input type="checkbox"/> About the same (35)	46
c. In the past year, about how much weight have you [gained/lost]?	c.	_____ Pounds 999 <input type="checkbox"/> DK	47-49
35a. About how much did you weigh when you were 25 years old? <i>Read if female: If you were pregnant when you were 25, tell me your weight just before you became pregnant.</i>	35a.	_____ Pounds 999 <input type="checkbox"/> DK	50-52
b. What is the most you have EVER weighed? <i>Read if female: Except when you were pregnant.</i>	b.	_____ Pounds 999 <input type="checkbox"/> DK	53-55
c. About how old were you when you FIRST weighed that much?	c.	00 <input type="checkbox"/> Now _____ Years old	56-57

Section Q2 — DIABETES FOLLOWUP QUESTIONS — Continued

PERSON 1

Hand card Q2. Read categories if telephone interview.

36a. Where have you obtained information about diabetes?

Mark all mentioned. Do not probe.

- 36a.**
- 00 Nowhere (39) 58-59
 - 01 Doctor's office — doctor 60-61
 - 02 Doctor's office — nurse 62-63
 - 03 Dietitian or nutritionist 64-65
 - 04 Doctor or nurse in a hospital 66-67
 - 05 Relative or friend 68-69
 - 06 Another diabetic 70-71
 - 07 Health department 72-73
 - 08 Diabetes organization 74-75
 - 09 National Diabetes Information Clearing House 76-77
 - 10 Diabetes support group 78-79
 - 11 Library 80-81
 - 12 Newspapers 82-83
 - 13 Diabetes education class 84-85
 - 88 Other — Specify 86-87

If three sources or less in 36a, mark boxes without asking and skip to 37.

b. Which three of these sources have provided you with the MOST USEFUL information about diabetes?

Mark up to 3.

- b.**
- 01 Doctor's office — doctor 88-89
 - 02 Doctor's office — nurse 90-91
 - 03 Dietitian or nutritionist 92-93
 - 04 Doctor or nurse in a hospital
 - 05 Relative or friend
 - 06 Another diabetic
 - 07 Health department
 - 08 Diabetes organization
 - 09 National Diabetes Information Clearing House
 - 10 Diabetes support group
 - 11 Library
 - 12 Newspapers
 - 13 Diabetes education class
 - 88 Other — Specify

37a. Have you ever taken a course or class in how to manage your diabetes yourself?

- 37a.**
- 1 Yes 94
 - 2 No
 - 9 DK } (38)

b. About how many hours of instructions did you receive on how to manage your diabetes?

- b.**
- _____ Hours 95-97
- 999 DK

c. Did this course include any of the following subjects —

- c.**
- 1 Yes 98
 - 2 No

(1) How to inject insulin?

- (1)**
- 1 Yes 99
 - 2 No

(2) How to change the insulin dose?

- (2)**
- 1 Yes 100
 - 2 No

(3) How to manage your diabetes when you are sick?

- (3)**
- 1 Yes 101
 - 2 No

(4) How to test your blood or urine for sugar?

- (4)**
- 1 Yes 102
 - 2 No

(5) How to plan meals?

- (5)**
- 1 Yes 103
 - 2 No

(6) How to take care of your feet?

- (6)**
- 1 Yes 104
 - 2 No

38. Have you ever attended any (other) education program or class about your diabetes?

- 38.**
- 1 Yes 104
 - 2 No
 - 9 DK

39. Were either of your parents EVER told that they had diabetes? Do not include pre, potential, or borderline diabetes.

If "Yes," ask: Which?

- 39.**
- 1 Yes, father 105
 - 2 Yes, mother
 - 3 Yes, both
 - 4 No
 - 9 DK

40. How many children have you had, including any that may have died?

Read if female: Do not include stillbirths or miscarriages.

- 40.**
- 00 None 106-107
 - _____ Total number of children
 - 99 DK

Section R — OROFACIAL PAIN

<p>CHECK ITEM 1</p>	<p>Status of sample person.</p>	<p>0 <input type="checkbox"/> No person 18+ in family (Cover page of HIS-1A) 1 <input type="checkbox"/> Available (Intro) 2 <input type="checkbox"/> Callback required (Hhld page of HIS-1) 3 <input type="checkbox"/> Noninterview (Section T)</p>	<p>5</p>
<p>INTRO These next questions concern conditions of the teeth, mouth, or face. Tell me if you experienced any of these conditions MORE THAN ONCE in the past 6 months.</p>			
<p>CHECK ITEM 2</p>	<p>Refer to 4b and 4f, "Dental" page 26, for sample person.</p>	<p>1 <input type="checkbox"/> Sample person has no teeth (2) 8 <input type="checkbox"/> Other (1)</p>	<p>6</p>
<p>1a. During the past 6 months, did you have a toothache more than once, when biting or chewing?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2)</p>	<p>7</p>	
<p>b. Did you first have this pain more than 6 months ago?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>8</p>	
<p>2a. (During the past 6 months) Did you have painful sores or irritations around the lips or on the tongue, cheeks, or gums more than once?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (3)</p>	<p>9</p>	
<p>b. Did you first have the sores or irritations more than 6 months ago?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>10</p>	
<p>3a. (During the past 6 months) Did you have a prolonged, unexplained burning sensation in your tongue or any other part of your mouth more than once?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (4)</p>	<p>11</p>	
<p>b. When you have this sensation, does it come and go or is it continuous and uninterrupted?</p>	<p>1 <input type="checkbox"/> Come and go 2 <input type="checkbox"/> Continuous/uninterrupted 8 <input type="checkbox"/> Other 9 <input type="checkbox"/> DK</p>	<p>12</p>	
<p>c. During how many DIFFERENT MONTHS in the past 6 months did you have this sensation?</p>	<p><input type="text"/> Months</p>	<p>13</p>	
<p>d. How many total days in the past 6 months did you have this sensation?</p>	<p>1 <input type="checkbox"/> 1-3 days 4 <input type="checkbox"/> 16-30 days 7 <input type="checkbox"/> "Everyday" 2 <input type="checkbox"/> 4-10 days 5 <input type="checkbox"/> 31-45 days 9 <input type="checkbox"/> DK 3 <input type="checkbox"/> 11-15 days 6 <input type="checkbox"/> 46+ days</p>	<p>14</p>	
<p>e. Did you first have this sensation more than 6 months ago?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>15</p>	
<p>4a. (During the past 6 months) Did you have pain in the jaw joint or in front of the ear more than once?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)</p>	<p>16</p>	
<p>b. When you have this pain, does it come and go or is it continuous and uninterrupted?</p>	<p>1 <input type="checkbox"/> Come and go 2 <input type="checkbox"/> Continuous/uninterrupted 8 <input type="checkbox"/> Other 9 <input type="checkbox"/> DK</p>	<p>17</p>	
<p>c. During how many DIFFERENT MONTHS in the past 6 months did you have this pain?</p>	<p><input type="text"/> Months</p>	<p>18</p>	
<p>d. How many total days in the past 6 months did you have this pain?</p>	<p>1 <input type="checkbox"/> 1-3 days 4 <input type="checkbox"/> 16-30 days 7 <input type="checkbox"/> "Everyday" 2 <input type="checkbox"/> 4-10 days 5 <input type="checkbox"/> 31-45 days 9 <input type="checkbox"/> DK 3 <input type="checkbox"/> 11-15 days 6 <input type="checkbox"/> 46+ days</p>	<p>19</p>	
<p>e. Did you first have this pain more than 6 months ago?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>20</p>	
<p>f. On a scale of 1-10, where 1 is mild and 10 is severe, how would you rate this pain at its worst? Circle only one.</p>	<p>1 2 3 4 5 6 7 8 9 10</p>		<p>21-22</p>
<p>5a. (During the past 6 months) Did you have a dull, aching pain across your face or cheek more than once? Do not count sinus pain.</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Check Item 3)</p>	<p>23</p>	
<p>b. When you have this pain, does it come and go or is it continuous and uninterrupted?</p>	<p>1 <input type="checkbox"/> Come and go 2 <input type="checkbox"/> Continuous/uninterrupted 8 <input type="checkbox"/> Other 9 <input type="checkbox"/> DK</p>	<p>24</p>	
<p>c. During how many DIFFERENT MONTHS in the past 6 months did you have this pain?</p>	<p><input type="text"/> Months</p>	<p>25</p>	
<p>d. How many total days in the past 6 months did you have this pain?</p>	<p>1 <input type="checkbox"/> 1-3 days 4 <input type="checkbox"/> 16-30 days 7 <input type="checkbox"/> "Everyday" 2 <input type="checkbox"/> 4-10 days 5 <input type="checkbox"/> 31-45 days 9 <input type="checkbox"/> DK 3 <input type="checkbox"/> 11-15 days 6 <input type="checkbox"/> 46+ days</p>	<p>26</p>	
<p>e. Did you first have this pain more than 6 months ago?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>27</p>	
<p>f. On a scale of 1-10, where 1 is mild and 10 is severe, how would you rate this pain at its worst? Circle only one.</p>	<p>1 2 3 4 5 6 7 8 9 10</p>		<p>28-29</p>

Section R — OROFACIAL PAIN — Continued

**CHECK
ITEM 3**

Refer to 3c, 4c, and 5c.

- 1 Two or more months in any one of 3c, 4c, or 5c (6)
 8 Other (Section S)

30

6a. In the past 6 months, did you see or talk to a **DENTIST** for the pain we just discussed?

- 1 Yes
 2 No (6c)

31

b. How many times during the last 6 months did you see or talk to a dentist about the pain?

_____ Times
 999 DK

32-34

c. (In the past 6 months) Did you see or talk to a **MEDICAL DOCTOR** about the pain?

- 1 Yes
 2 No (6e)

35

d. How many times?

_____ Times
 999 DK

36-38

e. (In the past 6 months) Did you see or talk to any other type of health professional about the pain?

- 1 Yes
 2 No (6h)

39

f. What kind of health professional?

Health professional

40-41

g. How many times during the past 6 months did you see or talk to the *(person in 6f)*?

_____ Times
 999 DK

42-44

h. (In the past 6 months) Did you worry about the health of your teeth and gums because of the pain?

- 1 Yes
 2 No

45

i. (In the past 6 months) Did you worry about the health of your body because of the pain?

- 1 Yes
 2 No

46

HAND CARD R1 . Read list if telephone interview.

7. Here is a list of things people do when they have teeth, mouth, or face pain. Please tell me the things you did for the pain during the past 6 months.

Circle all that apply.

1 — Use a hot or cold compress

1

1

47

2 — Take a prescription drug

2

2

48

3 — Take an over-the-counter drug

3

3

49

4 — Drink some liquor or wine because of the pain

4

4

50

5 — Take time off work

5

5

51

6 — Stay home more than usual

6

6

52

7 — Avoid family and friends

7

7

53

8 — Anything else? (Specify)

8 (Specify) _____

8

54

0 — None of the above

0

0

55

9 — Don't know

9

9

56

Notes

Section S — DIGESTIVE DISORDERS

Section S1 — SPECIFIC CONDITIONS

3-4

<p>1. DURING THE PAST 12 MONTHS, did you have gallstones?</p>	<p>1 <input type="checkbox"/> Yes (5) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p>5</p>
<p>2. DURING THE PAST 12 MONTHS, did you have any other gallbladder trouble?</p>	<p>1 <input type="checkbox"/> Yes (5) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p>6</p>
<p>3. Have you ever had gallstones?</p>	<p>1 <input type="checkbox"/> Yes (5) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p>7</p>
<p>4. Have you ever had any other gallbladder trouble?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (8) 9 <input type="checkbox"/> DK</p>	<p>8</p>
<p>5. When did a doctor first tell you that you had [gallstones/gallbladder trouble]?</p>	<p>1 <input type="checkbox"/> Less than 3 months ago 2 <input type="checkbox"/> 3 months, less than 1 year 3 <input type="checkbox"/> 1 year, less than 2 years 4 <input type="checkbox"/> 2 years, less than 5 years</p> <p>5 <input type="checkbox"/> 5 years, less than 10 years 6 <input type="checkbox"/> 10 years or more 7 <input type="checkbox"/> Doctor never seen (8) 9 <input type="checkbox"/> DK when</p>	<p>9</p>
<p>6a. Have you ever had gallbladder surgery?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (7) 9 <input type="checkbox"/> DK</p>	<p>10</p>
<p>b. When did you last have gallbladder surgery?</p>	<p>1 <input type="checkbox"/> Less than 3 months ago 2 <input type="checkbox"/> 3 months, less than 1 year 3 <input type="checkbox"/> 1 year, less than 2 years 4 <input type="checkbox"/> 2 years, less than 5 years</p> <p>5 <input type="checkbox"/> 5 years, less than 10 years 6 <input type="checkbox"/> 10 years or more 9 <input type="checkbox"/> DK when</p>	<p>11</p>
<p>7. Have you ever had any of the following tests to help diagnose your [gallstones/gallbladder condition] —</p>		<p>12</p>
<p>a. An X-ray of your gallbladder or abdomen?</p> <p><i>Read if necessary: For this X-ray you would have been given either pills the night before or an intravenous injection just before the X-rays were taken.</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	
<p>b. A sonogram or ultrasound of your gallbladder?</p> <p><i>Read if necessary: For this test, a gel is rubbed on your upper right side and an instrument is moved around the area while an examiner watches on a television screen.</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p>13</p>
<p>c. An upper GI series?</p> <p><i>Read if necessary: For an upper GI series, you drink a chalky white liquid called barium, and then X-rays are taken.</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p>14</p>
<p>8. DURING THE PAST 12 MONTHS, did you have an ulcer?</p>	<p>1 <input type="checkbox"/> Yes (10) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p>15</p>
<p>9. Have you ever had an ulcer?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (13) 9 <input type="checkbox"/> DK</p>	<p>16</p>
<p>10. When did a doctor first tell you that you had an ulcer?</p>	<p>1 <input type="checkbox"/> Less than 3 months ago 2 <input type="checkbox"/> 3 months, less than 1 year 3 <input type="checkbox"/> 1 year, less than 2 years 4 <input type="checkbox"/> 2 years, less than 5 years</p> <p>5 <input type="checkbox"/> 5 years, less than 10 years 6 <input type="checkbox"/> 10 years or more 7 <input type="checkbox"/> Doctor never seen (13) 9 <input type="checkbox"/> DK when</p>	<p>17</p>
<p>11. Did the doctor say you had a gastric, duodenal, or peptic ulcer, some other type, or were you not told?</p> <p><i>Mark all that apply</i></p>	<p>0 <input type="checkbox"/> Skin (13) 1 <input type="checkbox"/> Gastric 2 <input type="checkbox"/> Duodenal 3 <input type="checkbox"/> Peptic 4 <input type="checkbox"/> Stomach 7 <input type="checkbox"/> Not told 8 <input type="checkbox"/> Other — Specify <u> </u> 9 <input type="checkbox"/> DK</p>	<p>18 19 20 21 22 23 24</p>

Section S1 – SPECIFIC CONDITIONS – Continued

<p>12. Have you ever had any of the following tests to help diagnose your ulcer –</p> <p>a. An upper GI series? <i>Read if necessary: For an upper GI series, you drink a chalky white liquid called barium, and then X-rays are taken.</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	25
<p>b. An upper endoscopy or gastroscopy? <i>Read if necessary: For this test, a long flexible tube with a light on the end is inserted down the throat so that the lining of the stomach and the upper intestine can be examined.</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	26
<p>13. DURING THE PAST 12 MONTHS, did you have diverticulitis?</p>	<p>1 <input type="checkbox"/> Yes (15) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	27
<p>14. Have you ever had diverticulitis?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (18)</p>	28
<p>15. When did a doctor first tell you that you had diverticulitis?</p>	<p>1 <input type="checkbox"/> Less than 3 months ago 2 <input type="checkbox"/> 3 months, less than 1 year 3 <input type="checkbox"/> 1 year, less than 2 years 4 <input type="checkbox"/> 2 years, less than 5 years</p> <p>5 <input type="checkbox"/> 5 years, less than 10 years 6 <input type="checkbox"/> 10 years or more 7 <input type="checkbox"/> Doctor never seen (18) 9 <input type="checkbox"/> DK when</p>	29
<p>16a. Have you ever been in the hospital overnight for diverticulitis?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (17)</p>	30
<p>b. When were you last in the hospital overnight for diverticulitis?</p>	<p>1 <input type="checkbox"/> Less than 3 months ago 2 <input type="checkbox"/> 3 months, less than 1 year 3 <input type="checkbox"/> 1 year, less than 2 years 4 <input type="checkbox"/> 2 years, less than 5 years</p> <p>5 <input type="checkbox"/> 5 years, less than 10 years 6 <input type="checkbox"/> 10 years or more 9 <input type="checkbox"/> DK when</p>	31
<p>17. Have you ever had a barium enema to help diagnose your diverticulitis? <i>Read if necessary: For this X-ray, you would have been given an enema containing barium and X-rays of your abdomen would be taken.</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	32
<p>18a. DURING THE PAST 12 MONTHS, have you had a spastic colon, functional bowel, irritable colon or irritable bowel syndrome?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (19)</p>	33
<p>b. Which – spastic colon, functional bowel, irritable colon, or irritable bowel syndrome? <i>Mark all reported, do not probe.</i></p>	<p>1 <input type="checkbox"/> Spastic colon 2 <input type="checkbox"/> Functional bowel 3 <input type="checkbox"/> Irritable colon 4 <input type="checkbox"/> Irritable bowel syndrome 8 <input type="checkbox"/> Other similar condition mentioned – <i>Specify</i> _____</p>	<p>} (19c) 34 35 36 37 38</p>
<p>19a. Have you ever had a spastic colon, functional bowel, irritable colon, or irritable bowel syndrome?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (20)</p>	39
<p>b. Which – Spastic colon, functional bowel, irritable colon, or irritable bowel syndrome? <i>Mark all reported, do not probe.</i></p>	<p>1 <input type="checkbox"/> Spastic colon 2 <input type="checkbox"/> Functional bowel 3 <input type="checkbox"/> Irritable colon 4 <input type="checkbox"/> Irritable bowel syndrome 8 <input type="checkbox"/> Other similar condition mentioned – <i>Specify</i> _____</p>	<p>40 41 42 43 44</p>
<p>c. When did a doctor first tell you you had (entry in 18b or 19b)?</p>	<p>1 <input type="checkbox"/> Less than 3 months ago 2 <input type="checkbox"/> 3 months, less than 1 year 3 <input type="checkbox"/> 1 year, less than 2 years 4 <input type="checkbox"/> 2 years, less than 5 years</p> <p>5 <input type="checkbox"/> 5 years, less than 10 years 6 <input type="checkbox"/> 10 years or more 7 <input type="checkbox"/> Doctor never seen 9 <input type="checkbox"/> DK when</p>	45
<p>20. Have you had hemorrhoids in the past 12 months?</p>	<p>1 <input type="checkbox"/> Yes (21b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	46
<p>21a. Has a doctor ever told you that you had hemorrhoids?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Section S2)</p>	47
<p>b. When did you last talk to a doctor about your hemorrhoids?</p>	<p>1 <input type="checkbox"/> Less than 3 months ago 2 <input type="checkbox"/> 3 months, less than 1 year 3 <input type="checkbox"/> 1 year, less than 2 years 4 <input type="checkbox"/> 2 years, less than 5 years</p> <p>5 <input type="checkbox"/> 5 years, less than 10 years 6 <input type="checkbox"/> 10 years or more 7 <input type="checkbox"/> Doctor never seen 9 <input type="checkbox"/> DK when</p>	48
<p>22. Have you ever had surgery in a doctor's office, clinic, or hospital for hemorrhoids?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	49

Section S2 – ABDOMINAL PAIN

Hand Card S1.

The next questions are about pain and discomfort in the abdomen. By abdomen, we mean [the shaded area on this diagram/the area between the lower ribs and the hips]. Do not include pain related to kidneys, bladder, or arthritis (menstruation or pregnancy).

1. DURING THE PAST 12 MONTHS, have you had any type of pain or severe discomfort in your abdomen three or more times?

- 1 Yes
 2 No
 9 DK } (Section S3)

2. Have you ever made a visit to a doctor for your abdominal pain? If asked: or the condition that caused the pain.

- 1 Yes
 2 No
 9 DK } (4)

3a. What condition did the doctor say was the cause of the pain?
 Enter first 5 code numbers and the conditions in the order mentioned.
 Do not probe.

- 98 Doctor didn't say } (4)
 99 DK

Code Condition

_____	_____	7-8
_____	_____	9-10
_____	_____	11-12
_____	_____	13-14
_____	_____	15-16

If only one response to 3a, enter in 3b without asking.

b. Which of these conditions caused the MOST pain during the past 12 months?

Enter code number and condition.

_____ (Check item 1) 17-18

99 DK (Check item 1)

4a. What condition do you think was the cause of the pain?
 Enter first 5 code numbers and the conditions in the order mentioned.
 Do not probe.

99 DK (5)

Code Condition

_____	_____	19-20
_____	_____	21-22
_____	_____	23-24
_____	_____	25-26
_____	_____	27-28

If only one response to 4a, enter in 4b without asking.

b. Which of these conditions caused the MOST pain during the past 12 months?

Enter code number and condition.

_____ (Check item 1) 29-30

99 DK (Check item 1)

- | | | |
|-----------------------------|------------------------------|---------------------------|
| 01 Spastic colon | 22 Gallstones | 43 Tension |
| 02 Functional bowel | 23 Gastritis | 44 Trouble swallowing |
| 03 Irritable colon | 24 Gastroenteritis | 45 Tumor |
| 04 Irritable bowel syndrome | 25 Growth | 46 Ulcer |
| 05 Allergies | 26 Heartburn | 47 Ulcerative colitis |
| 06 Anxiety | 27 Hepatitis | 48 Virus |
| 07 Appendicitis | 28 Hernia, other than hiatal | |
| 08 Cancer | 29 Hiatal hernia | * 55 Arthritis |
| 09 Cirrhosis | 30 Impacted bowels | * 56 Back problems |
| 10 Colitis | 31 Indigestion | * 57 Bladder |
| 11 Constipation | 32 Infection | * 58 Kidneys |
| 12 Crohn's disease | 33 Influenza | * 59 Menstruation |
| 13 Depression | 34 Lactose Intolerance | * 60 Other female trouble |
| 14 Diarrhea | 35 Medication side effects | * 61 Pregnancy |
| 15 Diverticulitis | 36 Nerves | * 62 Prostate |
| 16 Diverticulosis | 37 Obstructed bowels | 63 Other — Specify above |
| 17 Enteritis | 38 Other bowel trouble | 64 Other — Specify above |
| 18 Esophagitis | 39 Other liver trouble | 65 Other — Specify above |
| 19 Flu | 40 Other stomach trouble | 66 Other — Specify above |
| 20 Food poisoning | 41 Peritonitis | 67 Other — Specify above |
| 21 Gallbladder problem | 42 Stress | |

* Do not ask questions 5-27 about these conditions

Section S2 — ABDOMINAL PAIN — Continued

Ask questions 5—27 about the first condition coded 01—04 in 3a or 4a. If none, ask about condition in 3b or 4b. If this is an asterisked condition, ask about next condition mentioned. If no other condition, go to Section S3.

CHECK ITEM 1	Enter code and condition.	Code _____	31—32	10. Was the pain on the right side, the left side, or down the middle? 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Middle Mark all that apply.	55 56 57
(These next questions are about pain related to your (condition in Check Item 1)). Ask if "Yes" in 2; otherwise go to 8.		Condition _____		11. When you get this pain, how long does it USUALLY last? _____ <div style="display: inline-block; vertical-align: middle; margin-left: 10px;"> { 1 <input type="checkbox"/> Minutes 2 <input type="checkbox"/> Hours 3 <input type="checkbox"/> Days </div> 7777 <input type="checkbox"/> Constant, all the time 8888 <input type="checkbox"/> Varies too much for a usual duration	58—61
5. How many DIFFERENT doctors have you visited for this pain?		0 <input type="checkbox"/> None (8) 1 <input type="checkbox"/> One 2 <input type="checkbox"/> Two 3 <input type="checkbox"/> Three or more	33		
6. DURING THE PAST 12 MONTHS, how many doctor visits did you have because of this pain?		000 <input type="checkbox"/> None 001 <input type="checkbox"/> One _____ Number of visits	34—36	12. During how many days in the past year did you have this pain? 001 <input type="checkbox"/> One (15) _____ Days 365 <input type="checkbox"/> Everyday If more than 14 days in 12, go to 14	62—64 65
7. Were any of the following tests done to diagnose your (condition in check item 1)?			37	13. Did all of this pain occur during one two week period? 1 <input type="checkbox"/> Yes (15) 2 <input type="checkbox"/> No	66—67
a. Upper GI series? <i>Read if necessary: You drink a chalky white liquid called barium and then X-rays are taken.</i>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK		14. During how many DIFFERENT months in the past year did you have this pain? _____ Months	68—69
b. Barium enema? <i>Read if necessary: You are given an enema containing barium and X-rays of your abdomen are taken.</i>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	38	15. On a scale from 1 to 10, where 1 is mild and 10 is severe, how would you rate this pain at its worst? <i>Circle one</i>	70
c. Upper endoscopy or gastroscopy? <i>Read if necessary: A long flexible tube with a light on the end is inserted down the throat so that the lining of the stomach and the upper intestine can be examined.</i>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	39	16. Have you ever taken any medication for the pain? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (18)	71
d. Lower endoscopy or colonoscopy? <i>Read if necessary: A long flexible tube with a light on the end is inserted in the rectum so that the lining of the large intestine can be examined.</i>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	40	17. Was any of the medication you took prescribed for you by a doctor? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	72
e. Sonogram or ultrasound? <i>Read if necessary: A gel is rubbed on your upper right side and an instrument is moved around the area while an examiner watches on a television screen.</i>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	41	18. When this pain starts, do you have to stop what you are doing because it hurts? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	73
Mark box or ask. Hand Card S1. 8. Looking at this card, tell me the numbers that show where the pain (from the (condition in Check Item 1)) was located? Mark all that apply. Do not probe.		0 <input type="checkbox"/> Telephone interview (9)	42	19. When you have this pain, do you usually have bowel movements? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	74
		1 <input type="checkbox"/> } 2 <input type="checkbox"/> } 3 <input type="checkbox"/> } 4 <input type="checkbox"/> } 5 <input type="checkbox"/> } (11) 6 <input type="checkbox"/> } 7 <input type="checkbox"/> } 8 <input type="checkbox"/> } 9 <input type="checkbox"/> }	43 44 45 46 47 48 49 50 51	20. When you have this pain, are your bowel movements usually looser than normal? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	75
				21. When you have this pain, are your bowel movements usually more frequent than normal? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	76
				22. Is the pain usually relieved or lessened by having a bowel movement? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	77
				23. Is the pain relieved by passing gas? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	78
				24. When you have this pain, is your abdomen usually swollen or bloated? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	79
				25. When you have this pain, are you ever awakened from sleep? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	80
				26. In the past 30 days, has this pain caused you to cut down on the things you usually do? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Section S3)	81—82
				27. In the past 30 days, how many days did you cut down for more than half the day? 00 <input type="checkbox"/> None _____ Days	
				Notes	
9. Was the pain above the waistline, below the waist, or around the waistline? <i>Mark all that apply.</i>		1 <input type="checkbox"/> Above 2 <input type="checkbox"/> Below 3 <input type="checkbox"/> Around	52 53 54		

Section S3 – NORMATIVE BOWEL FUNCTIONS

These next questions are about bowel habits during the past 12 months. (Because these questions are personal, I can read the questions to you or if you prefer, you can fill them out yourself.)

_____ Times per day

OR

_____ Times per week

00 Less than one time per week

1. How often do you usually have bowel movements?

Hand Card Q1. Read answer categories if telephone interview.

2. During the past 12 months, how often have your bowel movements been—

Always Most of the time Some of the time Rarely Never DK

a. Hard? 1 2 3 4 5 9 9

b. Accompanied by mucus? 1 2 3 4 5 9 10

c. Accompanied by pain? 1 2 3 4 5 9 11

d. Accompanied by swelling or bloating? 1 2 3 4 5 9 12

e. Accompanied by straining to move bowels? 1 2 3 4 5 9 13

f. Followed by a feeling of not being finished after moving bowels? 1 2 3 4 5 9 14

3. During the past 12 months, how often have you been constipated?

- 1 Always
- 2 Most of the time
- 3 Some of the time
- 4 Rarely
- 5 Never

15

4. How often have you had diarrhea?

- 1 Always
 - 2 Most of the time
 - 3 Some of the time
 - 4 Rarely
 - 5 Never
- } (B)

16

5. DURING THE PAST 12 MONTHS, have you seen a doctor about your diarrhea?

- 1 Yes
- 2 No (B)

17

6. How many times in the past 12 months have you seen a doctor about your diarrhea?

_____ Times

18-19

7. What did the doctor say caused the diarrhea?

Mark first 4 mentioned. Do not probe.

- | | |
|--|---|
| 01 <input type="checkbox"/> Enteritis | 09 <input type="checkbox"/> Lactose Intolerance |
| 02 <input type="checkbox"/> Diverticulitis | 10 <input type="checkbox"/> Travelers diarrhea |
| 03 <input type="checkbox"/> Crohn's disease | 11 <input type="checkbox"/> "Something I ate" |
| 04 <input type="checkbox"/> Intestinal flu or virus | 12 <input type="checkbox"/> Dysentery |
| 05 <input type="checkbox"/> Spastic colon, functional bowel, irritable bowel syndrome, irritable colon | 13 <input type="checkbox"/> Medication |
| 06 <input type="checkbox"/> Colitis | 14 <input type="checkbox"/> Nerves or stress |
| 07 <input type="checkbox"/> Ulcerative colitis | 88 <input type="checkbox"/> Something else |
| 08 <input type="checkbox"/> Infection | 98 <input type="checkbox"/> Doctor didn't say |
| | 99 <input type="checkbox"/> DK |

20-21

22-23

24-25

26-27

8a. IN THE PAST 30 DAYS, did you take any laxatives or stool softeners, such as Ex-Lax, Metamucil or Fiberall, to help move your bowels?

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

28

b. How many times have you taken laxatives or stool softeners in the past 30 days?

_____ Times

29-30

9. How often do you think a person should have bowel movements?

_____ Times per day

OR

_____ Times per week

00 Less than 1 time per week

31-32

33-34

Notes

Section S3 – NORMATIVE BOWEL FUNCTIONS – Continued

10. I am going to read a list of health problems that may have been a lot of trouble for you in the past year. By "a lot of trouble" we mean that in the past year, you saw or talked to a doctor or other health professional, you took medication more than once, or the problem interfered with your life or usual activities.

Hand Card S2.

In the past 12 months, have you had a lot of trouble with –

Yes No

a. Dizziness? 1 2 **35**

b. Nausea? 1 2 **36**

c. Diarrhea? 1 2 **37**

d. Feeling sickly? 1 2 **38**

e. Abdominal pain? 1 2 **39**

In the past 12 months, have you had a lot of trouble with –

f. Abdominal gas? 1 2 **40**

g. Chest or heart pain? 1 2 **41**

h. Fainting spells? 1 2 **42**

i. Pain in the joints? 1 2 **43**

j. Pain in your arms and legs, other than in the joints? 1 2 **44**

In the past 12 months, have you had a lot of trouble with –

k. Vomiting? 1 2 **45**

l. Weakness? 1 2 **46**

m. Backaches? 1 2 **47**

n. Headaches? 1 2 **48**

o. Nervousness or anxiety? 1 2 **49**

In the past 12 months, have you had a lot of trouble with –

p. Feeling tense or keyed up? 1 2 **50**

q. Feeling sad, blue or depressed? 1 2 **51**

r. Pain when you urinate or pass your water? 1 2 **52**

53

**CHECK
ITEM 2**

Mark appropriate box.

1 Completed by interviewer
2 Completed by respondent

Notes

Section T — DIABETES RISK FACTOR QUESTIONS (SP)

<p>CHECK ITEM 1</p>	<p>Refer to letter indicator on sample selection label.</p>	<p>1 <input type="checkbox"/> Letter M (Cover page of HIS-1A) 2 <input type="checkbox"/> Letter T (Check Item 2)</p>	<p>5</p>
<p>CHECK ITEM 2</p>	<p>Refer to Section Q1, item 1b on page 32.</p>	<p>1 <input type="checkbox"/> Diabetic box marked in 1b } (Cover page of HIS-1A) 2 <input type="checkbox"/> Section Q1 noninterview } 3 <input type="checkbox"/> All others (1)</p>	<p>6</p>
<p>1. Has a doctor EVER told you that you had —</p> <p>a. Protein or albumin in your urine?</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p>7</p>
<p>b. Kidney disease? Do not include kidney stones or bladder infection.</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (1d) 9 <input type="checkbox"/> DK }</p>	<p>8</p>
<p>c. Polycystic kidney disease?</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p>9</p>
<p>d. Periodontal or gum disease?</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p>10</p>
<p>2. About how many times in the past 12 months has a doctor or other health professional —</p> <p>a. Checked you for diabetes?</p>		<p>00 <input type="checkbox"/> None _____ Times 99 <input type="checkbox"/> DK</p>	<p>11-12</p>
<p>b. Checked your blood pressure?</p>		<p>000 <input type="checkbox"/> None _____ Times 999 <input type="checkbox"/> DK</p>	<p>13-15</p>
<p>3. About how many different times in the past 12 months have you had a bladder or urinary tract infection?</p>		<p>00 <input type="checkbox"/> None _____ Times 99 <input type="checkbox"/> DK</p>	<p>16-17</p>
<p>4. Have you ever had symptoms of a bladder infection that lasted more than 3 months, such as frequent urination and pain in your bladder?</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (6) 9 <input type="checkbox"/> DK }</p>	<p>18</p>
<p>5a. When you had these symptoms, were you told that you had painful bladder syndrome or interstitial cystitis? (in'ter-stish'al sis-ti'tis)</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (6) 9 <input type="checkbox"/> DK }</p>	<p>19</p>
<p>b. How old were you when you were first told that you had painful bladder syndrome or interstitial cystitis? (in'ter-stish'al sis-ti'tis)</p>		<p>_____ Years old 99 <input type="checkbox"/> DK</p>	<p>20-21</p>
<p>6. When you urinate —</p> <p>a. Do you USUALLY have trouble starting?</p>		<p>0 <input type="checkbox"/> NA/Dialysis (8) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p>22</p>
<p>b. Do you USUALLY feel like you have not completely emptied your bladder?</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p>23</p>
<p>7a. Do you USUALLY have to get up at night to go to the bathroom to urinate? Exclude nights when you drink a lot of liquids.</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (8) 9 <input type="checkbox"/> DK }</p>	<p>24</p>
<p>b. About how many times each night do you have to get up?</p>		<p>_____ Times 00 <input type="checkbox"/> Less than once a night</p>	<p>25-26</p>
<p>8. During the past 6 months have you had any sores or irritations on your feet or ankles that did not heal normally?</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p>27</p>

Section T – DIABETES RISK FACTOR QUESTIONS (SP) – Continued

<p>9. Have you ever had an amputation of your toe, foot, leg, or part of leg? <i>If "Yes," ask: Which?</i> <i>Mark all that apply.</i></p>	<p>1 <input type="checkbox"/> Yes, toe 2 <input type="checkbox"/> Yes, foot 3 <input type="checkbox"/> Yes, leg or part of leg 4 <input type="checkbox"/> No</p>	<p align="right">28 29</p>
<p>10. During the past 3 months have you had --</p> <p>a. Numbness or loss of feeling in your hands or feet other than from your hands or feet falling asleep?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p align="right">30</p>
<p>b. A painful sensation or tingling in your hands or feet? Do not include normal foot aches from standing or walking for long periods.</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p align="right">31</p>
<p>c. Decreased ability to feel hot or cold in things you touch?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p align="right">32</p>
<p>11a. Do you NOW smoke cigarettes?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (12)</p>	<p align="right">33</p>
<p>b. About how many cigarettes do you smoke per day?</p>	<p>00 <input type="checkbox"/> Less than 1 per day _____ Per day 99 <input type="checkbox"/> Don't smoke regularly</p>	<p align="right">34-35</p>
<p>12a. Have you tried to lose weight in the past year?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p align="right">36</p>
<p>b. Is your weight now more, less, or about the same as a year ago?</p>	<p>1 <input type="checkbox"/> More 2 <input type="checkbox"/> Less 3 <input type="checkbox"/> About the same (13)</p>	<p align="right">37</p>
<p>c. In the past year, about how much weight have you [gained/lost]?</p>	<p>_____ Pounds 999 <input type="checkbox"/> DK</p>	<p align="right">38-40</p>
<p><i>Ask if 26 or older; otherwise, go to 14.</i></p>		
<p>13a. About how much did you weigh when you were 25 years old? <i>For females: If you were pregnant when you were 25, tell me your weight just before you became pregnant.</i></p>	<p>_____ Pounds 999 <input type="checkbox"/> DK</p>	<p align="right">41-43</p>
<p>b. What is the most you have ever weighed? <i>For females: Except when you were pregnant?</i></p>	<p>_____ Pounds 999 <input type="checkbox"/> DK</p>	<p align="right">44-46</p>
<p>c. About how old were you when you FIRST weighed that much?</p>	<p>00 <input type="checkbox"/> Now _____ Years old</p>	<p align="right">47-48</p>
<p>14. Do you have serious trouble seeing with one or both eyes even when wearing glasses?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p align="right">49</p>
<p>15. Were either of your parents ever told that they had diabetes? Do not include pre, potential, or borderline diabetes. <i>If "Yes," ask: Which?</i></p>	<p>1 <input type="checkbox"/> Yes, father 2 <input type="checkbox"/> Yes, mother 3 <input type="checkbox"/> Yes, both 4 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p align="right">50</p>
<p>16. How many children have you had, including any that may have died? <i>For females: Do not include stillbirths or miscarriages.</i></p>	<p>00 <input type="checkbox"/> None _____ Total number of children 99 <input type="checkbox"/> DK</p>	<p align="right">51-52</p>

Notes

CARD R

RACE

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

HS-501 (1-85) (HS-20-27)

CARD O

ORIGIN

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

Card B
Card C

(Cut along broken line.)

HS-501 (1-85) (HS-20-27)

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

HS-501 (1-85) (HS-20-27)

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

Card I
Card J

(Cut along broken line.)

HS-501 (1-85) (HS-20-27)

MEDICARE

Health  Insurance

S O C I A L S E C U R I T Y A C T

NAME OF BENEFICIARY
John Q. Public

CLAIM NUMBER SEX
000-00-0000-A MALE

IS ENTITLED TO EFFECTIVE DATE
Hospital Insurance 7-1-66
Medical Insurance 7-1-66

SIGN HERE *John Q. Public*

SAMPLE

CARD M

REASONS FOR NOT HAVING HEALTH INSURANCE

1. Job layoff, job loss, or any reasons related to unemployment
2. Can't obtain insurance because of poor health, illness, or age
3. Too expensive, can't afford health insurance
4. Dissatisfied with previous insurance
5. Don't believe in insurance
6. Have been healthy, not much sickness in the family, haven't needed health insurance
7. Covered by some other health plan
8. Some other reason

Medicare
Card M

(Cut along dotted line)

HS-501 (12/68) 15-1-66

STATE NAMES FOR MEDICAID

MEDI - CAL

California

MEDI - KAN

Kansas

HEALTH CARE COST CONTAINMENT SYSTEM (HCCCS)

Arizona

MEDICAID AND/OR MEDICAL ASSISTANCE

All other States

HS-501 (12/68) 15-1-66

CARD O1

1. No difficulty
2. Some difficulty
3. A lot of difficulty
4. Completely unable to do because of disorder

CARD Q2

Adapin	Nardil
Amitid	Navane
Amitril	Norpramin
Asendin	Pamelor
Ativan	Parnate
Aventyl	Paxipam
Azene	Permitil
Centrax	Pertofrane
Cibalith-S	Presamine
Compazine	Proketzazine
Daxolin	Prolixin
Desyrel	Quide
Dexedrine	Repoise
Elavil	Ritalin
Endep	Serax
Eskalith	Serentil
Haldol	Sinequan
Imavate	Stelazine
Janimine	Taractan
Librax	Tegretol
Libritabs	Thorazine
Librium	Tindal
Lidone	Tofranil
Lithane	Tranxene
Lithobid	Triafon
Loxitane	Valium
Ludomil	Vesprin
Marplan	Vestran
Mellaril	Vivactil
Moban	Xanax

HS-501 (1/80) (2-1-80)

CARD Q1

1. Always
2. Most of the time
3. Some of the time
4. Rarely
5. Never

Card Q2

Card Q1

(Cut along broken line)

HS-501 (1/80) (2-1-80)

CARD Q2

00. Nowhere
01. Doctor's office — doctor
02. Doctor's office — nurse
03. Dietitian or nutritionist
04. Doctor or nurse in a hospital
05. Relative or friend
06. Another diabetic
07. Health department
08. Diabetes organization
09. National Diabetes Information Clearing House
10. Diabetes support group
11. Library
12. Newspapers
13. Diabetes education class
88. Other

HS-501 (1/80) (2-1-80)

CARD R1

1. Use a hot or cold compress
2. Take a prescription drug
3. Take an over-the-counter drug
4. Drink some liquor or wine because of the pain
5. Take time off work
6. Stay home more than usual
7. Avoid family and friends
8. Something else

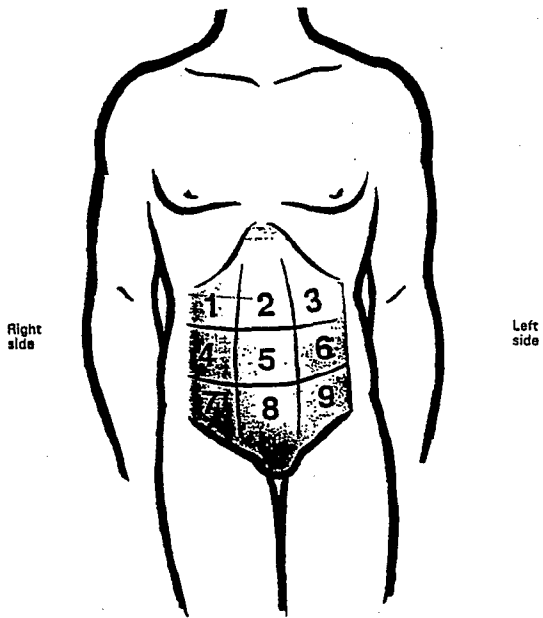
Card Q2

Card R1

(Cut along broken line)

HS-501 (1/80) (2-1-80)

CARD S1



HS-501 (1999) 15-1-00

CARD S2

In the past year . . .
Saw or talked to a doctor or other health professional
or
Took medication more than once
or
Problem interfered with your life or usual activities

HS-501 (1999) 15-1-00

Card
Card
Card

CARD A

1. Definitely true
2. Probably true
3. Probably false
4. Definitely false
9. Don't know if true or false

CARD B

1. Very likely
2. Somewhat likely
3. Somewhat unlikely
4. Very unlikely
5. Definitely not possible
9. Don't know how likely

CARD C

1. Very effective
2. Somewhat effective
3. Not at all effective
4. Don't know how effective
9. Don't know method

CARD D

You have hemophilia and have received clotting factor concentrates since 1977.

You are a native of Haiti or Central or East Africa who has entered the United States since 1977.

You are a man who has had sex with another man at some time since 1977, even one time.

You have taken illegal drugs by needle since 1977.

Since 1977, You are or have been the sex partner of any person who would answer "yes" to any of the items above on this card.

You have had sex for money or drugs at any time since 1977.

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Appendix I

Data collection procedures

Data are collected through a personal household interview conducted by interviewers employed and trained by the U.S. Bureau of the Census according to procedures specified by the National Center for Health Statistics.

All adult members of the household 18 years of age and over who are at home at the time of the interview are invited to participate and to respond for themselves. Information for children and for adults not at home during the interview is provided by a responsible adult family member (19 years of age and over) residing in the household. Between 65 and 70 percent of the adults 18 years of age and over are self-respondents. Generally, a random subsample of adult household members is selected to respond for themselves to questions on current health topics.

Nationally, there are approximately 250 interviewers trained and directed by health survey supervisors in each of the 12 U.S. Bureau of the Census regional offices. The supervisors are career civil service employees whose primary responsibility is the National Health Interview Survey. The interviewers are part-time employees selected through an examination and testing process. Interviewers receive thorough training in basic interviewing procedures and in the concepts and procedures unique to the National Health Interview Survey.

Depending on the family size and the nature and extent of health conditions of family members, the length of interview ranges from 30 to 90 minutes. On average, the interviews require about 50 minutes in the household.

Appendix II

NHIS design and estimation structures

The NHIS is designed to provide statistics on the civilian noninstitutionalized population. To produce these statistics and to produce standard errors for these statistics, one has to take into account the survey's complex statistical design. In this section the NHIS sample design is described and a methodology for producing NHIS estimates and their standard errors is provided.

A conceptual model of the NHIS

A detailed description of the NHIS design is given in Series 2, No. 110, in the *Vital and Health Statistics* series (2). The annual NHIS itself consists of two surveys, a core survey of general health characteristics and supplemental survey(s) on current health topics of interest. For practical purposes, the sample design for the NHIS can be conceptualized in a classical hierarchical framework.

NHIS sample design

The target population for the NHIS is the civilian noninstitutionalized population of the United States. The NHIS is a stratified, multistage sample. Primary sampling units (PSU's) for the NHIS are usually counties or groups of counties. The strata and sampling units of the NHIS core and/or supplement samples have the following hierarchical levels:

1. *Stratum*: 52 self-representing (SR) and 73 non-self-representing (NSR) strata.
2. *Primary sampling unit (PSU)*: Self-representing strata are defined as containing a single PSU; each SR PSU is in the sample with certainty. For the NSR strata, a sample of the population PSU's is selected from each stratum. For the current NHIS design (1985-94), two PSU's are selected from each NSR stratum. The PSU's are selected with probability proportional to PSU population size using Durbin's (3) method.
3. *Substratum*: Once selected into the sample, each PSU is (or may be) partitioned into at most three parts. This allows for differential sampling rates to ensure target sample sizes for specific subdomains of the population, such as blacks. The differential sampling is not used in every PSU.
4. *Secondary sampling unit (SSU)*: Within each substratum, a cluster of dispersed housing units is selected. This cluster is called a secondary sampling unit.

5. *Sample household*: Within each SSU, a sample of households (usually all) is designated for interview.
6. *Sample person*: For the NHIS core sample, all eligible persons within each household are selected for interview. For the supplement(s) sample, typically one sample adult is selected from each family in the household for interview; under special circumstances, that are specific to a supplement, sometimes more than one person in a family is selected for interview.

Subdesigns

To allow for flexibility due to budget constraints, the NHIS was further partitioned into four subdesigns called panels. Each panel is formed by the appropriate grouping of PSU's. The subdesigns are generated so that each panel, and any combination of panels, is representative of the target population.

For most years, all four panels are used in the NHIS. However, in 1985, budgetary restrictions resulted in NCHS fielding a three-panel design. Similarly, in 1986 the NHIS was limited to a two-panel design.

Sampling weights

In order to produce a national estimate, a sampling weight must be associated with each interviewed sample person. At each stage of the sample design, there is a known probability of selection into the sample. The basic (or inflation) sampling weight is the product of the reciprocal of the hierarchical probabilities of selection at each stage of the sample design. Unfortunately, all household sample surveys experience nonresponse and incomplete population coverage. To produce a final survey weight for each individual respondent, the basic sampling weight, for example, is adjusted for nonresponse and then ratio adjusted to population control totals. This last ratio adjustment is called poststratification.

Estimation

If x_i represents a characteristic of interest for respondent i , and w_i is the NHIS (annual) final sampling weight for respondent i , then the aggregate estimator

$$X = \sum_i w_i x_i$$

is assumed to be an unbiased estimator for the population total for the characteristic of interest. NHIS descriptive

statistics that are published by NCHS, such as totals, means, percentages, and ratios, are based upon this method of estimation.

Variability due to sampling

Whenever a descriptive statistic is published, it is considered a sound statistical practice to publish its estimated standard error. NCHS has developed variance estimation methodologies for the NHIS that exploit the detailed level of design information as outlined above. This information is used for NCHS analyses and in the production of generalized variance functions. In almost all NCHS series reports for statistical surveys, generalized variance functions are used to present standard errors because space limitations prevent including individual standard errors for each published statistic. If a sampling error was presented for each estimate in a report, the report would be too lengthy and too costly for consumers.

Nonetheless, while these generalized variance functions serve a useful purpose, they are subject to a number of limitations (see, for example, Wolter (4)). For the NHIS, the reader is referred to Massey et al. (2) and Parsons and Casady (5) for additional technical discussion.

An additional complication for variance estimation results from NCHS confidentiality constraints. Presently, NCHS confidentiality constraints limit the amount of design information that can be placed on public-use data tapes. By law, NCHS cannot release information that might lead to the identification of a survey respondent. In order to maximize the amount of analytic variables released to the public, some detailed sample design information is suppressed. This limits the public-use data tape user to a simpler conceptual design structure when analyzing the NHIS.

A simplified NHIS design has been developed for the users of NHIS public-use data tapes. The effect of using this simpler design structure has been reported by Parsons, Chan, and Curtin (6).

Simplified NHIS design structures and variance estimation methodology

Variance estimation software

The analysis of survey data usually requires computer software that can take into account the survey's complex design. Available software for the analysis of complex-survey data differs by features, including methodology, admissible class of survey designs, user support, ease of use, and operational costs. Some available software packages are SUDAAN (7), PC-CARP (8), OSIRIS IV (9), VPLX (10), and WESVAR (11). The first three are commercially available, while the latter two have been used with large-scale Government surveys and are available from the authors. Additional software is identified in Wolter (4). The SUDAAN package (partially funded by several U.S. Public Health Service agencies with such

support coordinated by NCHS/CDC) uses Taylor linearization methodology and has been used extensively by NCHS/CDC in analyzing the NHIS.

Variance estimation for person data using SUDAAN and the NHIS public-use person data tapes, 1987-92

Design information is available on the NHIS public-use basic health and demographic and current health topic data tapes.

All of the following variables are not used for some methods of variance approximation. Field locations may change on some tapes; the user should check file documentation.

Variable name	Location	Field label	Values
Stratum	179-81	Full sample stratum identifier	
CSTRATUM	187-8	"Pseudo PSU codes," first two columns	1, 2, . . . , 62
CPSU	189	"Pseudo PSU codes," last column	1, 2, 3, 4
SUB	178	Type of substratum	0, 1, 2
SSU	5-12	Concatenation of "processing quarter," "random recode of PSU number," and "week-census code," and "segment number"	
TYPE_PSU	185	"Type of PSU," self-representing of PSU, and non-self-representing PSU	1, 4 3, 6
WTF	207-12	"Final basic weight"	

Method 1—Single-stage PSU's sampled with replacement within strata design for 1985-94 NHIS

This method is statistically less efficient than the method described below but is more flexible. This method requires no recoding of design variables, may be applicable to many complex survey sample design computer programs, and covers the 1985-94 NHIS survey years. Using the variables CSTRATUM, CPSU, and WTF, the PSU unit CPSU is treated as being sampled with replacement within stratum unit CSTRATUM. The data file needs to be sorted only by CSTRATUM and PSU prior to SUDAAN.

For the above simplification of the NHIS sample design structure, use the following SUDAAN design statements:

```
PROC ... DESIGN = WR;
NEST CSTRATUM CPSU;
```

Method 2—Multistage stratified sampling design for the 1987-94 NHIS

This design provides for more statistically efficient variance estimation than Method 1, since it makes fewer simplifications of the NHIS sample design structure but is only applicable to SUDAAN. This method also requires recodes of the design variables and is only applicable to survey years 1987-94 NHIS person data.

Prior to use of this method, the following recoding must be done on the HIS file. This example is in SAS but other programming languages may be used.

```
If (TYPE_PSU = 1 or TYPE_PSU = 4) then do:
  PSU = 1;
  POPPSU = 0;
END.
```

```
If (TYPE_PSU = 3 or TYPE_PSU = 6) then do:
  PSU = CPSU;
  POPPSU = -1;
END.
```

On the record for each person, this recode creates two new variables PSU and POPPSU for use by SUDAAN's NEST and TOTCNT statements. For more information on the purpose of these statements refer to SUDAAN documentation. With these additional variables, the following describes SUDAAN code for NHIS data sets assuming a multistage stratified sampling design.

Before running SUDAAN against the data file, however, sort the input file by the NEST variables (STRATUM, PSU, SUB, and SSU).

For SUDAAN describe the NHIS sampling plan as follows:

```
PROC ... DESIGN = WOR;
  NEST STRATUM PSU SUB SSU /MISSUNIT;
  TOTCNT POPPSU _ZERO_ _MINUS1_ _ZERO_.
```

Caution. This method assumes that all records on the basic health and demographic (BHD) or current health topic (CHT) tape are being used. If, however, you keep only select records on a file, for example, persons aged 65 years and older (which may delete all records from one or more SSU's), care must be taken to preserve the integrity of the sampling design. A methodology for preserving the NHIS sample design integrity on subsetted files, which exploits a feature in SUDAAN 6.XX or later, follows.

All SR SSU's (TYPE_PSU = 1 or 4) listed on the full NHIS tape (BHD or CHT) must have at least one representative on the data file used for input to SUDAAN. Moreover, all NSR PSU's must have at least one record

for a person on this data file. The NEST variables (STRATUM, PSU, SUB, and SSU) along with the weight variable must be on each record of the analysis file. All data fields other than the design variables and the weight must be defined as missing ".". This can be achieved by creating a "design" file as follows using SAS or some other programming language:

- Sort the full file by the NEST variables (after making the above recodes).
- Arbitrarily select and save in a separate file (call this the design file), one record from each SR SSU or NSR PSU (either, for example, the first or last record will do). Each record in this file must contain the design variables (STRATUM, PSU, SUB, and SSU) but the remainder of the fields on the design file (except the weight variable) must be set to missing in SAS or "." in text file.
- Set the weight variable(s) in the design file to a very small value, say 10^{-10} .
- To preserve the design integrity, append the "design file" created above to the subsetted analytic file. This is the new analysis file that consists of the subsetted analysis file plus the newly created "design file."
- On the new analysis file, define a new variable, say "DUMMY" that takes the value 1 if the corresponding record corresponds to data from a respondent and takes the value 0 for other records. With this approach, in SUDAAN 6.XX or later, it is important to add the following SUBPOPN statement to the SUDAAN code: "SUBPOPN DUMMY = 1;"
- Finally, prior to running SUDAAN against the new analysis file, sort this file by the new analysis file by the NEST variables (STRATUM, PSU, SUB, and SSU). SUDAAN assumes its input file is sorted by the NEST variables.
- Run SUDAAN against the new analysis file created by the preceding steps.

If subsetted data sets are used without a "design fix-up" like the above, the self-representing component of variance may be biased.

Appendix III

Response rates

Two components comprise the response rates shown in the table that summarizes the characteristics of the current health topic questionnaires: the completion rate for the current health topic questionnaire and the completion rate for the basic health and demographic questionnaire. Multiplying the two rates together yielded the response rate presented for each current health topic in the table. For example, the completion rate for the 1985 child safety and infant feeding questionnaire was 92.7 and the completion rate for the 1985 NHIS basic health and demographic questionnaire was 95.1. The overall response rate for the questionnaire $(0.927) \times (0.951)$ was 88.7.

Completion rates were calculated using either numbers compiled by the Bureau of the Census or numbers available on in-house data tapes prepared by the Division of Health Interview Statistics (DHIS), NCHS. Counts were obtained from DHIS tapes if the counts were not available from the Census Bureau or if the Census Bureau did not compile separately the count of respondents and nonrespondents needed to calculate the completion rate for a particular current health topic.

The completion rate for the NHIS basic health and demographic questionnaire was based either on data from the NHIS found in the Current Estimate series report for

the particular interview year or on numbers provided by the Census Bureau. A completion rate for the NHIS basic health and demographic questionnaire was based on counts obtained from the Census Bureau if the completion rate for the current health topic was based on Census data. To this extent the response rates are limited and should be used as a gauge.

The completion rate for each current health topic was calculated in one of two ways, either by dividing the number of completed and/or partial interviews by the number of persons eligible for the questionnaire or by dividing the number of dummy records created by the number of persons eligible for the questions. The latter method was sometimes used because not all current health topic questionnaires included information that identified interviews as complete, partial, or noninterviews. Usually, this information was missing when the current health topic was printed and administered as part of the basic health and demographic questionnaire. A dummy record was created when a person responded to questions in the basic health and demographic questionnaire and was eligible for the current health topic questionnaire but for one reason or another he or she did not respond to the current health topic questions.

Appendix IV

Topical index to questionnaire items, by year

Topic	Questionnaire item	Year
Abdominal Pain (see also Digestive Disorders)		
	During the past 12 months, have you had any type of pain or severe discomfort in your abdomen three or more times	1989
	Have you ever made a visit to a doctor for your abdominal pain	1989
	What condition did the doctor say was the cause of the pain	1989
	Which of these conditions caused the most pain during the past 12 months	1989
	What condition do you think was the cause of the pain during the past 12 months:	1989
	spastic colon	
	functional bowel	
	irritable colon	
	irritable bowel syndrome	
	allergies	
	anxiety	
	appendicitis	
	cancer	
	cirrhosis	
	colitis	
	constipation	
	Crohn's disease	
	depression	
	diarrhea	
	diverticulitis	
	diverticulosis	
	enteritis	
	esophagitis	
	flu	
	food poisoning	
	gallbladder problem	
	gallstones	
	gastritis	
	gastroenteritis	
	growth	
	heartburn	
	hepatitis	
	hernia, other than hiatal	
	hiatal hernia	
	impacted bowels	
	indigestion	
	infection	

Topic	Questionnaire item	Year
Abdominal Pain (continued)		
	influenza	
	lactose intolerance	
	medication side effects	
	nerves	
	obstructed bowels	
	other bowel trouble	
	other liver trouble	
	other stomach trouble	
	peritonitis	
	stress	
	tension	
	trouble swallowing	
	tumor	
	ulcer	
	ulcerative colitis	
	virus	
	arthritis	
	back problems	
	bladder	
	kidneys	
	menstruation	
	other female trouble	
	pregnancy	
	prostate	
	other (specify)	1989
	How many different doctors have you visited for this pain:	
	none	
	one	
	two	
	three or more	1989
	During the past 12 months, how many doctor visits did you have because of this pain	1989
	Were any of the following tests done (to diagnose) your (condition):	
	upper GI series	
	barium enema	
	upper endoscopy or gastroscopy	
	lower endoscopy or colonoscopy	
	sonogram or ultrasound	1989
	Show where the pain from the (condition) was located	1989
	Was the pain above the waistline, below the waist, or around the waistline	1989
	Was the pain on the right side, the left side, or down the middle	1989
	When you get this pain, how long does it usually last:	
	number of minutes	
	number of hours	
	number of days	
	constant, all the time	
	varies too much for a usual duration	1989
	During how many days in the past year did you have this pain	1989
	Did all of this pain occur during one 2-week period	1989

Topic	Questionnaire item	Year
Abdominal Pain (continued)		
	During how many different months in the past year did you have this pain	1989
	On a scale from 1 to 10, where 1 is mild and 10 is severe, how would you rate this pain at its worst	1989
	Have you ever taken any medication for the pain	1989
	Was any of the medication you took prescribed for you by a doctor	1989
	When this pain starts, do you have to stop what you are doing because it hurts	1989
	When you have this pain do you usually have bowel movements	1989
	When you have this pain, are your bowel movements usually looser than normal	1989
	When you have this pain, are your bowel movements usually more frequent than normal	1989
	Is the pain usually relieved or lessened by having a bowel movement	1989
	Is the pain relieved by passing gas	1989
	When you have this pain, is your abdomen usually swollen or bloated	1989
	When you have this pain, are you ever awakened from sleep	1989
	In the past 30 days, has this pain caused you to cut down on the things you usually do	1989
	In the past 30 days, how many days did you cut down for more than half the day	1989
	How often do you usually have bowel movements	1989
	During the past 12 months, how often (always, most of the time, some of the time, rarely, never, don't know) have your bowel movements been:	
	hard	
	accompanied by mucus	
	accompanied by pain	
	accompanied by swelling or bloating	
	accompanied by straining to move bowels	
	followed by a feeling of not being finished after moving bowels	1989
	During the past 12 months, how often have you been constipated:	
	always	
	most of the time	
	some of the time	
	rarely	
	never	1989
	How often have you had diarrhea:	
	always	
	most of the time	
	some of the time	
	rarely	
	never	1989
	During the past 12 months, have you seen a doctor about your diarrhea	1989
	How many times in the past 12 months have you seen a doctor about your diarrhea	1989

Topic	Questionnaire Item	Year
Abdominal Pain (continued)		
	What did the doctor say caused the diarrhea: enteritis diverticulitis Crohn's disease intestinal flu or virus spastic colon, functional bowel, irritable bowel syndrome, irritable colon colitis ulcerative colitis infection lactose intolerance travelers diarrhea "something I ate" dysentery medication nerves or stress something else doctor didn't say don't know	1989
	In the past 30 days, did you take any laxatives or stool softeners such as Ex-lax, Metamucil, or Fiberall to help move your bowels	1989
	How many times have you taken laxatives or stool softeners in the past 30 days	1989
	How often do you think a person should have bowel movements	1989
	In the past 12 months, have you had a lot of trouble with: dizziness nausea diarrhea feeling sickly abdominal pain abdominal gas chest or heart pain fainting spells pain in the joints pain in your arms and legs, other than in the joints vomiting weakness backaches headaches nervousness or anxiety feeling tense or keyed up feeling sad, blue or depressed pain when you urinate or pass your water	1989

Access to Care (see Health Insurance and Usual Source of Care)

Adoption

Anyone in family ever adopted children	1987
Who in family adopted children	1987

Topic	Questionnaire item	Year
Adoption (continued)		
	Number of children adopted	1987
	Number of adopted children living in household	1987
	Name of adopted children living in household	1987
	Relationship of adopted child to adoptive mother	1987
	Adoptive child born in the United States or a foreign country	1987
	When was adoptive child born	1987
	Month and year adoptive child began living with adoptive mother	1987
	Adoption arranged through:	
	public agency	
	private agency	
	some other way	
	don't know	1987
AIDS		
	When was the last time you saw, heard or read something about AIDS:	
	today	
	number of days ago	
	number of weeks ago	
	number of months ago	
	number of years ago	
	never	
	don't know	1987
	Have you ever heard of AIDS	1987
	Compared to most people, how much would you say you know about AIDS . . . would you say:	
	a lot	
	some	
	a little	
	nothing	1987
	Tell me (interviewer) whether you think the statement is definitely true, probably true, probably false, or definitely false or you don't know if it's true or false:	
	AIDS is a disease caused by a virus	
	AIDS can cripple the body's natural protection against disease	
	AIDS is especially common in older people	
	the AIDS virus can damage the brain	
	AIDS usually leads to heart disease	
	AIDS leads to death	1987
	Where do you get most of your information about AIDS:	
	television	
	newspapers	
	brochures/fliers/pamphlets	
	clergy/church	
	doctor/HMO	
	company or industry clinic	
	hospital/emergency room/outpatient clinic	
	other clinic	
	magazines	
	medical journals	
	library	

AIDS (continued)

AIDS hot line
 public health department (local/State)
 Red Cross/blood bank
 radio
 relatives
 friends
 school (class/clinic)
 other source (specify)
 don't know 1987

If you wanted more specific information about AIDS, where would you get it:

television
 newspapers
 brochures/fliers/pamphlets
 clergy/church
 doctor/HMO
 company or industry clinic
 hospital/emergency room/outpatient clinic
 other clinic
 magazines
 medical journals
 library
 AIDS hot line
 public health department (local/State)
 Red Cross/blood bank
 radio
 relatives
 friends
 school (class/clinic)
 other source (specify)
 don't know 1987

Tell me (interviewer) whether you think the statement is definitely true, probably true, probably false, definitely false or you don't know if it is true or false:

a person can be infected with the AIDS virus and not have the disease AIDS
 you can tell if people have the AIDS virus just by looking at them
 any person with the AIDS virus can pass it on to someone else through sexual intercourse
 a pregnant woman who has the AIDS virus can give AIDS to her baby
 there is a vaccine available to the public that protects a person from getting the AIDS virus
 there is no cure for AIDS at present 1987

Tell me (interviewer) if you think it is very likely, somewhat likely, somewhat unlikely, very unlikely, definitely not possible or if you don't know how likely it is that a person will get AIDS or the AIDS virus infection from:
 receiving a blood transfusion
 donating or giving blood
 living near a hospital or home for AIDS patients

Topic	Questionnaire item	Year
AIDS (continued)		
	working near someone with AIDS	
	eating in a restaurant where the cook has AIDS	
	kissing, with exchange of saliva, a person who has AIDS	
	shaking hands with or touching someone who has AIDS	
	sharing plates, forks, or glasses with someone who has AIDS	
	using public toilets	
	sharing needles for drug use with someone who has AIDS	
	kissing on the cheek a person who has AIDS	
	being coughed or sneezed on by someone who has AIDS	
	attending school with a child who has AIDS	
	mosquitoes or other insects	
	pets or animals	
	having sex with a person who has AIDS	1987
	Have you ever had a blood test for infection with the AIDS virus	1987
	Does this blood test tell whether a person has the disease AIDS	1987
	If someone has a positive blood test for infection with the AIDS virus , does this mean that they can give someone else the AIDS virus through sexual intercourse	1987
	Have you had your blood tested for infection with the AIDS virus	1987
	Have you thought about having this blood test	1987
	Do you plan to be tested in the next 12 months	1987
	(If you were to be tested) Where would you go to have a blood test for the AIDS virus infection:	
	nowhere/wouldn't take test	
	AIDS clinic	
	company or industry clinic	
	doctor/HMO	
	hospital/emergency room/outpatient clinic	
	other clinic	
	public health department	
	Red Cross/blood bank	
	other (specify)	
	don't know	1987
	Where would you go to find out where to have this blood test:	
	nowhere	
	AIDS hot line	
	AIDS clinic	
	clergy/church	
	doctor/HMO	
	friends	
	hospital/emergency room/outpatient clinic	
	public health department	
	Red Cross/blood bank	
	relatives	
	other (specify)	
	don't know	1987
	Have you donated blood since January 1985	1987
	Have you ever personally known anyone who had the blood test for the AIDS virus infection	1987

Topic	Questionnaire item	Year
AIDS (continued)		
	What are the chances of someone you know getting the AIDS virus, would you say: high medium low none refused to respond don't know	1987
	What are your chances of getting the AIDS virus, would you say: high medium low none refused to respond don't know	1987, 1988, 1989
	Here are methods some people use to prevent getting the AIDS virus through sexual activity; tell me (interviewer) whether you think it is very effective, somewhat effective, not at all effective or if you don't know how effective it is in preventing getting the AIDS virus through sexual activity: using a diaphragm using a condom using a spermicidal jelly, foam, or cream being celibate, that is, not having sex at all two people who do not have the AIDS virus having a completely monogamous relationship, that is, having sex only with each other	1987
	Have you ever discussed AIDS with a friend or relative	1987, 1988
	When was the last time you discussed AIDS with a friend or relative: today number of days ago number of weeks ago number of months ago number of years ago don't know	1987, 1988, 1989
	Do you have any children aged 10 through 17	1987, 1988, 1989
	How many do you have	1987, 1988, 1989
	Have you ever discussed AIDS with (your child/ any of these children)	1987
	(Has your child/have your children) had instruction at school about AIDS	1987
	Have you ever personally known anyone with the AIDS virus	1987, 1988, 1989
	Have you ever personally known anyone with AIDS	1987
	Would you want to know the results of the blood test	1987
	In the past month, have you seen any public service announcements about AIDS on television	1988, 1989
	In the past month, have you heard any public service announcements about AIDS on the radio	1988, 1989

Topic	Questionnaire item	Year
AIDS (continued)		
	Were any of those public service announcements called "America Responds to AIDS"	1988, 1989
	In the past month, have you read any brochures or pamphlets about AIDS (do not include articles in magazines or newspapers)	1988, 1989
	Have you ever read any brochures or pamphlets about AIDS (do not include articles in magazines or newspapers)	1988, 1989
	Where did you get the pamphlets or brochures:	
	clinic, other than work clinic	
	doctor's office/HMO	
	drug store	
	public health department	
	received it in the mail without asking for it	
	Red Cross/with Red Cross blood donation	
	with other blood donation	
	school	
	sent/phoned for it myself, requested it	
	the Government—Federal, State or local	
	work, other than clinic or nurse	
	work, nurse or clinic	
	other (specify)	1988, 1989
	The Government is mailing a brochure with basic information about AIDS to each household in the country, the brochure is 8 1/2 by 11 inches, white with blue and black printing, and has a picture of Dr. C. Everett Koop, the Surgeon General of the United States, on the cover, with the title, "Understanding AIDS" printed at the top: Was this brochure received at this household	1988
	How much of the brochure did you read;	
	would you say:	
	all or almost all	
	about half	
	less than half	
	none of it	
	don't know	1988
	When you read it, did you read it carefully or did you just skim through it	1988
	Did the brochure give you any new information or answer any questions you had about AIDS	1988
	Did you discuss the brochure with anyone else in the family	1988
	Did this child/any of your children aged 10 through 17 read the brochure	1987, 1988, 1989
	Was the brochure discussed with this child/any of your children aged 10 through 17	1987, 1988, 1989
	Have you ever discussed AIDS with this child/any of your children aged 10 through 17	1987, 1988, 1989
	Has this child/have any or all of your children aged 10 through 17 had instruction at school about AIDS	1987, 1988, 1989
	How much would you say you know about AIDS:	
	a lot	

Topic	Questionnaire item	Year
AIDS (continued)		
	some a little nothing	1988, 1989
	To the best of your knowledge, is there a difference between having the AIDS virus and having the disease AIDS	1988, 1989
	Tell me (interviewer) whether you think the statement is definitely true, probably true, probably false, definitely false, or you don't know if it is true or false: AIDS can reduce the body's natural protection against disease AIDS is especially common in older people AIDS can damage the brain AIDS usually leads to heart disease AIDS is an infectious disease caused by a virus teenagers cannot get AIDS AIDS leads to death a person can be infected with the AIDS virus and not have the disease AIDS looking at a person is enough to tell if he or she has the AIDS virus any person with the AIDS virus can pass it on to someone else through sexual intercourse a person who has the AIDS virus can look and feel well and healthy a pregnant woman who has the AIDS virus can give the AIDS virus to her baby there is a vaccine available to the public that protects a person from getting the AIDS virus there is no cure for AIDS at present	1988, 1989
	After I read each statement, tell me if you think it is very likely, somewhat likely, somewhat unlikely, very unlikely, definitely not possible, or if you don't know how likely it is that a person will get AIDS or the AIDS virus infection that way, how likely do you think it is that a person will get AIDS or the AIDS virus infection from: living near a home or hospital for AIDS patients working near someone with the AIDS virus eating in a restaurant where the cook has the AIDS virus kissing, with exchange of saliva, a person who has the AIDS virus shaking hands, touching, or kissing on the cheek someone who has the AIDS virus sharing plates, forks, or glasses with someone who has the AIDS virus using public toilets sharing needles for drug use with someone who has the AIDS virus being coughed on or sneezed on by someone who has the AIDS virus attending school with a child who has the AIDS virus mosquitoes or other insects	1988, 1989
	Have you ever donated blood	1988, 1989
	Have you donated blood: since March 1985 in the past 12 months	1988, 1989
	Have you ever heard of a blood test that can detect the AIDS virus infection	1988, 1989

Topic	Questionnaire Item	Year
AIDS (continued)		
	To the best of your knowledge, are blood donations routinely tested now for the AIDS virus infection	1988, 1989
	Have you ever received counseling or had a talk with a health professional about taking the AIDS virus test	1988, 1989
	Was the discussion: with a private doctor at a family planning clinic on an AIDS hotline at a prenatal clinic at an STD or sexually transmitted disease clinic at an AIDS/HIV counseling and testing site with some other health professional with some other counselor	1988, 1989
	During that discussion, did you receive information about how to avoid getting or passing on the AIDS virus	1988, 1989
	Have you ever been advised by a health professional not to have the blood test for the AIDS virus infection	1988, 1989
	Have you ever been advised by friends or relatives not to have the blood test for the AIDS virus infection	1988, 1989
	Have you had your blood tested for AIDS virus infection	1988, 1989
	Have you had your blood tested for the AIDS virus infection more than once	1988, 1989
	Was your blood tested in the past 12 months	1988, 1989
	How many times have you had your blood tested for the AIDS virus infection	1988, 1989
	How many times in the past 12 months have you had your blood tested for the AIDS virus infection	1988, 1989
	Was the test/were any of the blood tests, including those you had before the past 12 months: part of a blood donation part of a blood transfusion voluntarily sought from a source such as your doctor, clinic, or HMO part of some other activity that requires a blood sample and includes automatic AIDS testing such as testing for the military or immigration	1988, 1989
	Where did you have your blood tested for AIDS virus infection: STD clinic family planning clinic prenatal clinic drug treatment facility tuberculosis clinic work clinic/health station AIDS counseling/testing site military induction immigration site other (specify) don't know	1988, 1989
	Did you get the results of your test/any of your tests	1988, 1989

Topic	Questionnaire item	Year
AIDS (continued)		
	<p>When you received your test results, did you receive counseling or talk with a health professional about how to lower your chances of becoming infected with the AIDS virus or how to avoid passing it to another person</p>	1988, 1989
	<p>Were you referred to a health professional to get counseling about the AIDS virus infection</p>	1988, 1989
	<p>Do you expect to have a blood test for the AIDS virus infection in the next 12 months</p>	1988, 1989
	<p>Will you have the blood test: as part of a blood donation voluntarily from a source such as your doctor, clinic, or HMO as part of some other activity that requires a blood sample and includes automatic AIDS testing, such as testing for the military or immigration</p>	1988, 1989
	<p>Where would you go to have a blood test for the AIDS virus infection: nowhere, wouldn't take the test AIDS clinic company or industry clinic doctor/HMO hospital/emergency room/outpatient clinic other clinic public health department Red Cross/blood bank other (specify) don't know</p>	1988, 1989
	<p>Did you have a blood transfusion at any time between 1977 and 1985</p>	1988, 1989
	<p>Do you think the present supply of blood is safe for transfusions</p>	1988, 1989
	<p>Here are some methods people use to keep from getting the AIDS virus through sexual activity. After I read each one, tell me whether you think it is very effective, somewhat effective, not at all effective, or if you don't know how effective it is in preventing getting the AIDS virus through sexual activity. How effective is: using a diaphragm using a condom using a spermicidal jelly, foam or cream having a vasectomy two people who do not have the AIDS virus having sex only with each other</p>	1988, 1989
	<p>What are your chances of having the AIDS virus; would you say: high medium low none refused to respond don't know</p>	1988, 1989

Topic	Questionnaire item	Year
AIDS (continued)		
	<p>People have different meanings when they say a "high," "medium," or "low" chance, if "no chance" is zero-out-of-one hundred, what would you say high/medium/low is, what number of times-out-of-one hundred</p>	1988, 1989
	<p>Do you say your chance of getting AIDS is high/medium because you: have had a blood transfusion have had sexual contact with someone who might have the virus some other reason (specify)</p>	1988, 1989
	<p>In the past 12 months, have you received services or care at: a prenatal health clinic a maternal and infant health clinic a family planning clinic a hospital, as an inpatient a hospital emergency room a tuberculosis clinic a drug treatment facility or clinic an STD, sexually transmitted disease, clinic an alcohol treatment facility or clinic an AIDS counseling and testing clinic a community health clinic a public health clinic</p>	1988, 1989
	<p>In the past 12 months, have you: been in the job corps had a physical examination to join the military been in prison</p>	1988, 1989
	<p>Have you ever personally known anyone with AIDS or the AIDS virus</p>	1988
	<p>How long has it been since you saw this person: within the past 2 weeks 2 weeks to less than 1 month 1 month to less than 3 months 3 months to less than 6 months 6 months or more don't know</p>	1988, 1989
	<p>How well do you know this person, would you say: very well, it is a close relationship fairly well, but it is not a close relationship not very well, it is only an acquaintance or casual relationship you don't really know them personally, such as a friend of a friend other (specify)</p>	1988, 1989
	<p>Please tell me (interviewer) if any of these statements is true for you, do not tell me which statement or statements are true for you, just if any of them are: you have hemophilia and have received clotting factor concentrates since 1977 you are a native of Haiti, Central or East Africa who has entered the United States since 1977 you are a man who has had sex with another man at some time since 1977, even one time you have taken illegal drugs by needle at any time since 1977 since 1977, you are or have been the sex partner of any person who would answer "yes" to any of the items listed above you have had sex for money or drugs at any time since 1977</p>	1988, 1989

Topic	Questionnaire item	Year
AIDS (continued)		
	The U.S. Public Health Service has said that AIDS is one of the major health problems in the country but exactly how many people it affects is not known. The Surgeon General has proposed that a study be conducted and blood samples be taken to help find out how widespread the problem is. If you were selected in this national sample of people to have their blood tested with assurances of privacy of tests results, would you have the test	1987, 1988, 1989
	Why wouldn't you take part in the test: don't want to know if I have AIDS don't want any counseling about AIDS fear I'll get AIDS don't like to give blood don't trust Government programs it is a waste of money don't believe AIDS can really be cured anyway other (specify) don't know	1988, 1989
	If it were not possible to provide you with the results of the test, would you still take part in the study	1988, 1989
	If the results of the test were not provided to you, then would you take part in the study	1988, 1989
	When Federal Public Health officials give information about AIDS, do you believe what they say or are you doubtful about the information they give	1988, 1989
	When they give advice about how to help keep from getting AIDS, do you believe their advice or are you doubtful about what they say	1988, 1989
Alcohol (see also Drinking)		
	In your entire life, have you had at least 12 drinks of any kind of alcoholic beverage	1985, 1988
	In the past 12 months did you have at least 12 drinks of any kind of alcoholic beverage	1988
	In any one year of your entire life did you have at least 12 drinks of any kind of alcoholic beverage	1985, 1988
	Have you had at least 1 drink of beer, wine, or liquor during the past year	1985
	What are your (main) reasons for not drinking: no need/not necessary infrequent drinker don't socialize very much don't care for it or dislike it am an alcoholic thought I might become an alcoholic had problems with my drinking have a responsibility to my family family member an alcoholic or problem drinker medical or health reasons religious or moral reasons brought up not to drink	

Topic	Questionnaire item	Year
Alcohol (continued)		
	<ul style="list-style-type: none"> makes me sick can't control my drinking costs too much or can't afford it dieting or too fattening other don't know 	1985, 1988
	<p>Of the reasons you have told me (interviewer), which of these is your most important reason for not drinking:</p> <ul style="list-style-type: none"> don't socialize very much don't care for it or dislike it am an alcoholic thought I might become an alcoholic had problems with my drinking have a responsibility to my family family member an alcoholic or problem drinker medical or health reasons religious or moral reasons brought up not to drink makes me sick can't control my drinking costs too much or can't afford it dieting or too fattening other don't know 	1988
	<p>In your opinion, how often must a person drink in order to be considered a heavy drinker:</p> <ul style="list-style-type: none"> every day days per week days per month days per year don't know 	1988
	<p>On those days, how many drinks must a person have in order to be considered a heavy drinker</p>	1988
	<p>In your opinion, how often must a person drink in order to be considered a moderate drinker:</p> <ul style="list-style-type: none"> every day days per week days per month days per year don't know 	1988
	<p>On those days, how many drinks must a person have in order to be considered a moderate drinker</p>	1988
	<p>In your opinion, how often must a person drink in order to be considered a light drinker:</p> <ul style="list-style-type: none"> every day days per week days per month days per year don't know 	1988
	<p>On those days, how many drinks must a person have in order to be considered a light drinker</p>	1988

Topic	Questionnaire item	Year
Alcohol (continued)		
	When you were growing up, that is, during your first 18 years, did you live with anyone who was a problem drinker or alcoholic	1988
	Was this your biological (natural), adoptive, step, or foster (mother/father)	1988
	Was this your full, half, adoptive, step, or foster (brother/sister)	1988
	For how long did you live with (person) while (person) was a problem drinker or alcoholic: days weeks months years	1988
	Have any of your other blood relatives ever been a problem drinker or alcoholic	1988
	Who was this: biological mother biological father biological brother(s) biological sister(s) half brother(s) half sister(s) biological son(s) biological daughter(s) grandmother(s) grandfather(s) aunt(s) uncle(s) niece(s) nephew(s) cousin(s) other blood relative(s) don't know	1988
	Have you ever been married to, or lived with someone as if you were married, who was a problem drinker or alcoholic	1988
	Please tell me (interviewer) which category best describes (each adult family member's) drinking during the past year: heavy moderate light very light or occasional quit drinking never drank don't know	1988
	Tell me (interviewer) whether or not you have had any of the following conditions even if you have mentioned them before: hypertension or high blood pressure (excluding during pregnancy) hardening of the arteries any heart disease arthritis or rheumatism an ulcer, not including skin ulcers	

Topic	Questionnaire item	Year
Alcohol (continued)		
	diabetes any disease of the liver, such as yellow jaundice, hepatitis or cirrhosis cancer, other than skin cancer alcoholism	1988
	Not counting small tastes, how old were you when you started drinking alcoholic beverages	1988
	In the past 12 months about how many drinks of any kind of alcoholic beverages did you have	1988
	When did you have your last drink of any kind of alcoholic beverage	1988
	What type of alcoholic beverage (do/did) you prefer to drink: beer wine liquor no preference don't know	1988
	When you (drink/drank) who (do/did) you usually drink with: friends relatives people from work other people self don't know	1988
	What are your reasons for not drinking very much: don't socialize very much don't care for it or dislike it am an alcoholic thought I might become an alcoholic had problems with my drinking have responsibility to my family family member an alcoholic or problem drinker medical or health reasons religious or moral reasons brought up not to drink makes me sick can't control my drinking costs too much or can't afford it dieting or too fattening other don't know	1988
	Of the reasons you have told me (interviewer), which of these is your most important reason for not drinking very much: don't socialize very much don't care for it or dislike it am an alcoholic thought I might become an alcoholic had problems with my drinking have responsibility to my family family member an alcoholic or problem drinker medical or health reasons	

Topic	Questionnaire item	Year
Alcohol (continued)		
	religious or moral reasons	
	brought up not to drink	
	makes me sick	
	can't control my drinking	
	costs too much or can't afford it	
	dieting or too fattening	
	other	
	don't know	1988
	On the average, how often do you drink any alcoholic beverage:	
	every day	
	days per week	
	days per month	
	days per year	
	don't know	1988
	On the average, on the days that you drink alcohol, how many drinks do you have a day	1988
	Did you have a drink during the 2-week period (outlined on the calendar) beginning Monday and ending Sunday	1988
	During that period, when did you last have a drink	1988
	When was your last drink prior to that 2-week period	1988
	During that 2-week period, on how many days did you drink any beer	1988
	On the day(s) when you drank beer, about how many beers did you drink a day	1988
	About how many ounces were in a typical can or bottle or glass of beer that you drank during that period	1988
	During that 2-week period, on how many days did you drink any wine	1988
	On the day(s) when you drank wine, about how many glasses of wine did you drink a day	1988
	About how many ounces of wine were in a typical glass that you drank during that period	1988
	During that 2-week period, on how many days did you drink any liquor, such as whiskey, rum, gin, or vodka	1988
	On the day(s) when you drank liquor, about how many drinks did you have a day	1988
	About how many ounces of liquor were in a typical drink that you had during that period	1988
	During the 2-week period (outlined on the calendar/ beginning Monday and ending Sunday), on how many days altogether did you drink alcoholic beverages, that is, beer, or wine, or liquor	1988
	During that 2-week period, did you have more than largest number reported	1988
	On how many days did you have more than (largest number) drink(s) of beer, or wine, or liquor	1988
	What was the largest number of drinks you had on any one of those days	1988
	On how many days during that 2-week period did you have (number of) drinks	1988

Topic	Questionnaire item	Year
Alcohol (continued)		
	How many drinks did you have on that day	1988
	Was the amount of your drinking during that 2-week period typical of your drinking during the past 12 months	1988
	Was the amount of your drinking during that 2-week period more or less than your drinking during the past 12 months	1988
	For how many years has this been typical of your drinking	1988
	During that 2-week period (ending the day of last drink), on how many days did you drink any beer	1988
	During that 2-week period (ending the day of last drink), on how many days did you drink any wine	1988
	During that 2-week period (ending the day of last drink), on how many days did you drink any liquor	1988
	During that 2-week period, did you drink more or less than usual	1988
	Do you think you will probably drink again or have you stopped drinking permanently: will probably drink again stopped permanently other don't know	1988
	Did you have at least one drink in every month (in the 12 months before last drink/last year/of that year)	1988
	In how many months did you have at least one drink	1988
	During (that month/those months), on how many days did you have 9 or more drinks of any alcoholic beverage	1988
	During (that month/those months), on how many days did you have 5 or more drinks of any alcoholic beverage	1988
	Do you now consider yourself to be a heavy, moderate, light, very light, or occasional drinker	1988
	In your entire life, when you drank the most, about how often did you drink: every day days per week days per month days per year don't know	1988
	On these days, about how many drinks did you have a day	1988
	For how long a period did you drink this amount: number of days number of weeks number of months number of years don't know	1988
	Before you stopped drinking, what type of alcoholic beverage (do/did) you prefer to drink: beer wine liquor no preference don't know	1988

Topic	Questionnaire item	Year
Alcohol (continued)		
	In the past 12 months about how many drinks of any kind of alcoholic beverage did you have	1988
	When did you have you last drink of any kind of alcoholic beverage	1988
	In your entire life, when you drank the most, about how often did you drink	1988
	On those days, about how many drinks did you have a day	1988
	For how long a period did you drink this amount: number of days number of weeks number of months number of years don't know	1988
	What are your reasons for drinking less than 12 drinks in the past year: don't socialize very much don't care for it or dislike it am an alcoholic thought I might become an alcoholic had problems with my drinking have responsibility to my family family member an alcoholic or problem drinker medical or health reasons religious or moral reasons brought up not to drink makes me sick can't control my drinking costs too much or can't afford it dieting or too fattening other don't know	1988
	Of the reasons you have told me (interviewer), which of these is your most important reason for drinking less than 12 drinks in the past year: don't socialize very much don't care for it or dislike it am an alcoholic thought I might become an alcoholic had problems with my drinking have responsibility to my family family member an alcoholic or problem drinker medical or health reasons religious or moral reasons brought up not to drink makes me sick can't control my drinking costs too much or can't afford it dieting or too fattening other don't know	1988
	In your entire life, have you ever: had a strong desire or urge to drink started drinking even though you hadn't intended to	

Alcohol (continued)

ended up drinking much more than you intended to
found it difficult to stop drinking once you had started
driven a car after having had too much to drink
been sick or vomited after drinking, or the morning after
done things when drinking that could have caused you to be hurt
felt the effects of alcohol sooner than you used to
kept on drinking for a longer period of time than you intended to
found that the same amount of alcohol had less effect than before
felt depressed, irritable, or nervous after drinking, or the morning after
felt powerless over your drinking
sought help from family, friends, professionals,
or self-help groups about your drinking
had a spouse or someone you lived with threaten
to leave you because of your drinking
gone on benders or binges that lasted two or more days
tried to cut down or stop drinking and found you couldn't do it
found yourself sweating heavily or shaking after drinking,
or the morning after
given up or cut down on activities or interests like sports
or associations with friends, in order to drink
been unable to remember some of the things you did while drinking
needed a drink so badly you couldn't think of anything else
found that you had to drink more than you once
did to get the same effect
stayed away from work or gone to work late because of
drinking or a hangover
spent money on drinks that was needed for essentials like food, or bills
lost ties with or drifted apart from a family member or
friend because of your drinking
gotten drunk instead of doing the things you were supposed to do
had a doctor suggest that you cut down or stop drinking alcohol
continued to drink alcohol even though it was a threat to your health
lost a job, or nearly lost one, because of drinking
had family, friends or co-workers suggest that you stop or
cut down on your drinking
done things when drinking that could have caused someone else to be hurt
felt uneasy if alcohol was not around in case you wanted a drink
spent a lot of time drinking, or getting over the effects of drinking
been so hungover that it interfered with doing
things you were supposed to do
kept drinking even though it caused you emotional problems
had your chances for promotion, raises, or better
jobs hurt by your drinking
heard or seen things that weren't really there after drinking, or the morning after
taken a drink to keep yourself from shaking or feeling sick either
after drinking, or the morning after
kept drinking even though it caused you problems
at home, work, or school
attended a meeting of Alcoholics Anonymous (AA)
because of your drinking
been arrested or had trouble with the police because of your drinking
wanted to cut down or stop your drinking and
found you couldn't do it

1988

Topic	Questionnaire item	Year
Alcohol (continued)		
	In the last 12 months, how many times have you: (See previous list)	1988
Birth (see also Child Health)		
	Have given birth to live infant in the past 5 years	1985
	In what month and year was your last child born	1985
Birth Control Pills (see also Cancer)		
	If a woman takes birth control pills is she more likely to have a stroke if she smokes than if she does not smoke	1985
	If a woman takes birth control pills is she much more likely or somewhat more likely to have a stroke	1985
Blood Pressure/Hypertension (see also Stress/Stroke)		
	Which of the following definitely increases, probably increases, probably does not, or definitely does not increase a person's chance of getting heart disease: cigarette smoking worry or anxiety high blood pressure diabetes being very overweight overworked drinking coffee with caffeine eating a diet high in animal fat family history of heart disease high cholesterol	1985
	Which one of the following substances in food is most often associated with high blood pressure: sodium cholesterol sugar other (specify) don't know	1985
	Have you ever been told by a doctor or other health professional that you had hypertension, sometimes called high blood pressure	1985
	About how long has it been since you last had your blood pressure taken by doctor or other health professional: number of days number of weeks number of months number of years don't know never	1985
	Blood pressure is usually given as one number over another. Were you told what your blood pressure was, in numbers	1985
	What was your blood pressure, in numbers	1985
	At that time, was your blood pressure: high	

Topic	Questionnaire item	Year
Blood Pressure/Hypertension (continued)		
	low	
	normal	
	other	
	don't know	1985
	Is this condition (high blood pressure/hypertension) completely cured or under control	1985
	Do you still have high blood pressure or hypertension	1985
	Were you told two or more different times that you had hypertension or high blood pressure	1985
	Are you now taking any medicine prescribed by a doctor for your hypertension or high blood pressure	1985
	Was any medicine ever prescribed by a doctor for your hypertension or high blood pressure	1985
	Did doctor advise you to stop taking medicine	1985
	Because of your hypertension or high blood pressure, has a doctor or other health professional ever advised you to:	
	diet to lose weight	
	cut down on salt or sodium in your diet	
	exercise	1985
	Have you ever followed this advice to:	
	diet to lose weight	
	cut down on salt or sodium in your diet	
	exercise	1985
	Are you now following this advice to:	
	diet to lose weight	
	cut down on salt or sodium in your diet	
	exercise	1985
Breastfeeding (see Child Health)		
Cancer (see also Smoking)		
Cancer Control		
<u>Acculturation</u>		
	Respondent speaks Spanish	1987
	Respondent speaks English	1987
	Respondent speaks mostly Spanish, mostly English or both Spanish and English about the same	1987
	Language respondent prefers	1987
	Can respondent read Spanish	1987
	Can respondent read English	1987
	Respondent reads better in Spanish or English	1987
	Can respondent write in Spanish	1987
	Can respondent write in English	1987
	Respondent writes better in Spanish or English	1987
	What is your ethnic identification: (see list below)	1987

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Acculturation (continued)</u>		
	What is respondent mother's ethnic identification: (see list below)	1987
	What is respondent father's ethnic identification:	1987
	Puerto Rican	
	Cuban	
	Mexican/Mexicano	
	Mexican American	
	Chicano	
	other Latin American	
	other Spanish	
	other (specify)	1987
	What country or State respondent born in	1987
	What country or State respondent's mother born in	1987
	What country or State respondent's father born in	1987
<u>Medical Care</u>		
	Needed medical care or advice in past 12 months	1987
	During past 12 months, did not get needed medical care or advice	1987
	Why didn't you get the care that you needed:	
	procrastinated/put it off	
	did not have health insurance	
	care was not available when needed	
	cost too much	
	didn't know where to go	
	didn't know what kind of doctor to see	
	didn't have a way to get there	
	hours not convenient	
	fear of being treated rudely or unkindly	
	other reason (specify)	
	don't know	1987
	Is there a particular doctor's office, clinic, health center, or place	
	you usually go to for medical care or advice	1987
	What kind of place is it:	
	doctor's office	
	hospital emergency room	
	hospital outpatient clinic	
	health center or private neighborhood health clinic	
	public health clinic	
	health clinic at work	
	HMO/prepaid group practice/"Group Health"	
	other (specify)	
	don't know	1987
	Where do you go when you are sick or need advice	
	about your health:	
	doctor's office	
	hospital emergency room	
	hospital outpatient clinic	
	health center or private neighborhood health clinic	
	public health clinic	
	health clinic at work	
	HMO/prepaid group practice/"Group Health"	

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Medical Care (continued)</u>		
	haven't needed a doctor	
	don't go anywhere	
	have two or more doctors or usual places depending on what is wrong	
	other (specify)	
	don't know	1987
Where do you get most useful information about how to prevent illness and improve your health:		
	telephone information – public service or hotline	
	family	
	friends	
	doctor	
	work	
	television	
	radio	
	books	
	newspaper	
	magazines	
	pamphlets in doctor's office	
	other source	
	nowhere/don't get information	
	don't know	1987
<u>Food Knowledge</u>		
	Ever made any lasting and major changes in what you eat and drink for health reasons	1987
	If foods changed, what foods you eat less of	1987
	If foods changed, what foods you eat more of	1987
	Have you made changes in what you eat or drink in past 5 years	1987
	Have you made changes in what you eat or drink in the past year	1987
	Are following statements true or false for respondent:	
	everything you eat is bad for you so why bother changing	
	respondent enjoys the things eaten and don't want to change	
	there are so many different recommendations, it's hard for respondent to know which ones to follow	
	respondent eats out so much that making changes would be hard	
	making changes in the kind of food respondent eats would be expensive	
	respondent would like to change but rest of family won't change	
	the things respondent eats are healthy so there is no reason to make changes	1987
	Respondent agrees most with one of the following two statements:	
	what people eat or drink has little effect on whether they will develop major diseases	
	by eating the right kinds of food, people can reduce their chances of developing major diseases	1987
	Which major diseases you think may be related to what people eat and drink:	
	cancer	
	heart disease	
	obesity/overweight	
	diabetes	

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Food Knowledge (continued)</u>		
	hypertension or high blood pressure	
	other	
	none	1987
	Do you think cancer may be related to what people eat and drink	1987
	What foods should people eat or drink MORE of to help prevent cancer	1987
	What foods should people eat or drink LESS of to help prevent cancer	1987
	What kinds of cancer do you think may be related to things people eat and drink:	
	all kinds of cancer	
	breast cancer	
	bladder cancer	
	cancer of the mouth/throat/esophagus	
	cancer of the colon/bowel/intestines/rectum	
	stomach cancer	
	prostate cancer	
	cancer of the uterus	
	lung cancer	
	liver cancer	
	other	
	don't know	1987
	Have you heard or read ANYTHING about how eating more of some foods and less of other foods can help prevent some major diseases	1987
	Which major diseases have you heard may be related to what people eat and drink:	
	cancer	
	heart disease	
	obesity/overweight	
	diabetes	
	hypertension or high blood pressure	
	other	
	none	
	don't know	1987
	Have you heard of foods containing fiber	1987
	Diet high, medium, or low in fiber	1987
	Tell me (interviewer) which of the foods listed is high in fiber:	
	bran flakes	
	corn flakes	
	hamburgers	
	lettuce	
	baked beans	
	carrots	
	white rice	
	raw apples	
	none	
	don't know	1987
	Diet high, medium, or low in fat	1987

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Food Knowledge (continued)</u>		
	Tell me (interviewer) which of the foods listed is high in fat:	
	fried chicken	
	white bread	
	soda or soft drinks	
	peanut butter	
	broiled fish	
	bananas	
	cold cuts or lunch meats	
	doughnuts	
	none	
	don't know	1987
	Thinking about what you eat and drink, which of the following are important concerns for you:	
	avoiding foods with too much salt or sodium	
	avoiding foods with too much sugar	
	eating foods to lower cholesterol	
	not having enough money to buy food	
	being overweight	
	being too thin	1987
<u>General Knowledge and Attitudes</u>		
	Which do you think increases a person's chances of getting cancer:	
	stress	
	inherited make-up or heredity	
	exposure to x-rays	
	poor eating practices	
	using chewing tobacco, snuff, pipes or cigars	
	air pollution	
	water pollution	
	some cloth dyes	
	exposure to toxic waste dumps	
	exposure to toxic substances on the job	
	exposure to people with cancer	
	excessive drinking of alcoholic beverages	
	exposure to the sun	
	cigarette smoking	
	exposure to nuclear waste	
	some strong soaps and detergents	
	viruses	
	some medicines	
	medical procedures using radiation	
	don't know	1987
	In your opinion, of the things you just mentioned (see list above), which two are responsible for the most cases of cancer in this country	1987
	Do you strongly agree, agree, disagree, or strongly disagree with this statement, or if you have no opinion:	1987
	there is very little a person can do to reduce his or her chances of getting cancer	1987

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>General Knowledge and Attitudes (continued)</u>		
	What do you think are warning signs or symptoms of cancer:	
	weight loss/loss of appetite	
	change in bowel or bladder habits	
	unusual bleeding or discharge	
	lump in breast or elsewhere	
	indigestion	
	difficulty in swallowing	
	change in a wart or mole	
	nagging cough or hoarseness	
	chest pain	
	shortness of breath	
	sores that don't heal	
	tired/fatigued	
	changes on skin/rash/blemish/sunspots/blotches	
	other	
	don't know	1987
	Would you attend, if convenient, a free 2 hour class on how to reduce your chances of getting cancer	1987
	Which of these places would be most convenient for you to attend class:	
	church	
	local school	
	hospital	
	club meeting	
	workplace	
	home	
	senior center	
	community center	
	other place	
	don't know	1987
<u>Screening Knowledge and Practice</u>		
	Ever heard of Pap smear test	1987
	Ever had a Pap smear	1987
	When had last Pap smear	1987
	Was Pap smear done:	
	within past year	
	a year or more ago	1987
	Was Pap smear:	
	less than 3 months	
	3 or more months ago	1987
	Was Pap smear:	
	3 years ago or less	
	between 3 and 5 years	
	5 or more years ago	1987
	Where was Pap smear done:	
	in a doctor's office	
	a clinic	
	a hospital	
	some other place	1987
	Did you have Pap smear because of health problem	1987

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Screening Knowledge and Practice (continued)</u>		
	What was problem for Pap smear:	
	follow-up tests/treatment	
	bleeding	
	pain	
	discharge	
	itching	
	burning	
	infection	
	unrelated medical problem	
	other	
	don't know	1987
	How were you told results of Pap smear:	
	in person	
	telephone	
	through the mail	
	combination of methods	
	never told; meaning results normal	
	never told; don't know if there is a problem	
	other	1987
	What was health problem for Pap smear:	
	follow-up tests/treatment	
	bleeding	
	pain	
	discharge	
	itching	
	burning	
	infection	
	unrelated medical problem	
	other	
	don't know	1987
	Have you ever had Pap smear and results not normal	1987
	Because of abnormal results, did you have additional tests	1987
	Because of abnormal results, did you have any surgery or other treatment	1987
	Did Pap smear/additional tests/surgery or other treatment indicate cancer	1987
	When were you diagnosed as having cancer	1987
	What is most important reason (why you have never had/not had a Pap smear in the past few years):	
	procrastinated/put it off	
	had a hysterectomy	
	didn't know I should	
	not needed/not necessary	
	cost too much	
	no insurance coverage	
	don't go to doctors	
	don't have a doctor	
	not recommended by doctor/Dr. never said it was needed	
	doctor said it wasn't needed	
	too embarrassing	
	haven't had any problems	

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Screening Knowledge and Practice (continued)</u>		
	fear	
	other	
	don't know	1987
	Do you have menstrual periods	1987
	Menstrual periods stopped due to surgery	1987
	Know how to examine breasts for lumps	1987
	How often you examine breasts for lumps:	
	day	
	week	
	month	
	year	
	never	
	other (specify)	
	don't know	1987
	Who taught you how to examine breasts:	
	doctor	
	nurse	
	other health professional	
	learned in a class/meeting	
	read in a book, pamphlet, magazine, etc.	
	television	
	other (specify)	
	don't know	1987
	Ever heard of a breast physical examination	1987
	Have you ever had breast physical exam	1987
	When did you have last breast physical exam:	1987
	days ago	
	weeks ago	
	months ago	
	years ago	
	don't know	1987
	Was breast exam:	
	within the past year	
	1 year or more ago	1987
	Was breast exam:	
	less than 3 months	
	3 or more months ago	1987
	Was breast exam:	
	3 years ago or less	
	between 3 and 5 years	
	5 or more years ago	1987
	Where was breast exam done:	
	doctor's office	
	clinic	
	hospital	
	other place (specify)	
	don't know	1987
	Did you go for last breast exam because of health problem	1987
	What was health problem:	
	follow-up tests/treatment	
	soreness	

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Screening Knowledge and Practice (continued)</u>		
	swelling	
	lumps	
	pain	
	discharge	
	complications related to breast feeding	
	unrelated medical problem	
	other	
	don't know	1987
	How were you told results of breast exam:	
	in person	
	telephone	
	through the mail combination of methods	
	never told; meaning results normal	
	never told; don't know if problem	
	other	1987
	Ever had a breast physical exam because of health problem	1987
	What was health problem:	
	follow-up tests/treatment	
	soreness	
	swelling	
	lumps	
	pain	
	discharge	
	complications related to breast feeding	
	unrelated medical problem	
	other	
	don't know	1987
	Ever had a breast physical exam where the results were not normal	1987
	Because of abnormal results, did you have additional tests	1987
	Because of abnormal results, did you have surgery or other treatment	1987
	Did breast physical exam/additional tests/surgery or other treatment indicate cancer	1987
	When were you diagnosed as having cancer:	
	days ago	
	weeks ago	
	months ago	
	years ago	
	don't know	1987
	Most important reason you have not/never had a breast physical exam in the past few years by a doctor or other health professional:	
	procrastinated/put it off	
	didn't know I should	
	not needed/not necessary	
	cost too much	
	no insurance coverage	
	don't go to doctors	
	don't have a doctor	
	not recommended by doctor/Dr. never said it was needed	
	doctor said it wasn't needed	
	too embarrassing	
	haven't had any problems	
	fear	
	examined own breast	

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Screening Knowledge and Practice (continued)</u>		
	other	
	don't know	1987
	Ever heard of a mammogram	1987
	Ever had a mammogram	1987
	When was last mammogram:	
	days ago	
	weeks ago	
	months ago	
	years ago	
	don't know	1987
	Was last mammogram:	
	within past year	
	1 year or more ago	1987
	Was last mammogram:	
	less than 3 months	
	3 or more months ago	1987
	Was last mammogram:	
	3 years ago or less	
	between 3 and 5 years	
	5 or more years ago	1987
	Where was mammogram test done:	
	doctor's office	
	clinic	
	hospital	
	imaging center/x-ray lab	
	other place (specify)	
	don't know	1987
	Did you go for last mammogram because of health problem	1987
	What was health problem:	
	thickening	
	soreness	
	swelling	
	lumps	
	pain	
	discharge	
	unrelated medical problem	
	other	
	don't know	1987
	How were you told results of mammogram:	
	in person	
	telephone	
	through the mail	
	combination of methods	
	never told; meaning results normal	
	never told; don't know if problem	
	other	1987
	Ever had mammogram because of health problem	1987
	What was health problem:	
	thickening	
	soreness	
	swelling	
	lumps	

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Screening Knowledge and Practice (continued)</u>		
	pain	
	discharge	
	unrelated medical problem	
	other	
	don't know	1987
	Ever had mammogram where the results were not normal	1987
	Because of abnormal results, did you have additional tests	1987
	Because of abnormal results, did you have any surgery or other treatment	1987
	Did mammogram/additional tests/surgery or other treatment indicate cancer	1987
	When were you diagnosed as having cancer:	
	days ago	
	weeks ago	
	months ago	
	years ago	
	don't know	1987
	What is most important reason why you have not had/never had a mammogram in the past few years:	
	procrastinated/put it off	
	didn't know I should	
	not needed/not necessary	
	cost too much	
	no insurance coverage	
	don't go to doctors	
	don't have a doctor	
	not recommended by doctor/Dr. never said it was needed	
	doctor said it wasn't needed	
	too embarrassing	
	haven't had any problems	
	fear	
	fear of radiation	
	painful procedure	
	unpredictable results	
	other	
	don't know	1987
	Ever heard of digital rectal exam	1987
	Ever had a digital rectal exam	1987
	When did you have your last digital rectal exam:	
	days ago	
	weeks ago	
	months ago	
	years ago	
	don't know	1987
	Was rectal exam:	
	within the past year	
	1 year or more ago	1987
	Was rectal exam:	
	less than 3 months	
	3 or more months ago	1987
	Was rectal exam:	
	3 years ago or less	
	between 3 and 5 years	
	5 or more years ago	1987

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Screening Knowledge and Practice (continued)</u>		
	Where was rectal exam done:	
	doctor's office	
	clinic	
	hospital	
	other place (specify)	1987
	Did you go for your last digital rectal exam because of a health problem	1987
	What was health problem:	
	pain	
	constipation	
	bowel trouble	
	blood in stool	
	difficulty urinating	
	prostate enlargement	
	bleeding	
	hemorrhoids	
	diverticulitis	
	unrelated medical problem	
	other	
	don't know	1987
	How were you told the results of the test:	
	in person	
	telephone	
	through the mail	
	combination of methods	
	never told; meaning results normal	
	never told; don't know if problem	
	other	1987
	Ever had digital rectal exam because of health problem	1987
	What was health problem:	
	pain	
	constipation	
	bowel trouble	
	blood in stool	
	difficulty urinating	
	prostate enlargement	
	bleeding	
	hemorrhoids	
	diverticulitis	
	unrelated medical problem	
	other	
	don't know	1987
	Ever had digital rectal exam where results were not normal	1987
	Because of abnormal results, did you have additional tests	1987
	Because of abnormal results, did you have surgery or other treatment	1987
	Did digital rectal exam/additional tests/surgery or other treatment indicate you had cancer	1987
	When were you diagnosed as having cancer:	
	days ago	
	weeks ago	
	months ago	
	years ago	
	don't know	1987

Topic	Questionnaire item	Year
Cancer Control (continued)		
Screening Knowledge and Practice (continued)		
	What is most important reason why you have (never had/not had a digital rectal exam in the past years): procrastinated/put it off didn't know I should not needed/not necessary cost too much no insurance coverage don't go to doctors don't have a doctor not recommended by doctor/Dr. never said it was needed Dr. said it wasn't needed too embarrassing haven't had any problems fear painful procedure unpredictable results other don't know	1987
	Ever heard of blood stool test	1987
	Ever had a blood stool test	1987
	When had last blood stool test: month/year days ago weeks ago months ago years ago	1987
	Was blood stool test: within the past year 1 year or more ago	1987
	Was blood stool test: less than 3 months 3 or more months ago	1987
	Was blood stool test: 3 years ago or less between 3 and 5 years 5 or more years ago	1987
	Blood stool test done by self, done by doctor or other medical person	1987
	Last blood stool test done because of health problem	1987
	What was problem: hemorrhoids bleeding pain constipation bowel trouble blood in stool ulcers unrelated medical problem other don't know	1987
	How were you told results of test: in person telephone	

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Screening Knowledge and Practice (continued)</u>		
	through the mail	
	combination of methods	
	never told; meaning results normal	
	never told; don't know if problem	
	other	1987
	Ever had a blood stool test because of health problem	1987
	What was problem:	
	hemorrhoids	
	bleeding	
	pain	
	constipation	
	bowel trouble	
	blood in stool	
	ulcers	
	unrelated medical problem	
	other	
	don't know	1987
	Ever had blood stool test where results not normal	1987
	Because of abnormal results, did you have additional tests	1987
	Because of abnormal results, did you have surgery or treatment	1987
	Did blood stool test/additional tests/surgery	
	or other treatment indicate you had cancer	1987
	When was cancer diagnosed:	
	days ago	
	weeks ago	
	months ago	
	years ago	
	don't know	1987
	What is most important reason why you have (never had/not had a blood stool test in the past few years):	
	procrastinated/put it off	
	didn't know I should	
	not needed/not necessary	
	cost too much	
	no insurance coverage	
	don't go to doctors	
	don't have a doctor	
	not recommended by doctor/Dr. never said it was needed	
	Dr. said it wasn't needed	
	too embarrassing	
	fear	
	haven't had any problems	
	painful procedures	
	unpredictable results	
	other	
	don't know	1987
	Ever heard of a proctoscopic exam	1987
	Ever had a proctoscopic exam	1987
	When was last proctoscopic exam:	
	days ago	
	weeks ago	
	months ago	
	years ago	1987

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Screening Knowledge and Practice (continued)</u>		
	Was the proctoscopic exam: within past year 1 year or more ago	1987
	Was the proctoscopic exam: less than 3 months 3 or more months ago	1987
	Was the proctoscopic exam: 3 years ago or less between 3 and 5 years 5 or more years	1987
	Where was proctoscopic exam done: in a doctor's office a clinic a hospital other place (specify) don't know	1987
	Did you go for last proctoscopic exam because of health problem	1987
	What was problem: bleeding pain constipation bowel trouble blood in stool unrelated medical problem other don't know	1987
	How were you told results of proctoscopic exam: in person telephone through the mail combination of methods never told; meaning results normal never told; don't know if problem other	1987
	Ever had proctoscopic exam because of health problem	1987
	What was problem: bleeding pain constipation bowel trouble blood in stool unrelated medical problem other don't know	1987
	Ever had proctoscopic exam where results not normal	1987
	Because of abnormal results, did you have additional tests	1987
	Because of abnormal results, did you have surgery or treatment	1987
	Did proctoscopic exam/additional tests/surgery or other treatment indicate you had cancer	1987

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Screening Knowledge and Practice (continued)</u>		
	When was cancer diagnosed:	
	days ago	
	weeks ago	
	months ago	
	years ago	
	don't know	1987
	What is most important reason why you have (never had/not had proctoscopic exam in the past few years):	
	procrastinated/put it off	
	didn't know I should	
	not needed/not necessary	
	cost too much	
	no insurance coverage	
	don't go to doctors	
	don't have a doctor	
	not recommended by doctor/Dr. never said it was needed	
	Dr. said it wasn't needed	
	too embarrassing	
	fear	
	haven't had any problems	
	painful procedures	
	unpredictable results	
	other	
	don't know	1987
	Ever heard of:	
	a breast physical exam	
	a mammogram	
	a digital rectal exam	
	a blood stool test	
	a proctoscopic exam	1987
	How often you think women should have a Pap smear:	
	number of week(s)	
	number of month(s)	
	number of year(s)	
	never	
	other (specify)	
	only if problem/symptoms	
	don't know	1987
	How often women age 50 and over should have breast physical exam by a doctor or health professional:	
	number of week(s)	
	number of month(s)	
	number of year(s)	
	never	
	other (specify)	
	only if problem/symptoms	
	don't know	1987
	How often women age 50 and over should have a mammogram:	
	number of week(s)	
	number of month(s)	
	number of year(s)	

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Screening Knowledge and Practice (continued)</u>		
	never	
	other (specify)	
	only if problem/symptoms	
	don't know	1987
	How often person age 40 and over should have digital rectal exam:	
	number of week(s)	
	number of month(s)	
	number of year(s)	
	never	
	other (specify)	
	only if problem/symptoms	
	don't know	1987
	How often person age 40 and over should have blood stool test:	
	number of week(s)	
	number of month(s)	
	number of year(s)	
	never	
	other (specify)	
	only if problem/symptoms	
	don't know	1987
	How often person age 40 and over should have a proctoscopic exam:	
	number of week(s)	
	number of month(s)	
	number of year(s)	
	never	
	other (specify)	
	only if problem/symptoms	
	don't know	1987
	Ever told by doctor or other health professional that you have cancer	1987
	Kind of cancer	1987
	Part of body affected by cancer	1987
	Age when cancer first diagnosed	1987
	Doctor told you about other cancer	1987
	Kind of other cancer	1987
	Part of body affected by other kind of cancer	1987
	Age when other kind of cancer first diagnosed by doctor	1987
<u>Smoking Habits and Tobacco Use</u>		
	Ever smoked 100 cigarettes in entire life	1987
	Age when first started smoking cigarettes fairly regularly	1987
	Do you smoke now	1987
	When you are inside public places that have no rules about smoking and someone lights up a cigarette, what are you most likely to do:	
	ask the person not to smoke	
	move away from the person	
	do nothing	
	something else	1987

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Smoking Habits and Tobacco Use (continued)</u>		
	About how long has it been since you last smoked cigarettes regularly	1987
	On the average, how many cigarettes did you usually smoke a day	1987
	How many minutes or hours after awakening did you usually have your first cigarette	1987
	Before you quit, did you make any other serious attempts to stop smoking	1987
	Including the last time you quit smoking, how many times did you make a serious attempt to stop smoking cigarettes	1987
	Before you quit smoking, what was the longest period you stayed off cigarettes	1987
	For how many years were you a regular smoker (do not include the times when you stayed off cigarettes) (When you quit smoking, did you ever/ In any of your quit attempts, did you ever):	1987
	switch to lower tar or nicotine cigarettes	
	use special filters or cigarette holders to regulate the amount of smoke inhaled	
	gradually decrease the number of cigarettes you smoked in a day	
	use prescription chewing gum called "nicorette"	
	participate in the Great American Smoke-out	
	stop smoking along with friends or relatives who were also trying to quit	
	stop by following instructions in a book or pamphlet	
	stop "cold turkey," that is, stopping all at once without cutting down	
	use some other method	1987
	Thinking of the methods you just mentioned (see previous list), which ones did you use the last time you quit smoking	1987
	Thinking of the time(s) you tried to quit smoking, please tell me the reasons you had for trying to quit :	
	health symptom/problem	
	present health	
	future health	
	both present and future health	
	cost of cigarettes	
	pressure from family and friends	
	advice from my doctor	
	setting a good example for children	
	effect my smoking had on others	
	pregnancy	
	lost desire	
	dirty habit	
	other	
	don't know	1987
	Was that concern for your health at the time or concern for your future health	1987
	Did you ever try to quit smoking because of a health condition you had at the time	1987

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Smoking Habits and Tobacco Use (continued)</u>		
	What was the health condition:	
	heart trouble/problem	
	high blood pressure	
	cancer	
	emphysema	
	cough	
	shortness of breath	
	cold/flu/virus	
	other respiratory problem	
	sore throat	
	pregnancy	
	other	
	don't know	1987
	Did a doctor ever advise you to quit smoking	1987
	Do you believe your smoking affected your health in any way	1987
	How did smoking affect your health:	
	heart trouble/problem	
	high blood pressure	
	cancer	
	emphysema	
	cough	
	shortness of breath	
	cold/flu/virus	
	other respiratory problem	
	sore throat	
	other	
	don't know	1987
	In order to get an accurate record of the brand of cigarette you smoke most often, I'd like to see the cigarette package (do you have the pack handy)	1987
	What brand or type of cigarette do you smoke most often	1987
	What type of cigarettes are the (brand) that you smoke, are they:	
	filter tip	
	non-filter tip	
	hard pack	
	soft pack	
	menthol	
	plain	
	regular	
	king-size	
	100 millimeter	
	120 millimeter	
	lights	
	ultra lights	
	don't know	1987
	What are the reasons you smoke cigarettes:	
	addicted	
	relaxes or calms me/nerves/stress/helps me cope	
	to keep my weight down	
	wakes me up	
	gives me something to do with my hands	

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Smoking Habits and Tobacco Use (continued)</u>		
	keeps me going/helps me concentrate/excuse to take a break habit	
	I like it/enjoy it	
	social reasons	
	other	
	don't know	1987
	Have you ever made a serious attempt to stop smoking cigarettes	1987
	Have you made more than one serious attempt	1987
	How many times within the last year have you made a serious attempt to stop smoking cigarettes	1987
	When did you make the serious attempt to quit smoking	1987
	When did you last make a serious attempt to quit smoking	1987
	When you tried to quit, for how long did you stay off cigarettes:	
	less than a day	
	days	
	weeks	
	months	
	years	
	don't know	1987
	Of all the times you have tried to quit smoking, what was the longest period you stayed off cigarettes:	
	less than a day	
	days	
	weeks	
	months	
	years	
	don't know	1987
	After your attempt(s) to quit, what were the reasons you started to smoke again:	
	fear of gaining weight	
	actual weight gain	
	headaches/irritability/difficulty concentrating/drowsiness	
	bored/blue/depressed	
	nervous/tense/angry/frustrated/stress	
	stressful life event	
	pressure from others to smoke	
	no support from others	
	habit/situation where used to smoke regularly	
	addiction/craving	
	pleasure of smoking/enjoy it	
	others smoking around me	
	not ready to quit/didn't want to quit	
	didn't try hard enough/no will power	
	any mention of alcohol	
	other	
	don't know	1987
	Of the reasons you have told me (see previous list), which of these was the most important to you as a reason for starting to smoke again	1987

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Smoking Habits and Tobacco Use (continued)</u>		
	Have you ever switched to a lower tar and nicotine cigarette just to reduce your health risk	1987
	Do you believe your smoking has affected your health in any way	1987
	How has your smoking affected your health: heart trouble/problem high blood pressure cancer emphysema cough shortness of breath cold/flu/virus other respiratory problem other don't know	1987
	Has a doctor ever advised you to quit smoking	1985, 1987
	For how many years have you been a regular smoker (do not include the times when you stayed off cigarettes)	1987
	Could you quit smoking permanently if you wanted to	1987
	How hard do you think it would be to quit smoking cigarettes entirely: very hard somewhat hard not hard at all	1987
	Have you ever used chewing tobacco, such as Redman, Levi Garrett, or Beechnut	1987
	Have you used chewing tobacco at least 20 times	1987
	How old were you when you first used chewing tobacco	1987
	Do you use chewing tobacco now	1987
	Altogether, about how long (did you use/have you used) chewing tobacco	1987
	On the average, how many days per month (did/do) you use chewing tobacco	1987
	On the days that you use(d) chewing tobacco, how many times (did/do) you use it	1987
	Have you ever used snuff, such as Skoal, Skoal Bandits, or Copenhagen	1987
	Have you used snuff at least 20 times	1987
	How old were you when you first used snuff	1987
	Do you use snuff now	1987
	Altogether, about how long (did you use/have you used) snuff	1987
	On the average, how many days per month (did/do) you use snuff	1987
	On the days you use(d) snuff, how many times (did/do) you use it	1987
	(Did/Do) you use snuff by sniffing it or by placing it in your mouth	1987
	Have you ever smoked a pipe	1987
	Have you smoked a pipe at least 50 times	1987
	How old were you when you first smoked a pipe	1987

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Smoking Habits and Tobacco Use (continued)</u>		
	Do you smoke a pipe now	1987
	Altogether, about how long (did you smoke/have you smoked) a pipe	1987
	On the average, how many days per month (did/do) you smoke a pipe	1987
	On the days you smoke(d) a pipe, how many pipefuls of tobacco (did/do) you smoke	1987
	Have you ever smoked cigars	1987
	Have you smoked at least 50 cigars in your entire life	1987
	How old were you when you first smoked cigars	1987
	Do you smoke cigars now	1987
	Altogether, about how long (did you smoke/have you smoked) cigars	1987
	On the average, how many days per month (did/do) you smoke cigars	1987
	On the days you smoke(d) cigars, how many (did/do) you smoke	1987
	Do you believe cigarette smoking is related to: emphysema gallstones lung cancer chronic bronchitis diabetes cancer of the mouth and throat heart disease	1987
	Do you think that using chewing tobacco on a regular basis can increase a person's chances of getting mouth and throat cancer	1987
	What about using snuff by mouth	1987
	What about smoking a pipe	1987
	What about smoking cigars	1987
	Do you think there is a strong, moderate, slight connection between mouth and throat cancer and: using chewing tobacco using snuff by mouth smoking a pipe smoking cigars	1987
	Please tell me (interviewer) whether you strongly agree, agree, disagree, or strongly disagree, or if you have no opinion on each of the following statements about cigarette smoking: everything causes cancer anyway so it really doesn't matter if you smoke smoking by a pregnant woman may harm the baby the smoke from someone else's cigarette is harmful to you most deaths from lung cancer are caused by cigarette smoking people who smoke low tar and nicotine cigarettes are less likely to get cancer than people who smoke high tar and nicotine cigarettes	

Topic	Questionnaire item	Year
Cancer Control (continued)		
<u>Smoking Habits and Tobacco Use (continued)</u>		
	if people want to smoke, they should not do so inside public places where it might disturb others	1987
	How long since last smoked	1987
<u>Occupational Exposure</u>		
	Exposed to any substances that would be harmful if you breathed them or got them on your skin on current job	1987
	Knowledge of how substances affect your health	1987
	Where did you learn that substances could affect your health:	
	employer	
	union	
	health clinic at work	
	magazines	
	newspapers	
	notices posted at work	
	doctor	
	television	
	read container label	
	other	
	don't know	1987
	Work at least half day in office building or work mostly outside	1987
	Are there at least five other people working in building	1987
	Smoking allowed at work	1987
	Smoking and non-smoking areas at work	1987
	Employer restricts smoking to certain areas for health reasons	1987
	Work area:	
	very smoky	
	somewhat smoky	
	not smoky at all	
	don't know	1987
	Smoke from other people's cigarettes:	
	very annoying	
	somewhat annoying	
	not at all annoying	1987
<u>Height and Weight</u>		
	Height without shoes	1985, 1987
	Weight without shoes	1985, 1987
	When you weighed the most, how much did you weigh	1987
Cancer Epidemiology		
<u>Acculturation (see Cancer Control)</u>		
<u>Food Frequency</u>		
	How often usually ate/drank during past year or so:	
	orange juice or grapefruit juice	

Topic	Questionnaire item	Year
Cancer Epidemiology (continued)		
<u>Food Frequency (continued)</u>		
	other fruit juices or fortified fruit drinks	
	oranges	
	grapefruit	
	cantaloupe in season	
	apples or applesauce	1987
	How often usually ate during the past year or so:	
	beans	
	carrots	
	tomatoes	
	green salad	
	salad dressing or mayonnaise	
	broccoli	
	spinach	
	mustard greens, turnip greens, or collards	
	coleslaw, cabbage, or sauerkraut	
	french fries or fried potatoes	
	potatoes, baked, boiled, or mashed	
	sweet potatoes or yams	
	rice	1987
	How often usually ate during the past year or so:	
	hamburgers, cheeseburgers or meatloaf	
	beef, such as steaks or roast	
	beef stew or potpie with vegetables	
	liver, including chicken liver	
	pork, such as pork chops or roasts	
	fried chicken	
	chicken or turkey, baked, stewed or broiled	
	fried fish or fish sandwiches	
	spaghetti, lasagna or pasta with tomato sauce	1987
	How often usually ate during past year or so:	
	cooked cereals like oatmeal	
	high fiber cereals like bran, granola, or shredded wheat	
	highly fortified cereals like Product 19, Total, or Most	
	other cold cereals like Rice Krispies or corn flakes	
	eggs	
	bacon	
	sausage	1987
	How often usually ate during past year or so:	
	vegetable soup, vegetable beef, minestrone or tomato soup	
	hot dogs	
	ham or lunch meats	
	white breads, rolls or crackers	
	dark breads	
	corn bread, corn muffins, corn tortillas, or grits	
	butter on bread, rolls or vegetables	
	margarine on bread, rolls or vegetables	
	cheese or cheese spreads, not including cottage cheese	
	peanuts or peanut butter	
	salty snacks like chips or popcorn	1987
	How often usually ate during past year or so:	
	ice cream	
	pie	
	doughnuts, cookies, cake or pastry	

Topic	Questionnaire item	Year
Cancer Epidemiology (continued)		
<u>Food Frequency (continued)</u>		
	chocolate candy	
	sugar in coffee or tea or on cereal	
	whole milk or drinks made with whole milk	
	2% milk or drinks made with 2% milk	
	skim milk or 1% milk or buttermilk	
	milk or cream in coffee or tea	
	soda or soft drinks with sugar	1987
	How often drank beer during past year or so:	
	every day/daily	
	number of weeks	
	number of months	
	number of years	
	never	1987
	Days you drank beer, how many cans, bottles or glasses drank	1987
	Cans, bottles, or glasses of beer small, medium, or large	1987
	How often drank wine during past year or so:	
	every day/daily	
	number of weeks	
	number of months	
	number of years	
	never	1987
	Days you drank wine, how many glasses drank	1987
	Glasses of wine small, medium, or large	1987
	How often you drank liquor during the past year or so:	
	every day/daily	
	number of weeks	
	number of months	
	number of years	
	never	1987
	Days drank liquor, how many drinks did you have	1987
	Liquor drinks small, medium, or large	1987
	Any period in life when you drank five or more drinks of any alcoholic beverage almost every day	1987
	How long did period last:	
	number of days	
	number of weeks	
	number of months	
	number of years	
	don't know	1987
	How often eat chicken or other poultry with skin on:	
	often or always	
	sometimes	
	rarely	
	never	
	don't eat chicken or poultry	1987
	When eating red meat, how often eat the fat:	
	often or always	
	sometimes	
	rarely	
	never	
	don't eat red meat	1987
	On most weekdays, how many meals eaten each day	1987

Topic	Questionnaire item	Year
Cancer Epidemiology (continued)		
<u>Food Frequency (continued)</u>		
	On most weekdays, how many snacks eaten each day	1987
	On most Saturdays or Sundays, number of meals eaten each day	1987
	On most Saturdays or Sundays, number of snacks eaten each day	1987
	In a typical week, number of meals eaten in restaurants, cafeterias, or fast food places	1987
<u>Vitamin and Mineral Intake</u>		
	Took vitamin or mineral supplements during past 12 months	1987
	Multiple vitamins taken during past 12 months	1987
	Brand name of multiple vitamin	1987
	Brand name taken most often during past 12 months	1987
	Vitamin therapeutic type, stress-tab type or one-a-day type	1987
	How many of the past 12 months did you take multiple vitamins	1987
	Days per month took multiple vitamins	1987
	Day you took multiple vitamins, how many pills taken per day	1987
	Multiple vitamins taken during past month	1987
	Took vitamin A during past 12 months	1987
	How many of the past 12 months did you take vitamin A	1987
	How many days per month took vitamin A	1987
	How many vitamin A pills you usually take per day	1987
	Units of vitamin A in each pill taken	1987
	Vitamin A taken during past month	1987
	Took vitamin C during past 12 months	1987
	How many of the past 12 months did you take vitamin C	1987
	How many days per month took vitamin C	1987
	On the days you took vitamin C, how many pills did you usually take per day	1987
	Milligrams of vitamin C in each pill taken	1987
	Vitamin C taken during past month	1987
	Took vitamin E during past 12 months	1987
	How many of the past 12 months did you take vitamin E	1987
	How many days per month took vitamin E	1987
	How many vitamin E pills did you take per day	1987
	Units of vitamin E in each pill taken	1987
	Vitamin E taken during past month	1987
	Took calcium during past 12 months	1987
	How many days per month took calcium	1987
	On the days you took calcium, how many pills did you usually take per day	1987
	Milligrams of calcium in each pill taken	1987
	Calcium taken during past month	1987

Topic	Questionnaire item	Year
Cancer Epidemiology (continued)		
<u>Food Knowledge</u>		
	Made lasting and major changes in eating and drinking for health reasons	1987
	In making changes, what foods eat more of	1987
	In making changes, what foods eat less of	1987
	Changes in eating and drinking made in the past 5 years	1987
	Did you make these changes in the past year	1987
	What were changes (in way food is cooked) more or less:	
	baking	
	boiling	
	broiling	
	steaming	
	frying	
	stir-frying/wok	
	sauteing	
	grilling/barbecuing	
	salting	
	microwaving	
	pressure-cooking	
	using non-stick pans	
	other	
	don't know	1987
	Agree most with what people eat or drink has little effect on whether they will develop major diseases or by eating certain kinds of foods, people can reduce their chances of developing major diseases	1987
	Which major diseases you think are related to what people eat and drink	
	cancer	
	heart disease	
	obesity/overweight	
	diabetes	
	hypertension/high blood pressure	
	other	
	none	
	don't know	1987
	Cancer related to what people eat and drink	1987
	Ever heard of foods containing fiber	1987
	Diet high, medium, or low in fiber	1987
	Diet high, medium, or low in fat	1987
	Gone on diet for weight loss or any other medical reason during past 12 months	1987
<u>Smoking Habits and Other Tobacco Use (see Smoking Habits and Tobacco Use in Cancer Control)</u>		
	How old were you when you stopped smoking cigarettes	1987
	For how many years (have you been/were you) a regular smoker (do not include the times you may have stayed off cigarettes)	1987

Topic	Questionnaire item	Year
Cancer Epidemiology (continued)		
<u>Reproduction and Hormone Use</u>		
	Given birth to a live born infant	1987
	How many live births	1987
	Age when first child was born:	
	20 years or younger	
	older than 20 years	
	21 to 24	
	25 to 29	
	30 to 34	
	35 or older	
	don't know	1987
	Had other pregnancies lasting 6 months or more	1987
	How many other pregnancies lasting 6 months or more	1987
	How old were you at end of pregnancies lasting 6 months or more:	
	20 years or younger	
	older than 20 years	
	21 to 24	
	25 to 29	
	30 to 34	
	35 or older	1987
	Breast-fed any children	1987
	Age menstrual cycle began:	
	younger than 10	
	10	
	10 to 12	
	13 to 15	
	16 or older	
	don't know	1987
	Menstrual cycles stopped permanently	1987
	Age when menstrual cycle stopped permanently:	
	younger than 20	
	20 to 29	
	30 to 39	
	40 to 44	
	45 to 49	
	50 to 54	
	55 or older	
	don't know	1987
	Menstrual periods stopped due to surgery	1987
	Ever had operation to remove NONCANCEROUS lump from breast	1987
	How many operations to remove NONCANCEROUS lump from breast	1987
	Age when you had first operation to remove NONCANCEROUS lump from breast	1987
	Ever use birth control pills	1987
	Age when started using birth control pills	1987
	younger than 25	
	25 or older	
	18 or younger	
	19 to 21	
	22 to 24	
	25 to 29	

Topic	Questionnaire item	Year
Cancer Epidemiology (continued)		
<u>Reproduction and Hormone Use (continued)</u>		
	30 to 34	
	35 or older	
	don't know	1987
How long respondent took birth control pills:		
	number of days	
	number of months	
	number of years	
	less than 1 month	
	less than 1 year	
	1 year or more	
	3 years or less	
	more than 3 but less than 5 years	
	5 or more years	
	don't know	1987
Ever taken estrogen pills		
		1987
Age when started taking estrogen pills:		
	younger than 20 to 29	
	30 to 39	
	40 to 44	
	45 to 49	
	50 to 54	
	55 or older	
	don't know	1987
How long respondent took estrogen pills:		
	number of days	
	number of months	
	number of years	
	less than 1 month	
	less than 1 year	
	1 year or more	
	3 years or less	
	more than 3 but less than 5 years	
	5 or more years	
	don't know	1987
Brand name of estrogen pills		
		1987
<u>Family History of Cancer</u>		
	Year of natural mother's/father's birth	1987
	Mother/father still living	1987
	Age when mother/father died	1987
	Mother/father diagnosed by doctor as having cancer	1987
	Kind of cancer mother/father had	1987
	Part of mother's/father's body affected by cancer	1987
	Other type of cancer mother/father had diagnosed by doctor	1987
	Type of cancer first diagnosed for mother/father	1987
	Part of mother's/father's body affected when first diagnosed with cancer	1987
	Mother's/father's age when cancer first diagnosed by doctor	1987
	Number of sisters respondent have (dead or alive)	1987
	Number of brothers respondent have (dead or alive)	1987
	Any sisters/brothers diagnosed by doctor as having cancer	1987

Topic	Questionnaire item	Year
Cancer Epidemiology (continued)		
<u>Family History of Cancer (continued)</u>		
	Kind of cancer sisters/brothers have	1987
	Part of sisters'/brothers' body affected by cancer	1987
	Did sister/brother have any other kind of cancer that was diagnosed by a doctor	1987
	The first time sister/brother was diagnosed with cancer, what kind of cancer was it	1987
	What part of the body was affected	1987
	Age of sisters/brothers when cancer first diagnosed by doctor	1987
	Year sisters/brothers born	1987
	Sisters/brothers alive	1987
	Age sisters/brothers died	1987
	How many natural daughters respondent has (dead or alive)	1987
	How many natural sons respondent has (dead or alive)	1987
	Any of respondent's natural children diagnosed by doctor as having cancer	1987
	Kind of cancer natural children have	1987
	Part of children's body affected by cancer	1987
	Children have any other type of cancer diagnosed by doctor	1987
	Type of cancer when first diagnosed by doctor	1987
	Part of children's body affected when first diagnosed with cancer	1987
	Age of children when first diagnosed by doctor	1987
	Year of birth for children diagnosed with cancer	1987
	Children still living	1987
	At what age did child die	1987
	Natural father/mother of children ever been diagnosed by a doctor as having cancer	1987
	Is father/mother natural parent of all children	1987
	Kind of cancer natural father/mother have	1987
	Part of natural father's/mother's body affected by cancer	1987
	Natural father/mother have any other cancer diagnosed by doctor	1987
	Type of cancer natural father/mother have when first diagnosed by doctor	1987
	Part of natural father's/mother's body affected when first diagnosed by doctor as having cancer	1987
	Age of natural father/mother when cancer first diagnosed by doctor	1987
	How many children are sons and how many are daughters (of natural father/mother)	1987
<u>Cancer Survivorship</u>		
	Ever told by doctor or other health professional you had cancer	1987
	Kind of cancer	1987
	Part of body affected by cancer	1987
	Age when cancer first diagnosed by a doctor	1987

Topic	Questionnaire item	Year
Cancer Epidemiology (continued)		
<u>Cancer Survivorship (continued)</u>		
	Respondent ever told by doctor had any other kind of cancer	1987
	Kind of other cancer	1987
	Part of body affected by other cancer	1987
	Age when other cancer was first diagnosed by doctor	1987
<u>Occupational Exposure</u>		
	Kind of work done the longest (including Armed Forces)	1987
	Most important activities or duties when doing longest kind of work	1987
	How long respondent did work	1987
	How old was respondent when respondent started doing this kind of work	1987
	Kind of business or industry respondent did longest work in:	
	an employee of a private company, business	
	or individual for wages, salary, or commission	
	a member of the Armed Forces	
	a Federal government employee	
	a State government employee	
	a local government employee	
	self-employed in own business, professional practice, or farm	
	is business incorporated	
	working without pay in family business or farm	1987
<u>Height and Weight (see Height and Weight in Cancer Control)</u>		
<u>Relationships and Social Activities</u>		
	Excluding spouse, how many friends can you talk to about private matters or can call on for help	1987
	Excluding spouse, how many relatives can you talk to about private matters or can call on for help	1987
	How many friends/relatives does respondent talk to at least once a month	1987
	How often attend or participate in group meetings or activities, such as social clubs, PTA, sporting events, church groups or other community service groups	1987
	How often respondent goes to church, temple, or other religious services	1987
<u>Car Safety Seats</u>		
	Have you heard about child safety seats, sometimes called car safety carriers, which are designed to carry children while they are riding in a car	1985
	Did a doctor or other health professional ever tell you about the importance of using car safety seats for your children	1985
	When child was brought home from the hospital following birth, was child buckled in a car safety seat	1985
	Does child now have a car safety seat	1985

Topic	Questionnaire item	Year
Car Safety Seats (continued)		
	When riding in a car, is child buckled in a car safety seat:	
	all or most of the time	
	some of the time	
	once in a while	
	never	1985
	When riding in a car, is seat belt worn:	
	all or most of the time	
	some of the time	
	once in a while	
	never	1985
Child Health (see also Car Safety Seats and Poisoning)		
	Month and year your last child born	1985
	Was child ever breastfed	1985
	How old was child when breastfeeding completely stopped:	
	still breastfed	
	age in days	
	age in weeks	
	age in months	
	age in years	1985
	Was (child) born in a hospital or some other place	1988
	How many nights was (child's biological mother) in the (hospital/birthing center) during this stay	1988
	How many nights was (child) in the (hospital/birthing center) during this stay	1988
	How much did (child) weigh at birth	1988
	Did (child) weigh more than 5 1/2 pounds or less	1988
	Did (child) weigh more than 9 pounds or less	1988
	How many months pregnant was (child's biological mother) when (child) was born	1988
	Was (child) born about when expected, or was it earlier or later	1988
	About how many weeks (earlier/later) than expected was (child) born	1988
	How many weeks pregnant were you when you first thought you were pregnant with (child)	1988
	Did you see or talk to a doctor to find out if you were pregnant	1988
	About how many weeks pregnant were you when you first found out from a doctor that you were pregnant:	
	4 weeks or less	
	5-13 weeks	
	14-27 weeks	
	28 weeks or more	
	don't know	1988
	Did you see or talk to a doctor about your pregnancy at any other time during that pregnancy	1988
	How many weeks or months pregnant were you when you first saw a doctor about your pregnancy	1988
	Altogether, how many pounds did you either gain or lose during that pregnancy	1988

Topic	Questionnaire item	Year
Child Health (continued)		
	Did (child) receive any newborn care in an intensive care unit, premature nursery, or any other type of special care unit	1988
	How many nights did (child) stay in the special care unit	1988
	Do you now have diabetes or sugar diabetes	1988
	At any time during your pregnancy with (child), did you have:	
	sugar in the urine	
	high sugar in the blood	
	diabetes	1988
	When did you first notice it—was it during your pregnancy with (child) or before	1988
	Did you have the (condition) for at least 3 months after (child) was born	1988
	Is child currently attending either kindergarten or first grade	1988
	At what time of day does the (kindergarten/first grade) start	1988
	At what time does the (kindergarten/first grade) end	1988
	Does the kindergarten have a day care or extended day program that child also takes part in	1988
	How many hours per week does child spend in this program	1988
	During the past 4 weeks has child attended nursery or preschool	1988
	Did the (nursery school/preschool) have a day care or extended day program that child also took part in	1988
	How many hours per week did child spend in the nursery school/preschool (with day care)	1988
	Have you/she worked at a job or business for pay in the last 4 weeks	1988
	How many hours a week do you usually work	1988
	Does she/do you work only while child is in school or does she/do you work other hours	1988
	Other than the (nursery school/preschool), in the past 4 weeks, has child been cared for in any kind of regular child care arrangement such as a day care center, playgroup, by a babysitter, relative, or some other regular arrangement	1988
	How was child usually cared for during the hours that child care was used:	
	day care center	
	babysitter in child's home	
	babysitter's home	
	father cares for child	
	mother cares for child while working at home	
	mother cares for child while working outside of home	
	child cares for self	
	other relative cares for child	
	day camp	
	other (specify)	1988

Topic	Questionnaire item	Year
Child Health (continued)		
	Other than (kindergarten/first grade/nursery school/preschool), how was child usually cared for while you worked:	
	day care center	
	babysitter in child's home	
	babysitter's home	
	father cares for child	
	mother cares for child while working at home	
	mother cares for child while working outside of home	
	child cares for self	
	other relative cares for child	
	day camp	
	other (specify)	1988
	How is this person related to child:	
	sibling	
	grandparent	
	other relative	
	don't know	1988
	Where does this person usually care for child, in child's home or somewhere else	1988
	About how many hours per week was child usually cared for by/at (arrangements)	1988
	Besides nursery or preschool and during the past 4 weeks, has child been cared for in any other regular child care arrangement	1988
	Other than nursery or preschool during the past 4 weeks, has child been cared for in any other regular child care arrangement:	
	day care center	
	babysitter in child's home	
	babysitter's home	
	father cares for child	
	mother cares for child while working at home	
	mother cares for child while working outside of home	
	child cares for self	
	other relative cares for child	
	day camp	
	other (specify)	1988
	Were any other child care arrangements used on a regular basis	1988
	How many additional hours a week was child care used	1988
	Now I would like to ask you about main child care arrangement. Including (child), how many children are usually cared for together, in the same group, at the same time (Do not include children in entire school or program.)	1988
	How many adults usually supervise the children in the same group as (child)	1988

Topic	Questionnaire item	Year
Child Health (continued)		
	Has the main person responsible for caring for (child) received education or training specifically related to young children, such as early childhood or elementary education, or child psychology	1988
	Was (child) ever cared for in any regular child care arrangement	1988
	When did (child) last receive care in a regular child care arrangement	1988
	How many times has main child care arrangement been changed in the past year	1988
	What was the last type of care used before (child) changed to the type of care is using now: nursery school or preschool nursery school or preschool with day care day care center babysitter in child's home in babysitter's home father cares for child mother cares for child while working at home mother cares for child while working outside of home summer day camp child cares for self other relative cares for child other (specify)	1988
	How is this person related to (child): sibling grandparent other relative don't know	1988
	How old was (child) when regular child care was begun	1988
	What type of child care arrangement was first used for (child): nursery school or preschool nursery school or preschool with day care day care center babysitter in child's home in babysitter's home father cares for child mother cares for child while working at home mother cares for child while working outside of home summer day camp child cares for self other relative cares for child other (specify)	1988
	How old was child's biological mother when (child) was born	1988
	Including (child), how many children has (child's biological mother) ever had, do not count miscarriages or stillbirths	1988
	Was (child) the first born (or) second born (or third, etc.)	1988
	How old was (child's biological mother) when the first child was born	1988
	Has (child) ever lived with (child's) biological mother for at least 4 consecutive months	1988

Topic	Questionnaire item	Year
Child Health (continued)		
	In what month and year did (child) last live with her	1988
	Is she now living or deceased	1988
	How often does (child) see her:	
	every day	
	almost every day	
	several times a week	
	about once a week	
	two or three times a month	
	about once a month	
	several times a year	
	once a year or less	
	never	
	don't know	1988
	Is (child's biological mother) now married, widowed, divorced, separated, or has (child's biological mother) never been married	1988
	How many times altogether has (child's biological mother) been married	1988
	Was (child's biological mother) ever married to (child's biological father)	1988
	In what month and year was (child's biological mother) married to (child's biological father)	1988
	Was (child's biological mother's) marriage to (biological father) ended by:	
	death	
	divorce	
	separation	
	annulment	
	don't know	1988
	In what month and year did (child's biological mother) stop living with (biological father)	1988
	In what month and year did the marriage to (child's biological father) legally end	1988
	In what month and year did (child's biological mother's) current marriage begin	1988
	Has (child) ever lived with (child's biological father) for at least 4 consecutive months	1988
	In what month and year did (child) last live with him	1988
	Is he now living or deceased	1988
	How often does (child) see him:	
	every day	
	almost every day	
	several times a week	
	about once a week	
	two or three times a month	
	about once a month	
	several times a year	
	once a year or less	
	never	
	don't know	1988

Topic	Questionnaire item	Year
Child Health (continued)		
	In what month and year did (child) move to this address or has (child) lived here since birth	1988
	About how far from here is the home (child) lived in before (child) moved to this home:	
	less than 1 mile	
	1 to 50 miles	
	more than 50 miles	
	don't know	1988
	Altogether, how many times has (child) ever moved	1988
	In what month and year did (child) begin living with you	1988
	During the past 12 months, did (child) have an accident, injury, or poisoning that required medical attention	1988
	How many accidents, injuries, or poisonings did (child) have in the last 12 months that required medical attention	1988
	(Beginning with the most recent,) what caused the accident, injury, or poisoning; for example, was (child) hit by a car while riding a bike, or burned by hot liquid or did (child) swallow an object or pills	1988
	Which of the conditions on this list or any other conditions resulted from the (cause of accident):	
	broken or dislocated bones	
	sprain, strain, or pulled muscle	
	cuts, scrapes, or puncture wounds	
	head injury, concussion	
	bruise, contusion, or internal bleeding	
	burn, scald	
	poisoning from chemicals, medicines, drugs	
	respiratory problem such as breathing, cough, pneumonia	
	other	
	don't know type of condition	
	none	1988
	Were there any other conditions that resulted from this accident, injury or poisoning	1988
	Where did this accident or injury or poisoning happen:	
	home (not necessarily child's)	
	day care location (preschool/nursery)	
	school (including grounds and athletic areas)	
	street or highway	
	public building or space (other than street or school)	
	farm or agricultural area, except farm home	
	place of recreation or sports, except at school	
	other	
	don't know	1988
	In what month and year did the accident, injury, or poisoning occur	1988

Topic	Questionnaire item	Year
Child Health (continued)		
	<p>Does (child) now have: a missing finger, hand, arm, toes, foot, or leg (which is it) is (child) missing one or both/more than one body part permanent impairment, stiffness or any deformity of the back, foot, or leg (which is it) is one both/more than one body part affected permanent impairment, stiffness or any deformity of the fingers, hand, or arm (which is it) is one or both/more than one body part affected</p>	1988
	<p>Did (child) ever have: repeated tonsillitis or enlargement of the the tonsils or adenoids frequent or repeated ear infections any kind of food or digestive allergy frequent or repeated diarrhea or colitis any other persistent bowel trouble (specify) diabetes sickle cell anemia anemia asthma mononucleosis hepatitis meningitis or spinal meningitis bladder infection or urinary tract infection rheumatic fever pneumonia hay fever any (other) kind of respiratory allergy deafness or trouble hearing with one or both ears; is it one or both ears blindness in one or both eyes; is it one or both eyes crossed eyes any other trouble seeing with one or both eyes, even when wearing glasses eczema or any kind of skin allergy epilepsy or repeated convulsions or seizures not associated with fever seizures associated with fever frequent or severe headaches, including migraines stammering or stuttering any other speech defect (specify) enuresis or bedwetting problem arthritis or any other joint disease or joint problem (specify) any other condition affecting the bone, cartilage, muscle, or tendon (specify) cerebral palsy congenital heart disease any other heart disease or condition any other condition that required surgery in past 12 months (specify) any other condition that lasted 3 months or more (specify)</p>	1988
	Did (child) have condition in the last 12 months	1988
	Has (child) had condition for at least 3 months in lifetime	1988

Topic	Questionnaire item	Year
Child Health (continued)		
	Is it an obviously permanent condition that began less than 3 months ago	1988
	How old was (child) when condition or AIP accident, injury and poisoning (happened/was first noticed)	1988
	Including nursery or preschool did (child) attend school at all during the past 12 months	1988
	During the past 12 months, did (condition/AIP) cause (child) to miss any time from school	1988
	How many days in the past 12 months did (child) miss all or part of the day	1988
	During the past 12 months, did (condition/AIP) cause child to stay in bed more than half of the day	1988
	How many days in past 12 months did (child) stay in bed more than half of the day	1988
	During the past 12 months, did (condition/AIP) limit or prevent (child) from doing usual childhood activities, such as playing with other children or participating in games or sports	1988
	During the past 12 months, about how many nights did (child) spend in the hospital because of (condition/AIP)	1988
	During the past 12 months, about how many times did (child/anyone) see or talk to a medical doctor or assistant about this (condition/AIP) (do not count doctors seen while an overnight patient in a hospital)	1988
	During the past 12 months, did this (condition/AIP) make it necessary for (child) to use any medicine, other than vitamins, that a doctor prescribed or told (child) to take	1988
	During the past 12 months did (child) have any surgery performed, including bone settings and stitches for this (condition/AIP)	1988
	In the last 12 months, how often did (this condition/the conditions) resulting from the (AIP) cause (child) pain or discomfort or upset: all of the time often once in a while never	1988
	When this condition did bother (child), was (child) bothered: a great deal some very little	1988
	Did the (condition) result from an accident, injury, or poisoning	1988
	Did this occur within the last 12 months	1988
	Which accident, injury, or poisoning was it	1988
	What kind of accident or injury or poisoning was it	1988
	Does (child) wear glasses or contact lenses	1988

Topic	Questionnaire item	Year
Child Health (continued)		
	About how long has it been since (child) last saw someone for dental care:	
	6 months ago or less	
	over 6 months to 12 months	
	over 12 months to 2 years	
	over 2 years to 5 years	
	more than 5 years	
	never	
	don't know	1988
	When riding in a car, does (child) wear a seat belt or restraint:	
	all or most of the time	
	some of the time	
	once in a while	
	never	
	don't know	1988
	Did you smoke cigarettes at all during the year before (child) was born	1988
	Did you continue to smoke during the entire pregnancy	1988
	Did you stop during the first 3 months of the pregnancy or later	1988
	About how many cigarettes a day did you usually smoke	1988
	Do you now smoke	1988
	How long ago did you stop:	
	number of days	
	number of months	
	number of years	
	never smoked	1988
	During most of your pregnancy, would you say you were in contact with persons who smoked cigarettes such as friends, co-workers or family members:	
	occasionally	
	often	
	always	
	never	1988
	Has anyone in your household smoked regularly since (child) was born	1988
	Is anyone in the household currently smoking cigarettes	1988
	How long has it been since anyone in the household smoked cigarettes	1988
	Please tell me (interviewer) whether each of the following statements about (child's) health is mostly true or mostly false:	
	health is excellent	
	seems to resist illness very well	
	seems less healthy than other children I know when there is something going around (child)	
	usually catches it	
	is somewhat clumsy	
	seems accident-prone	
	when (child) is sick or injured, (child) usually recovers quickly	1988

Topic	Questionnaire Item	Year
Child Health (continued)		
	Has (child) ever been seriously ill	1988
	Was (child) ever so sick that you thought (child) might die	1988
	On weeknights, (if over 4, during the school year), does (child) usually go to bed at about the same time each night, or does (child's) bedtime vary a lot from night to night	1988
	About what time does (child) usually go to bed	1988
	What is the latest time that (child) goes to bed on weekdays	1988
	Does (child) usually sleep in one room or in different rooms	1988
	Does (child) usually sleep alone in a room or share a room	1988
	Who usually sleeps in the room with (child):	
	brother(s)	
	sister(s)	
	other child(ren)	
	father	
	mother	
	other adult(s)	
	anyone else	
	don't know	1988
	Has (child) ever attended school	1988
	Is (child) now either going to school or on vacation from school	1988
	What grade (is child in now/will child be in)	1988
	Overall what kind of student would you say (child) is now, is (child):	
	one of the best	
	above the middle	
	in the middle	
	below the middle	
	near the bottom	1988
	Why did (child) stop going to school:	
	never went—health reasons	
	never went—other reasons	
	graduated	
	health problem	
	dropped out	
	other (specify)	1988
	How long ago did (child) stop going to school:	
	less than 12 months	
	12 months-less than 2 years	
	2 or more years	1988
	During the past 12 months, that is, since (date) a year ago, about how many days was (child) absent from school because of illness	1988
	Has (child) repeated any grades for any reason	1988
	What grade or grades did (child) repeat	1988
	Why did (child) repeat the grade(s):	
	academic failure	
	immature/acted too young	
	frequent absence	
	moved into more difficult school	
	other (specify)	

Topic	Questionnaire item	Year
Child Health (continued)		
	any other reasons	
	don't know	1988
	Has (child) ever been suspended, excluded, or expelled from school	1988
	How many times has this happened	1988
	Was it for health or behavior reasons	1988
	Not counting routine conferences, has anyone from (child's) school ever asked someone to come in to talk about problems (child) was having	1988
	How long ago was the last time:	
	number of days	
	number of weeks	
	number of months	
	number of years	1988
	Has (child) ever had:	
	a delay in growth or development	
	a learning disability	
	an emotional or behavioral problem that lasted 3 months or more	1988
	How old was (child) when the (condition) was first noticed	1988
	Has (child) ever received treatment or counseling for the (condition)	1988
	Has (child) received any such treatment or counseling during the past 12 months	1988
	During the past 12 months, about how many times did anyone see or talk to a doctor, psychologist, or counselor about this problem	1988
	During the past 12 months, did the (condition) cause (child to miss any time from school)	1988
	On how many days in the past 12 months, did (child) miss part or all of the school day because of this problem	1988
	During the past 12 months, did the (condition) make it necessary for (child) to attend special classes, or a special school, or get special help at school	1988
	During the past 12 months, has (child) been taking any medicine for the (condition)	1988
	Has (child) ever seen a psychiatrist, psychologist, doctor, or counselor about any emotional, mental, or behavior problem	1988
	When was the last time (child) saw this person	1988
	During the past 12 months, have you felt, or has anyone suggested, that (child) needed help for any emotional, mental, or behavioral problem	1988
	How long has it been since (child's) last visit to a clinic, health center, hospital, doctor's office or other place for routine health care:	
	less than 6 months	
	6 months, less than 1 year	
	1 year, less than 2 years	
	2 years, less than 5 years	
	5 or more years	

Topic	Questionnaire item	Year
Child Health (continued)		
	don't know never	1988
	Is there a particular clinic, health center, hospital, doctor's office or other place that (child) usually goes to for routine health care	1988
	What kind of place is it:	
	clinic:	
	private	
	hospital	
	outpatient	
	company or school	
	migrant	
	some other kind of health clinic	
	health center:	
	community health center	
	neighborhood health center	
	family health center	
	walk-in/emergency clinic	
	rural health center	
	HMO/prepaid group	
	some other kind of health center	
	hospital:	
	outpatient clinic	
	emergency room	
	doctor's office or private clinic	
	other place (specify)	1988
	Is there a particular clinic, health center, hospital, doctor's office or other place that (child) usually goes to when (child) is sick or injured	1988
	Is this the same kind of place (see above list) or is it somewhere else	1988
	Is there a particular medical person (child) usually sees at the (place) when (child) is sick	1988
	Is there someone at the (place), that knows about (child's) health history who will give you advice over the telephone	1988
	Many people do not have a particular place they usually go to when they are sick. (Could you please give me (interviewer) the number of the statement) which is the main reason (child) does not have a particular place (child) usually goes:	
	has two or more usual doctors or places	
	depending on what is wrong	
	has not needed a doctor	
	previous doctor no longer available	
	have not been able to find the right doctor	
	recently moved to area	
	other reason	1988
	During the past 12 months, that is since (12-month date) a year ago, did (child) receive any health care which has been or will be paid for by Medicaid	1988
	During the past 12 months, was (child) covered at any time by Medicaid	1988

Topic	Questionnaire item	Year
Child Health (continued)		
	During the past 12 months, did (child) receive assistance through "Aid to Families with Dependent Children" program, sometimes called AFDC or ADC	1988
	Is (child) now covered by a health insurance plan which pays any part of a hospital, doctor's or surgeon's bill	1988
	Has (child) ever been enrolled in the "Head Start" program	1988
	In which "Head Start" program was (child) enrolled, the Center based or the Home based program	1988
	Please tell me (interviewer) whether each of the following statements are often true, sometime true, or not true of (child) during the past 3 months:	
	has sudden changes in mood or feelings	
	feels or complains that no one loves (child)	
	is rather high strung, tense, or nervous	
	cheats or tells lies	
	is too fearful or anxious	
	argues too much	
	has difficulty concentrating, cannot pay attention for too long	
	is easily confused, seems to be in a fog	
	bullies, or is cruel or mean to others	
	is disobedient at home	
	is disobedient at school	
	does not seem to feel sorry after (child) misbehaves	
	has trouble getting along with other children	
	has trouble getting along with teachers	
	is impulsive, or acts without thinking	
	feels worthless or inferior	
	is not liked by other children	
	has a lot of difficulty getting (child's) mind off certain thoughts, has obsessions	
	is restless or overly active, cannot sit still	
	is stubborn, sullen, or irritable	
	has a very strong temper and loses it easily	
	is unhappy, sad or depressed	
	is withdrawn, does not get involved with others	
	breaks things on purpose, deliberately destroys (child's) own or others' things	
	clings to adults	
	cries too much	
	demands a lot of attention	
	is too dependent on others	
	feels others are out to get (child)	
	hangs around with kids who get into trouble	
	is secretive, keeps things to (himself/herself)	
	worries too much	1988
	How is (name of person) related to (child)	1988
	Is (name of sibling)—full, half, adoptive, step or foster (brother/sister)	1988
	Which family member know the most about the health related matters of (child)	1988

Topic	Questionnaire item	Year
Cholesterol		
	Have you ever been told by a doctor or other health professional that you had high cholesterol	1985
Dental Care		
	Have you ever heard of dental sealants	1985
	Which of the following best describes the purpose of dental sealants:	
	to prevent gum disease	
	to prevent tooth decay	
	to hold dentures in place	1985
	Tell me (interviewer) if you think it is definitely important, probably important, probably not, or definitely not important in preventing tooth decay:	
	seeing dentist regularly	
	drinking water with fluoride from early childhood	
	regular brushing and flossing of the teeth	
	using fluoride toothpaste or fluoride mouth rinse	
	avoiding between-meal sweets	1985
	In your opinion, how important or not important is each of the following in preventing gum disease:	
	seeing dentist regularly	
	drinking water with fluoride from early childhood	
	regular brushing and flossing of the teeth	
	using fluoride toothpaste or fluoride mouth rinse	
	avoiding between-meal sweets	1985
	In your opinion which of the following is the main cause of tooth loss in children:	
	tooth decay	
	gum disease	
	injury to the teeth	1985
	In your opinion which of the following is the main cause of tooth loss in adults:	
	tooth decay	
	gum disease	
	injury to the teeth	1985
	What is the purpose of adding fluoride to the public drinking water	1986
	Does the water that you drink at home come from a public water system or another source, such as a well	1986
	Does this drinking water have fluoride in it	1986
	During the 2 weeks (outlined on calendar) did anyone in the family go to a dentist (include all types)	1986
	During those 2 weeks, how many times did person go to a dentist	1986
	During the past 12 months, how many visits did person make to a dentist	1986
	How long since last went to a dentist:	
	over 2 weeks, less than 6 months	
	6 months, less than 1 year	
	1 year, less than 2 years	
	2 years, less than 5 years	

Topic	Questionnaire Item	Year
Dental Care (continued)		
	5 years or more never	1986
	What was the main reason person last went to the dentist: went in on own for check-up, examination, or cleaning was called in by the dentist for check-up, examination, or cleaning something was wrong, bothering, or hurting went for treatment of a condition that dentist discovered at earlier check-up or examination other (specify) don't know	1986
	Anyone in family lost all of his or her natural teeth	1986
	What does person use when brushing teeth, toothpaste, tooth powder, or something else	1986
	What brand did persons use most often during the past 2 weeks	1986
	Anyone in family now use a fluoride mouthrinse at home	1986
	What brand did person use most often in the past 2 weeks	1986
	Does person now take part in a fluoride mouthrinse program at school	1986, 1989
	Does anyone in the family now take vitamins with fluoride in them or any other kind of fluoride drops, pills, or tablets at home or school	1986
	Anyone in family had dental sealants placed on their teeth	1986
	During those 2 weeks did anyone in the family go to a dentist (include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists)	1989
	Who was this	1989
	During those 2 weeks, did anyone else in the family go to a dentist	1989
	During those 2 weeks, how many times did (name) go to a dentist	1989
	During the past 12 months (that is, since (12-month date) a year ago), about how many visits did (name) make to a dentist (include the number of visits you already told me about)	1989
	About how long has it been since (name) last went to a dentist: 2 weeks over 2 weeks, less than 6 months 6 months, less than 1 year 1 year, less than 2 years 2 years, less than 5 years 5 years or more never	1989
	What are the reasons (name) has (not visited the dentist in over 12 months/never gone to the dentist): afraid nervous needles cost don't know dentist dentist too far	

Topic	Questionnaire item	Year
Dental Care (continued)		
	can't get there	
	no problems	
	no teeth	
	not important	
	didn't think of it	
	other (specify)	
	don't know	1989
	Is there anyone in the family who has lost all of upper (permanent) natural teeth	1989
	Who is this	1989
	Does (name) have an upper denture or plate	1989
	Is there anyone in the family who has lost all of his or her lower (permanent) natural teeth	1989
	Who is this	1989
	Does (name) have a lower denture or plate	1989
	Dental sealants are special plastic coatings that are painted on the tops of the back teeth to prevent tooth decay, they are different from fillings, caps, crowns, and fluoride treatments, has anyone in the family ever had dental sealants painted on their teeth	1989
	Who is this	1989
	In the past 2 weeks has anyone in the family used a mouthwash or mouthrinse at home	1989
	Who is this	1989
	What brand did (name) use most often during the past 2 weeks:	
	Act	
	Flurigard	
	Kolynos	
	Listermint	
	Reach	
	StanCare	
	Prescription fluoride rinse	
	PLAX	
	Scope, Listerine, Lavioris	
	other (specify)	
	don't know	1989
	Does this mouthrinse contain fluoride	1989
	Does (name) now take vitamins with fluoride in them or any other kind of fluoride tablets, drops, or supplements	1989
	During the 2-week period, did anyone in the family miss any time from work or school because of a dental problem or dental visit	1989
	Who was this	1989
	How much time did (name) miss because of a dental problem or dental visit:	
	less than 1 hour	
	1 hour, less than 3 hours	
	3 hours, less than 5 hours	

Topic	Questionnaire item	Year
Dental Care (continued)		
	5 hours, less than 7 hours 7 hours or more	1989
	During that 2-week period, did anyone in the family miss any time from work or school to assist a relative or friend with a dental problem or dental visit	1989
	Who was this	1989
	How much time did (name) miss because (name) was assisting a relative or friend with a dental problem or visit:	
	less than 1 hour	
	1 hour, less than 3 hours	
	3 hours, less than 5 hours	
	5 hours, less than 7 hours	
	7 hours or more	1989
	Was there any (other) time during those 2 weeks	1989
	Did anyone in the family cut down on normal activities for more than half of the day because of a dental problem or dental visit	1989
	Who was this	1989
	During that period, how many (other) days did (name) cut down for more than half of the day because of a dental problem or dental visit	1989
Diabetes		
	Do you now have diabetes or sugar diabetes	1985
	Has any adult in this family ever been told by a doctor that they had diabetes (do not include pre, potential, or borderline diabetes)	1989
	Who is this	1989
	Has any other adult in this family been told they have diabetes (do not include pre, potential, or borderline diabetes)	1989
	How old were you when you got diabetes (do not include pre, potential, or borderline diabetes)	1989
	Are you now diabetic	1989
	When you first learned that you might have diabetes , were you sick or feeling diabetic symptoms, or was the diabetes discovered by chance	1989
	Were you at:	
	doctor's office	
	patient in hospital	
	somewhere else	
	don't know	1989
	Was the diabetes discovered while getting:	
	routine physical	
	screening test for diabetes	
	treated for something else	
	other	
	don't know	1989

Topic	Questionnaire item	Year
Diabetes (continued)		
	When your diabetes was first diagnosed, did you have:	
	blood test	
	urine test	
	both	
	don't know	1989
	Was the blood test an oral glucose tolerance test	1989
	Were you pregnant when you were first told that you had diabetes	1989
	Other than during pregnancy, did a doctor ever tell you that you had diabetes	1989
	Are you now taking insulin	1989
	For how long have you been taking insulin:	
	less than 1 month	
	number of months	
	number of years	
	don't know	1989
	Currently, about how often do you use insulin:	
	times per day	
	times per week	
	use insulin pump	
	don't know	1989
	On an average day, about how many units of insulin do you take	1989
	Have you ever used an insulin pump	1989
	Are you now taking diabetes pills to lower your blood sugar	1989
	For how long have you been taking them:	
	less than 1 month	
	number of months	
	number of years	
	don't know	1989
	About how often do you take them:	
	times per day	
	times per week	
	don't know	1989
	Has a doctor or other health professional ever given you a diet or instructions on what foods you should eat as a diabetic	1989
	In the past 12 months, have you tried to follow the diet or instructions	1989
	In the past 12 months, about how often have you been able to follow the diet or instructions:	
	always	
	most of the time	
	some of the time	
	rarely	
	never	
	don't know	1989
	Is it difficult for you to stay on your diet:	
	when you eat in restaurants	
	when you go to parties or social events	
	when you are busy with other activities	
	when you go on a trip	

Topic	Questionnaire item	Year
Diabetes (continued)		
	when you are feeling upset or angry	
	when you are feeling sad, depressed, or blue	
	when you are feeling bored	1989
	Do you (also) find it difficult to stay on your diet:	
	because foods you should eat do not taste good	
	because you crave foods not on your diet	
	because you have to prepare food separately for yourself	
	because of lack of help or support from your family or friends	
	because you are unsure about what foods you should eat	1989
	How important do you think what you eat or drink is in controlling your diabetes:	
	very important	
	somewhat important	
	not important	
	don't know	1989
	Is there one doctor you usually see for your diabetes	1989
	How many times have you seen this doctor in the past 12 months	1989
	Which of the following did you see in the past 12 months for any reason:	
	a cardiologist or heart doctor	
	an ophthalmologist, that is, a medical doctor who specializes in eye care	
	an obstetrician or gynecologist	
	a podiatrist or foot doctor	
	a psychologist or psychiatrist	
	a dietitian or nutritionist	
	any other medical doctor (specify)	1989
	About how many times in the past 6 months has a health professional checked your urine for glucose or sugar (do not count times when an overnight patient in the hospital)	1989
	On your own, about how often do you check your urine for glucose or sugar (include times when checked by a family member or friend):	
	never	
	number of times per day	
	number of times per week	
	number of times per month	
	number of times per year	
	don't know	1989
	Based on all your urine tests during the past 6 months, how often would you say you have had glucose or sugar in your urine:	
	always	
	most of the time	
	some of the time	
	rarely	
	never	
	don't know	1989
	Have you been tested for ketones in the past 6 months	1989
	Were any of these tests positive	1989

Topic	Questionnaire item	Year
Diabetes (continued)		
	About how many times in the past 6 months has a health professional checked your blood for glucose or sugar (do not count times when an overnight patient in a hospital)	1989
	On your own, about how often do you check your blood for glucose or sugar (include times when checked by a family member or friend): never number of times per day number of times per week number of times per month number of times per year don't know	1989
	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 : always most of the time some of the time rarely never don't know	1989
	Have you ever heard of glycosylated hemoglobin or hemoglobin "A one C"	1989
	About how many times in the past 6 months has a doctor, nurse, or other health professional checked you for glycosylated hemoglobin "A one C"	1989
	About how many times in the past 6 months has a health professional checked your feet for any sores or irritations	1989
	About how often do you check your feet for sores or irritations : never number of times per day number of times per week number of times per month don't know	1989
	During the past 6 months have you had any sores or irritations on your feet or ankles that did not heal normally	1989
	When was the last time you had an eye exam in which the pupils were dilated (this would have made you temporarily sensitive to bright light): less than 1 month 1 to 12 months 13 to 24 months more than 2 years never don't know	1989
	Have you had any kind of eye exam by a doctor within the past 2 years	1989
	Have you had any kind of eye exam by a doctor within the past 12 months	1989

Topic	Questionnaire item	Year
Diabetes (continued)		
	Have you ever been told that diabetes has affected the back of your eyes, that is, the retina	1989
	How old were you when the doctor first told you this	1989
	Have you ever had laser or photocoagulation treatment for this problem (do not include treatment for cataracts)	1989
	Did you receive this treatment within the past 12 months	1989
	Was this the first time you had this treatment	1989
	Have you ever had photographs taken of the retina or inside of your eyes	1989
	Do you have serious trouble seeing with one or both eyes even when wearing glasses	1989
	About how many times in the past 12 months has a doctor or other health professional checked your blood pressure (do not count times when an overnight patient in a hospital)	1989
	Has a doctor ever told you that you had high blood pressure or hypertension	1989
	Are you doing any of the following (for your/to prevent) high blood pressure: taking prescribed medication losing weight or controlling weight cutting down on salt or sodium getting physical activity or exercise	1989
	The last time you had your blood pressure checked, were you told it was: high borderline low normal were you not told	1989
	Has a doctor ever told you that you had: glaucoma angina any other heart trouble a stroke cataracts protein or albumin in your urine periodontal or gum disease	1989
	Are you now taking any medication for any of these (glaucoma, angina, other heart trouble)	1989
	Has a doctor ever told you that you had: protein or albumin in your urine kidney disease (do not include kidney stone or bladder infection) polycystic kidney disease periodontal or gum disease	1989
	Not counting times while an overnight patient in a hospital, about how many times in the past 12 months has a doctor or other health professional: checked you for diabetes checked your blood pressure	1989

Topic	Questionnaire item	Year
Diabetes (continued)		
	About how many different times in the past 12 months have you had a bladder or urinary tract infection	1989
	Have you ever had symptoms of a bladder infection that lasted more than 3 months, such as frequent urination and pain in your bladder	1989
	When you had these symptoms, were you told that you had painful bladder syndrome or interstitial cystitis	1989
	How old were you when you first told that you had painful bladder syndrome or interstitial cystitis	1989
	When you urinate: do you usually have trouble starting do you usually feel like you have not completely emptied your bladder	1989
	Do you usually have to get up at night to go to the bathroom to urinate (exclude nights when you drink a lot of liquids)	1989
	About how many times each night do you have to get up	1989
	During the past 3 months have you had: numbness or loss of feeling in your hands or feet other than from your hands or feet falling asleep a painful sensation or tingling in your hands or feet (do not include normal foot aches from standing or walking for long periods) decreased ability to feel hot or cold in things you touch	1989
	Have you tried to lose weight in the past year	1989
	Is your weight now more, less, or about the same as a year ago	1989
	In the past year, about how much weight have you (gained/lost)	1989
	About how much did you weigh when you were 25 years old (if pregnant, weight just before becoming pregnant)	1989
	What is the most you have ever weighed (except when you were pregnant)	1989
	About how old were you when you first weighed that much	1989
	Do you have serious trouble seeing with one or both eyes even when wearing glasses	1989
	Where have you obtained information about diabetes: nowhere doctor's office—doctor doctor's office—nurse dietitian or nutritionist doctor or nurse in a hospital relative or friend another diabetic health department diabetes organization National Diabetes Information Clearinghouse diabetes support group library newspapers diabetes education class other (specify)	1989

Diabetes (continued)

Which three of these sources have provided you with the most useful information about diabetes:		
doctor's office—doctor		
doctor's office—nurse		
dietitian or nutritionist		
doctor or nurse in a hospital		
relative or friend		
another diabetic		
health department		
diabetes organization		
National Diabetes Information Clearinghouse		
diabetes support group		
library		
newspapers		
diabetes education class		
other (specify)		1989
Have you ever taken a course or class in how to manage your diabetes yourself		1989
About how many hours of instruction did you receive on how to manage your diabetes		1989
Did this course include any of the following subjects:		
how to inject insulin		
how to change the insulin dose		
how to manage your diabetes when you are sick		
how to test your blood or urine for sugar		
how to plan meals		
how to take care of your feet		1989
Have you ever attended any (other) education program or class about your diabetes		1989
Were either of your parents ever told that they had diabetes (do not include pre, potential, or borderline diabetes or step, adoptive, or foster parents) Which one		1989
How many children have you had, including any that may have died (do not include step, adoptive, or foster children/stillbirths or miscarriages)		1989

Digestive Disorders (see also Abdominal Pain)

During the past 12 months, did you have gallstones		1989
During the past 12 months, did you have any other gallbladder trouble		1989
Have you ever had gallstones		1989
Have you ever had any other gallbladder trouble		1989
When did a doctor first tell you that you had (gallstones/gallbladder trouble):		
less than 3 months ago		
3 months, less than 1 year		
1 year, less than 2 years		
2 years, less than 5 years		
5 years, less than 10 years		
10 years or more		

Topic	Questionnaire item	Year
Digestive Disorders (continued)		
	doctor never seen	
	don't know when	1989
	Have you ever had gallbladder surgery	1989
	When did you last have gallbladder surgery:	
	less than 3 months ago	
	3 months, less than 1 year	
	1 year, less than 2 years	
	2 years, less than 5 years	
	5 years, less than 10 years	
	10 years or more	
	don't know when	1989
	Have you ever had any of the following tests to help diagnose your (gallstones/gallbladder) condition:	
	an X-ray of your gallbladder or abdomen	
	a sonogram or ultrasound of your gallbladder	
	an upper GI series	1989
	During the past 12 months, did you have an ulcer	1989
	Have you ever had an ulcer	1989
	When did a doctor first tell you that you had an ulcer:	
	less than 3 months ago	
	3 months, less than 1 year	
	1 year, less than 2 years	
	2 years, less than 5 years	
	5 years, less than 10 years	
	10 years or more	
	doctor never seen	
	don't know when	1989
	Did the doctor say you had a gastric, duodenal, or peptic ulcer, some other type, or were you not told:	
	skin	
	gastric	
	duodenal	
	peptic	
	stomach	
	not told	
	other (specify)	
	don't know	1989
	Have you ever had any of the following tests to help diagnose your ulcer:	
	an upper GI series	
	an upper endoscopy or gastroscopy	1989
	During the past 12 months, did you have diverticulitis	1989
	Have you ever had diverticulitis	1989
	When did a doctor first tell you that you had diverticulitis:	
	less than 3 months ago	
	3 months, less than 1 year	
	1 year, less than 2 years	
	2 years, less than 5 years	
	5 years, less than 10 years	
	10 years or more	
	doctor never seen	
	don't know when	1989

Topic	Questionnaire item	Year
Digestive Disorders (continued)		
	Have you ever been in the hospital overnight for diverticulitis	1989
	When were you last in the hospital overnight for diverticulitis:	
	less than 3 months ago	
	3 months, less than 1 year	
	1 year, less than 2 years	
	2 years, less than 5 years	
	5 years, less than 10 years	
	10 years or more	
	don't know when	1989
	Have you ever had a barium enema to help diagnose your diverticulitis	1989
	During the past 12 months, have you had a spastic colon, functional bowel, irritable colon or irritable bowel syndrome	1989
	Which one:	
	spastic colon	
	functional bowel	
	irritable colon	
	irritable bowel syndrome	
	other similar condition mentioned (specify)	1989
	Have you ever had:	
	spastic colon	
	functional bowel	
	irritable colon	
	irritable bowel syndrome	
	other similar condition mentioned (specify)	1989
	Which one:	
	spastic colon	
	functional bowel	
	irritable colon	
	irritable bowel syndrome	
	other similar condition mentioned (specify)	1989
	When did a doctor first tell you that you had (condition):	
	less than 3 months ago	
	3 months, less than 1 year	
	1 year, less than 2 years	
	2 years, less than 5 years	
	5 years, less than 10 years	
	10 years or more	
	doctor never seen	
	don't know when	1989
	Have you had hemorrhoids in the past 12 months	1989
	Has a doctor ever told you that you had hemorrhoids	1989
	When did you last talk to a doctor about your hemorrhoids:	
	less than 3 months ago	
	3 months, less than 1 year	
	1 year, less than 2 years	
	2 years, less than 5 years	
	5 years, less than 10 years	

Topic	Questionnaire item	Year
<u>Digestive Disorders (continued)</u>		
	10 years or more doctor never seen don't know when	1989
	Have you ever had surgery in a doctor's office, clinic, or hospital for hemorrhoids	1989
<u>Doctor Visit (see Usual Source of Care)</u>		
	Is there one particular doctor you usually see	1985
	When visiting a doctor or other health professional for routine care, are proper foods discussed:	
	often	
	sometimes	
	rarely	
	never	1985
<u>Drinking (see also Alcohol)</u>		
	Tell me (interviewer) if you think heavy alcohol drinking definitely increases, probably increases, probably does not, or definitely does not increase a person's chances of getting the following problems:	
	throat cancer	
	cirrhosis of the liver	
	bladder cancer	
	cancer of the mouth	
	arthritis	
	blood clots	1985
	Have you had at least one drink of beer, wine, or liquor during the past year	1985
	What is your main reason for not drinking (in the past year):	
	no need/not necessary	
	don't care for/dislike it	
	medical/health reasons	
	religious/moral reasons	
	brought up not to drink	
	costs too much	
	family member an alcoholic or problem drinker	
	infrequent drinker	
	other (specify)	1985
	In the past 2 weeks beginning Monday and ending this past Sunday, on how many days did you drink any alcoholic beverages, such as beer, wine, or liquor	1985
	On the days that you drank alcoholic beverages, how many drinks did you have per day, on the average	1985
	Was the amount of your drinking during that 2-week period typical of your drinking during the past 12 months	1985
	Was the amount of your drinking during that 2-week period more or less than your drinking during the past 12 months	1985

Topic	Questionnaire item	Year
<u>Drinking (continued)</u>		
	During the past 12 months , in how many months did you have at least one drink of any alcoholic beverage	1985
	During (that month/those months) on how many days did you have 9 or more drinks of any alcoholic beverage	1985
	During (that month/those months) on how many days did you have 5 or more drinks of any alcoholic beverage	1985
	During the past year, how many times did you drive when you had perhaps too much to drink	1985
	Do you think heavy alcohol drinking definitely increases, probably increases, probably does not, or definitely does not increase a person's chances of getting the following problems: throat cancer cirrhosis of the liver bladder cancer cancer of the mouth arthritis blood clots	1985
	Does heavy drinking during pregnancy definitely increase, probably increase, probably not, or definitely not increase the chances of: miscarriage mental retardation of the newborn low birth weight of the newborn birth defects	1985
	Have you ever heard of Fetal Alcohol Syndrome	1985
	In your opinion, which one of the following best describes Fetal Alcohol Syndrome: a baby is born drunk born addicted to alcohol born with certain birth defects	1985
<u>Eating Habits (see also Cancer)</u>		
	How often do you eat breakfast: almost every day sometimes rarely never	1985
	How often do you eat between meals: almost every day sometimes rarely never	1985
	When you visit a doctor or other health professional is eating proper foods discussed: often sometimes rarely or never don't visit for routine care	1985

Topic	Questionnaire item	Year
Emotional/Personal Problems (see also Cancer and Mental Health)		
	In the past year, did you think about seeking help for any personal or emotional problems from family or friends	1985
	In the past year, did you think about seeking help for any personal or emotional problems from a helping professional or a self-help group	1985
	Did you actually seek any help (for emotional problems)	1985
	From whom did you seek help (for emotional problems):	
	family member or relative	
	friend	
	psychologist	
	psychiatrist	
	psychiatric social worker	
	other mental health professional	
	medical doctor	
	religious counselor	
	Alcoholics Anonymous	
	Gamblers Anonymous	
	Weight Watchers	
	counselor at work	
	counselor at school	
	probation officer	
	other (specify)	1985
Employment (see also Work Injuries and Work Risk)		
	The kind of work you have done the longest, not counting work around the house. What kind of work did you do the longest (include work done while in the Armed Forces)	1986, 1988
	When you were doing this kind of work, what were your most important activities or duties	1988
	How long did you do this kind of work	1986, 1988
	How old were you when you started doing this kind of work	1988
	In what kind of business or industry did you do this kind of work the longest, were you:	
	an employee of a private company, business or individual for wages, salary, or commission	
	a member of the Armed Forces	
	a Federal government employee	
	a State government employee	
	a local government employee	
	self-employed in own business, professional practice or farm	
	working without pay in family business or farm	1986, 1988
	Was the worker's compensation claim for your injury awarded, denied, or is it still in process	1988
	Was the worker's compensation claim for your skin condition awarded, denied, or is it still in process	1988

Topic	Questionnaire Item	Year
Employment (continued)		
Was the worker's compensation claim for your condition awarded, denied, or is it still in process	1988	
In the industry where you worked the longest as a (name of occupation) were you:		
an employee of a private company, business or individual for wages, salary, or commission		
a member of the Armed Forces		
a Federal government employee		
a State government employee		
a local government employee		
self-employed in own business, professional practice or farm		
is the business incorporated		
working without pay in family business or farm	1988	
During the past 12 months, that is, since (12-month date) a year ago, did you work at any time at a job or business, not counting work around the house (include unpaid work in the family business or farm)	1988	
How long has it been since you last worked at a job or business:		
number of weeks		
number of months		
number of years	1988	
For whom did you work at your last job or business	1988	
What kind of business or industry is this	1988	
What kind of work were you doing	1988	
What were your most important activities or duties at that job	1988	
Were you:		
an employee of a private company, business or individual for wages, salary, or commission		
a member of the Armed Forces		
a Federal government employee		
a State government employee		
a local government employee		
self-employed in own business, professional practice or farm		
is business incorporated		
working without pay in family business or farm	1988	
How long did you work as a (name of occupation) for (name of employer):		
number of weeks		
number of months		
number of years	1988	
Considering all of your employers, for how many years altogether did you do this kind of work	1988	
Which of these statements describe the reason or reasons you stopped working:		
stopped working because of own illness, injury, disability or other health problem that was job-related		
stopped working because of own illness, injury, disability or other health problem that was not job-related		
retired		
child/family care		

Topic	Questionnaire item	Year
Employment (continued)		
	on layoff from job	
	some other reason (specify)	
	don't know	1988
	Was a worker's compensation claim filed for your illness, injury, disability, or other health problem	1988
	Have you received any money or other benefits from worker's compensation since you stopped working (number of weeks, months, years) ago	1988
	Was a claim filed for any other income or benefits because your health problem was job-related	1988
	Earlier I was told that you had a job during the 2 weeks (outlined on the calendar/beginning Monday (date) and ending Sunday (date)). For whom did you work	1988
Exercise		
	In the past 2 weeks beginning Monday (date) and ending this past Sunday (date), have you done any (of the following exercises, sports, or physically active hobbies):	
	walking for exercise	
	jogging or running	
	hiking	
	gardening or yard work	
	aerobics or aerobic dancing	
	other dancing	
	calisthenics or general exercise	
	golf	
	tennis	
	bowling	
	biking	
	swimming or water exercises	
	yoga	
	weight lifting or training	
	basketball	
	baseball or softball	
	football	
	soccer	
	volleyball	
	handball, racquetball, or squash	
	skating	
	skiing	1985
	Have you done any other exercises, sports, or physically active hobbies in the past 2 weeks	1985
	In the past 2 weeks beginning Monday (date) and ending this past Sunday (date), have you done any exercises, sports, or physically active hobbies	1985
	What were the (exercises, sports, or physically active hobbies)	1985
	Knowledge of strengthening heart and lungs through exercise	1985
	How many days a week do you think a person should exercise to strengthen the heart and lungs	1985
	For how many minutes do you think a person should exercise on each occasion so that the heart and lungs are strengthened	1985

Topic	Questionnaire item	Year
Exercise (continued)		
	During those minutes (of exercise), how fast do you think a person's heart rate and breathing should be to strengthen the heart and lungs	1985
	Do you think that the heart and breathing rate (for exercise) should be: no faster than usual a little faster than usual a lot faster but talking is possible so fast that talking is not possible don't know	1985
	Do you exercise or play sports regularly	1985
	For how long have you exercised or played sports regularly: number of days number of weeks number of months number of years	1985
	How much hard physical work is required on your job: a great deal a moderate amount a little none	1985
	About how many hours per day do you perform hard physical work on your job	1985
	How much hard physical work is required in your main daily activity: a great deal a moderate amount a little none	1985
Functional Limitations		
	Because of a health or physical problem, do you have any difficulty (by yourself and without using special equipment): bathing or showering dressing eating getting in and out of bed or chairs walking getting outside using the toilet, including getting to the toilet	1986
	If doesn't do activity listed above, is it because of a health or physical problem	1986
	By yourself and without using special equipment, how much difficulty do you have (in activity): some a lot unable	1986
	Do you receive help from anyone in (activity)	1986
	Who gives this help:	

Topic	Questionnaire item	Year
Functional Limitations (continued)		
	household member	
	relative	
	nonrelative	
	non-household member	
	relative	
	nonrelative	1986
	Is this help paid for	1986
	Which helpers are paid	1986
	Do you use any special equipment or aids in (activity)	1986
	What special equipment or aids do you use	1986
	Do you have difficulty controlling your bowels	1986
	How frequently do you have this difficulty:	
	daily	
	several times a week	
	once a week	
	less than once a week	
	don't know	1986
	Do you have a colostomy or a device to help control	
	bowel movements	1986
	Do you need help from anyone in taking care of this device	1986
	Do you have difficulty controlling urination	1986
	How frequently do you have this difficulty:	
	daily	
	several times a week	
	once a week	
	less than once a week	
	don't know	1986
	Do you have a urinary catheter or a device to	
	help control urination	1986
	Do you need help from anyone in taking care of this device	1986
	Because of a health or physical problem, do you usually:	
	stay in bed all or most of the time	
	stay in a chair all or most of the time	1986
	Because of a health or physical problem, do you	
	have any difficulty:	
	preparing your own meals	
	shopping for personal items (such as	
	toilet items or medicines)	
	managing your money (such as keeping	
	track of expenses or paying bills)	
	using the telephone	
	doing heavy housework (such as scrubbing	
	floors or washing windows)	
	doing light housework (such as doing dishes,	
	straightening up, or light cleaning)	1986
	If doesn't do activity listed above, is this because	
	of a health or physical problem	1986
	By yourself and without using special equipment,	
	how much difficulty do you have (in activity):	
	some	
	a lot	
	unable	1986

Topic	Questionnaire item	Year
Functional Limitations (continued)		
	Do you receive help from anyone in (activity)	1986
	Who gives this help:	
	household member	
	relative	
	nonrelative	
	non-household member	
	relative	
	nonrelative	1986
	Is this help paid for	1986
	Which helpers are paid	1986
	Is it necessary to go up or down a step to get into this (house/apartment) from the outside:	
	1 step	
	more than 1 step	1986
	Counting basements and stepdown living areas as separate levels, does this (house/apartment) have more than one floor or level	1986
	Does this (house/apartment) have a bathroom, bedroom, and kitchen all on the same floor or level	1986
	Does this (house/apartment) have a walk-in shower, that is, where you don't step over the side of the tub to get into the shower	1986
	Because of a health or physical problem do you need a bathroom, bedroom, and kitchen all on the same floor or level	1986
	Because of a health or physical problem do you need a walk-in shower	1986
Health Insurance/Health Care Coverage		
	Now covered by the part of Social Security Medicare which pays for hospital bills	1986, 1989
	Now covered by that part of Medicare which pays for doctor bills	1986, 1989
	Social Security Medicare card (s) seen to determine type of coverage	1986
	Now covered by health insurance plan which pays for any part of a hospital, doctor's, surgeon's, or dentist's bill	1986, 1989
	Is plan a Health Maintenance Organization (HMO)	1986, 1989
	Was plan (HMO) obtained through an employer or union	1986, 1989
	Is (HMO) plan now carried through an employer or union	1986, 1989
	Does plan (HMO) pay any part of a hospital expense	1986, 1989
	Does this plan (HMO) pay any part of doctor's or surgeon's bills for operations	1986, 1989
	Does plan (HMO) pay for any dental services other than oral surgery	1986, 1989
	Who is covered under this plan (HMO)	1986, 1989
	Main reason not covered by health insurance (or Medicare)	1986
	Is anyone in this family, that is (read names), now covered by Medicare	1986, 1989

Topic	Questionnaire item	Year
Health Insurance/Health Care Coverage (continued)		
	Is (names) now covered	1986, 1989
	May I please see the Social Security Medicare card(s) for (names) to determine the type of coverage and to record the health insurance claim number	1989
	It's important that we have the complete and accurate name of your health insurance plan . What is the complete name of the plan	1986, 1989
	Is anyone in the family now covered by any other health insurance plan (again, do not include plans that pay for only one service)	1986, 1989
	Does it pay for any prescription drugs other than those administered during a hospital stay	1989
	Does it pay for any mental health , alcoholism, or drug abuse services	1989
	Is anyone in the family now covered by an insurance plan that pays for only one type of health care service , such as nursing, home care, eye care, or prescriptions	1989
	Is (name) covered by this type of plan	1989
	What type of service does (name) plan pay for: prescriptions eyecare cancer treatment catastrophic nursing home care accidents dental care other (specify)	1989
	Is (name) now covered by any other insurance plan that pays for only one service	1989
	Which of these statements describes why (name) is not covered by any health insurance (or Medicare) : job layoff, job loss, or any reasons related to unemployment can't obtain insurance because of poor health, illness, or age too expensive, can't afford health insurance dissatisfied with previous insurance don't believe in insurance have been healthy, not much sickness in the family, haven't needed health insurance covered by some other health plan some other reason	1989
	What is the main reason (name) is not covered by any health insurance (or Medicare)	1989
	Does anyone in the family now receive assistance through the "Aid to Families with Dependent Children" program, sometimes called "AFDC" or "ADC"	1986, 1989
	Does (name) now receive AFDC or ADC	1989
	Does anyone in the family now receive the "Supplemental Security Income" or "SSI" check	1986, 1989
	Does (name) now receive this check	1989

Topic	Questionnaire item	Year
Health Insurance/Health Care Coverage (continued)		
	During the past 12 months, has anyone in this family received health care which has been or will be paid for by Medicaid	1989
	Has (name) received this care in the past 12 months	1989
	Does anyone in the family now have a Medicaid card	1989
	Does (name) now have this card	1989
	May I please see (name(s)) card(s)	1989
	Is anyone in the family now covered by any other public assistance program that pays for health care	1986, 1989
	Is (name) now covered	1989
	Is anyone in this family now covered by health care benefits from the Armed Forces or Veterans' Administration	1989
	Does anyone in the family now receive military retirement payments from any branch of the Armed Forces or a pension from the Veterans' Administration (do not include VA disability compensation)	1986, 1989
	Does (name) now receive military retirement or a VA pension	1989
	Which does (name) receive: The Armed Forces retirement, the VA pension, or both	1989
	Is anyone in the family now covered by CHAMPUS, which is a program of medical care for dependents of military personnel	1986, 1989
	Is (name) now covered by CHAMPUS	1986, 1989
	Is anyone in the family now covered by CHAMP-VA, which is medical insurance for dependents or survivors of disabled veterans	1986, 1989
	Is (name) now covered by CHAMP-VA	1986, 1989
	Is anyone in the family now covered by any other program that provides health care for military dependents or survivors of military persons	1986, 1989
	Is (name) now covered	1986, 1989
	Does (name) have a disability related to (name's) service in the Armed Forces of the United States	1986, 1989
	Does (name) now receive compensation for this disability from the Veterans' Administration	1986, 1989
	Has (name) ever applied for a service-connected disability rating from the Veterans' Administration	1986, 1989
	Was it approved or denied	1986, 1989
	During the past 12 months, that is since (12-month date) a year ago, have (names) been laid off from a job or lost a job	1986, 1989
	Who was this	1986, 1989
	How many times has (name) been laid off or lost a job during the past 12 months	1986, 1989
	In what month and year was (name) laid off or did (name) lose a job (the last time/the time before that)	1986, 1989
	For any time during that/those job layoff(s) or job loss(es), did (name) receive unemployment insurance benefits	1986, 1989

Topic	Questionnaire item	Year
Health Insurance/Health Care Coverage (continued)		
	Because of (name(s)) job layoff(s) or job loss(es), did anyone in the family lose any health insurance coverage that had been carried through that/those job(s)	1986, 1989
	Who was this	1986, 1989
	Was (name) covered by some other health insurance plan at any time during that/those job layoff(s) or job loss(es) (do not count military insurance or health programs such as Medicaid or AFDC)	1989
	Was (name) covered by another plan for the entire time (name(s)) was/were off work	1989
	For how long was (name) not covered by any kind of health insurance plan	1986, 1989
	At any time during that/those job layoff(s) or job loss(es), was (name) covered by a military program or by a health program such as Medicaid or AFDC	1986, 1989
	For how long was (name) covered by this kind of program	1986, 1989
	Does the employer or union pay any part of the cost for this (name) plan	1989
	Does the employer or union pay for all or just part of the cost	1989
	In whose name is the (name) plan	1989
Health Insurance (Conducted only in California)		
	Female respondents (15–45 years of age) have health care coverage for prenatal care	1989
	Children respondents (under 15 years of age) have health care coverage for check-ups, that is visits when not sick	1989
	Place respondent goes to when in need of professional medical care	1989
	Kind of place respondent goes to for professional medical care:	
	doctor's office or private clinic	
	company or school clinic	
	community/neighborhood, or migrant/rural clinic	
	county clinic	
	private hospital clinic or emergency room	
	county hospital clinic or emergency room	
	other hospital clinic or emergency room	
	HMO/prepaid group	
	some other place (specify)	1989
	Particular person respondent usually sees when respondent goes there	1989
	During past 12 months, did respondent need or thought he/she needed medical care or surgery but did not get it	1989
	The last time this happened, what was the main reason respondent didn't get medical care: could not afford it	

Topic	Questionnaire item	Year
Health Insurance (Conducted only in California) (continued)		
	no insurance	
	not serious enough	
	wait too long in clinic/office	
	difficulty getting an appointment	
	don't like/trust/believe in doctors	
	didn't know where to go	
	no way to get there	
	hours not convenient	
	other reason (specify)	1989
	Was lack of insurance or lack of money a reason why respondent didn't get medical care respondent needed	1989
	Was respondent self-employed at job worked at during past 2 weeks	1989
	How many hours per week respondent worked at job during past 2 weeks	1989
	How long respondent worked at current job:	
	number of weeks	
	number of months	
	number of years	
	don't know	1989
	Is respondent paid by the hour at current job	1989
	How much respondent earns per hour	1989
	How much does respondent usually earn per week at this job before deductions	1989
	At respondent's work place, are there:	
	fewer than 25 full and part-time employees	
	less than 10 or 10 to 24 full and part-time employees	
	less than 50, 50 to 99, or 100 or more full and part-time employees	1989
	Respondent employer has additional employees working in other locations	1989
	(Asked only of sample persons)	
	Has sample person heard or read about large number of people without health insurance	1989
	Has sample person heard or read about proposals to deal with issue of people who don't have health insurance	1989
	Does sample person believe government should give tax breaks to encourage employers to provide health insurance to their employees:	
	strongly favor	
	somewhat favor	
	somewhat oppose	
	strongly oppose	
	no opinion/don't know	1989
	Does sample person believe government should require employer to provide health insurance to all employees who work full or part-time:	
	strongly favor	
	somewhat favor	
	somewhat oppose	

Topic	Questionnaire item	Year
Health Insurance (Conducted only in California) (continued)		
	strongly oppose no opinion/don't know	1989
	Does sample person believe that government should develop some form of national health insurance that would cover everyone:	
	strongly favor somewhat favor somewhat oppose strongly oppose no opinion/don't know	1989
	Does sample person believe that government should develop health insurance for people who are uninsured:	
	strongly favor somewhat favor somewhat oppose strongly oppose no opinion/don't know	1989
Heart Disease		
	Do you have any kind of heart condition or heart trouble	1985
	List of things which may or may not affect a person's chances of getting heart disease. Tell me (interviewer) if you think it definitely increases, probably increases, probably does not or definitely does not increase a person's chances of getting heart disease:	
	cigarette smoking worry or anxiety high blood pressure diabetes being very overweight overworked drinking coffee with caffeine eating a diet high in animal fat family history of heart disease	1985
Height and Weight (see also Cancer)		
	About how much do you weigh without shoes	1985
	In your opinion which of these are the two best ways to lose weight:	
	don't eat at bedtime eat fewer calories take diet pills increase physical activity eat no fat eat grapefruit with each meal	1985
	Are you now trying to lose weight	1985
	Are you eating fewer calories to lose weight	1985
	Have you increased your physical activity to lose weight	1985
	Do you consider yourself overweight, underweight, or just about right	1985

Topic	Questionnaire item	Year
<u>Height/Weight (continued)</u>		
	Could you say you are very overweight, somewhat overweight, or only a little overweight	1985
<u>Hot Water Temperature</u>		
	Do you know about what the hot water temperature is in this home	1985
	About what temperature is the hot water	1985
	How did you estimate the hot water temperature: the setting on the hot water heater tested with thermometer guessed other (specify)	1985
	In the past 12 months, have you (or has anyone in your household) used a thermometer to test the temperature of the hot water here	1985
	About what temperature will hot water cause scald injuries	1985
<u>Immunization</u>		
	During the past 12 months, that is, since (12-month date) a year ago, have any adults in this family received a flu shot	1989
	Who was this	1989
	Have any adults in the family ever received a pneumonia vaccination	1989
	Who was this	1989
	Did (name) receive the pneumonia shot within the past 12 months	1989
	During the past 5 years, have any adults in the family had a tetanus shot	1989
	Who was this	1989
	About how long ago did (name(s)) have the last tetanus shot	1989
<u>Injuries (see Child Health, Poisoning, Work Injuries, and Work Risks)</u>		
<u>Medical Device Implant</u>		
	Does anyone in the family now have an artificial joint, such as an artificial hip, knee or finger joint	1988
	Who is this	1988
	Does anyone in the family now have any implants, such as pins, screws, nails, wires, rods or plates that have been surgically inserted in the body	1988
	Who is this	1988
	Does anyone in the family now have an artificial heart valve	1988

Topic	Questionnaire item	Year
Medical Device Implant (continued)		
	Who is this	1988
	Does anyone in the family now have a lens implant (do not include corneal transplants)	1988
	Who is this	1988
	Does anyone in the family now have a silicone implant (do not include silicone injections)	1988
	Who is this	1988
	Does anyone in the family now have a pacemaker	1988
	Who is this	1988
	Does anyone in the family now have ear vent tubes	1988
	Who is this	1988
	Does anyone in the family now have an infusion pump	1988
	Who is this	1988
	Does anyone in the family now have a shunt that drains fluid away from the brain or spinal column	1988
	Who is this	1988
	Does anyone in the family now have any other type of shunt or catheter implanted in the body	1988
	Who is this	1988
	Does anyone in the family now have any other kind of medical device that has been implanted in the body during surgery	1988
	Who is this	1988
	What kind of implant does (family member) have	1988
	What kind of artificial joint(s) do you have	1988
	How many artificial joints do you have	1988
	Do you have any other artificial joints	1988
	Was the joint actually replaced with an artificial (joint), or was something else implanted, such as a pin or plate	1988
	Is the artificial finger joint you have now made out of silicone or some other material	1988
	Is the artificial (joint) you have now a replacement for a previous artificial (joint)	1988
	How many times has this artificial (joint) been replaced	1988
	Why did you have the artificial (joint) replaced (the last time): normal growth defect or malfunction loosening infection pain some other reason (specify)	1988
	How long after that joint was implanted was this (reason for replacement) first noticed: less than 30 days 30 to 90 days more than 90 days	1988

Topic	Questionnaire item	Year
Medical Device Implant (continued)		
	How long did you have the artificial (joint) before it was replaced with the one you have now:	
	less than 6 months	
	6-11 months	
	number of years	1988
	In what month and year did you get it	1988
	How long have you had the artificial (joint) you have now	1988
	In what month and year did you get this one	1988
	Since you received the artificial (joint) you have now, would you say your mobility in that joint is improved, about the same, or worse than it was before this (last) implant	1988
	Have you had any of the following problems or complications with or as a result of the artificial (joint) you have now:	
	any blood clots	
	an infection	
	loosening	
	increased pain over time	
	any defects or failure to operate properly	
	any other problems or complications (specify)	1988
	(For each problem or complication) How long had you had the artificial (joint) when the (problem or complication) was first noticed:	
	less than 30 days	
	30 to 90 days	
	more than 90 days	1988
	Why did you need to get an artificial (joint) in the first place:	
	osteoarthritis	
	rheumatoid arthritis	
	arthritis, unspecified	
	injury	
	pain	
	some other reason (specify)	1988
	In what part of the body is your implant (such as pins, screws, nails, wires, rods or plates) located	1988
	Do you have any implants anywhere else	1988
	Have you ever had surgery to replace or repair the implant in your (body part)	1988
	How many times have you had surgery to replace or repair the implant in your (body part)	1988
	Why did you have to have surgery to replace or repair the implant in your (body part) (the last time):	
	normal growth	
	breakage or defect	
	healing problem	
	infection	
	pain or irritation	
	loosening	
	some other reason (specify)	1988

Topic	Questionnaire item	Year
Medical Device Implant (continued)		
	How long did you have the implant before the (problem) was first noticed: less than 30 days 30 to 90 days more than 90 days	1988
	How long has it been since the (surgery for/ last surgery on) the implant in your (body part): less than 6 months 6–11 months number of years	1988
	In what month and year did you have the (last) surgery	1988
	Since the (surgery for/last surgery on) the implant in your (body part) have you had any of the following problems or complications: infection healing problems pain (other than discomfort generally associated with surgery and healing) loosening a part breaking or wearing out any other problems or complications (specify)	1988
	How long after the (last) surgery was the (problem or complication) first noticed: less than 30 days 30 to 90 days more than 90 days	1988
	Why did you need to get the implant in your (body part) in the first place: injury deformity infection cancer other (specify)	1988
	How long ago did you get the first implant in your (body part): less than 6 months 6–11 months number of years	1988
	In what month and year did you get it	1988
	How many artificial heart valves do you now have	1988
	There are four different heart valves—the mitral valve, the aortic valve, the tricuspid valve, and the pulmonic valve. Which of these did you have replaced with (an) artificial valve(s)	1988
	Is the artificial heart valve (name) you have now a replacement for a previous artificial valve	1988
	How many times has this artificial valve been replaced	1988
	Why did you have the artificial heart valve (name) replaced (the last time): normal growth blood clots infection bleeding	

Topic	Questionnaire item	Year
Medical Device Implant (continued)		
	defect or malfunction	
	some other reason (specify)	1988
	How long after the heart valve was implanted was this (reason for replacement) first noticed:	
	less than 30 days	
	30 to 90 days	
	more than 90 days	1988
	How long did you have the artificial heart valve (name) before it was replaced with the one you have now:	
	less than 6 months	
	6-11 months	
	number of years	1988
	In what month and year did you get it	1988
	How long have you had the artificial heart valve (name) you have now:	
	less than 6 months	
	6-11 months	
	number of years	1988
	In what month and year did you get this one	1988
	What is your artificial heart valve made from:	
	manmade substance	
	animal tissue	
	human tissue	
	don't know	1988
	Did you get a registration card for this artificial heart valve	1988
	Do you know the name of the manufacturer	1988
	Who is the manufacturer	1988
	Have you had any of the following problems or complications with or as a result of the artificial heart valve (name) you have now:	
	blood clots	
	an infection or endocarditis	
	bleeding problems related to surgery	
	any defects or reason to believe it is not working properly	
	any other problems or complications (specify)	1988
	(For each problem or complication) How long had you had the artificial valve when the (problem or complication) was first noticed:	
	less than 30 days	
	30 to 90 days	
	more than 90 days	1988
	Anticoagulants are medications that help prevent blood clots. Do you take anticoagulants	1988
	Do you take aspirin or any other medication to help prevent blood clots	1988
	How many days a week do you take them	1988
	Why did you need to get an artificial heart valve (name) in the first place:	
	congenital defect	
	rheumatic heart disease	
	heart attack or myocardial infarction	

Topic	Questionnaire item	Year
Medical Device Implant (continued)		
	calcification endocarditis other (specify)	1988
	Do you now have a lens implant in your right eye, left eye, or both eyes	1988
	Is the lens implant you now have in your (right/left) eye a replacement for a previous lens implant in that eye	1988
	How many times has the lens implant in your (right/ left) eye been replaced	1988
	Why did you have the lens implant in your (right/left) eye replaced (the last time): normal growth injury glaucoma after implant irritation or inflammation trouble reading infection movement or displacement of the lens wrong lens power problem due to corneal transplant some other reason (specify)	1988
	How long after that lens was implanted was this (reason for replacement) first noticed: less than 30 days 30 to 90 days more than 90 days	1988
	How long did you have the lens implant in your (right/left) eye before it was replaced with the one you have now: less than 6 months 6-11 months number of years	1988
	In what month and year did you get it	1988
	How long have you had the lens you now have in your (right/left) eye: less than 6 months 6-11 months number of years	1988
	In what month and year did you get this one	1988
	Did your doctor tell you that the lens you now have in your (right/left) eye is an experimental lens	1988
	Does this lens have a substance in it that absorbs some types of light	1988
	Because of the lens implant in your (right/left) eye, did your doctor advise you to wear sunglasses when you are in bright light or sunlight	1988

Topic	Questionnaire item	Year
Medical Device Implant (continued)		
	<p>Have you had any of the following problems or complications with or as a result of the lens you now have in your (right/left) eye:</p> <ul style="list-style-type: none"> infection any healing problems pain, irritation, or inflammation of the inner eye glaucoma that started since lens was implanted clouding or blurred vision trouble reading newspaper print problems with glare or light streaks problems due to wrong lens power any other problems or complications (specify) 	1988
	<p>(For each problem or complication) How long had you had the lens when the (problem or complication) was first noticed:</p> <ul style="list-style-type: none"> less than 30 days 30 to 90 days more than 90 days 	1988
	<p>Have you had problems with your eyes feeling tired when you wake up</p>	1988
	<p>Did this problem start after the lens was implanted</p>	1988
	<p>How long had you had the lens when this trouble was first noticed:</p> <ul style="list-style-type: none"> less than 30 days 30 to 90 days more than 90 days 	1988
	<p>Why did you need to get a lens implant in your (right/left) eye in the first place:</p> <ul style="list-style-type: none"> cataract injury other (specify) 	1988
	<p>Is the pacemaker you have now a replacement for a previous pacemaker</p>	1988
	<p>How many times has your pacemaker been replaced (the last time):</p> <ul style="list-style-type: none"> normal growth battery failure lead failure other mechanical failure infection healing problem pain some other reason (specify) 	1988
	<p>How long after that pacemaker was implanted was this (reason for replacement) first noticed:</p> <ul style="list-style-type: none"> less than 30 days 30 to 90 days more than 90 days 	1988
	<p>How was that pacemaker monitored:</p> <ul style="list-style-type: none"> not monitored by telephone at a doctor's office at the hospital in some other way (specify) 	1988

Topic	Questionnaire item	Year
Medical Device Implant (continued)		
	How long did you have that pacemaker before it was replaced with the one you have now:	
	less than 6 months	
	6-11 months	
	number of years	1988
	In what month and year did you get it	1988
	How long have you had the pacemaker you have now:	
	less than 6 months	
	6-11 months	
	number of years	1988
	In what month and year did you get this one	1988
	How is this pacemaker monitored:	
	not monitored	
	by telephone	
	at a doctor's office	
	at the hospital	
	in some other way (specify)	1988
	Can the pacemaker you have now be programmed or adjusted without surgery	1988
	Please tell me if you have had any of the following problems or complications with or as a result of the pacemaker you have now:	
	an infection	
	any healing problems	
	pain, other than discomfort	
	generally associated with surgery and healing	
	any irregular heart beat	
	any mechanical problems (with the pacemaker you have now), such as battery failure or lead failure	1988
	What kind of mechanical problem did it have:	
	battery failure	
	lead failure	
	other mechanical problem (specify)	1988
	Have you had any other problems or complications (with or as a result of the pacemaker you have now)	1988
	What were they	1988
	How long had you had your pacemaker when the (type of problem or complication) was first noticed:	
	less than 30 days	
	30 to 90 days	
	more than 90 days	1988
	Is the infusion pump for chemotherapy, insulin treatment, or something else	1988
	Is the pump itself implanted inside your body, or is the pump worn on the outside	1988
	In what part of the body is the (other) device located	1988
	Do you have any other device	1988
	Is the (device) in your (body part) a replacement for a previous one	1988
	How many times has the (device) in your (body part) been replaced	1988

Topic	Questionnaire item	Year
Medical Device Implant (continued)		
	Why did you have the (device) replaced (the last time):	
	normal growth	
	infection	
	defect or malfunction	
	healing problem	
	pain	
	blood clots	
	bleeding	
	injury	
	some other reason (specify)	1988
	How long had you had that (device) when the (name of problem) was first noticed:	
	less than 30 days	
	30 to 90 days	
	more than 90 days	1988
	How long did you have the (device) before it was replaced with the one you have now:	
	less than 6 months	
	6-11 months	
	number of years	1988
	In what month and year did you get it	1988
	How long have you had the (device) you have now:	
	less than 6 months	
	6-11 months	
	number of years	1988
	In what month and year did you get this one	1988
	Please tell me if you have had any of the following problems or complications with or as a result of the (device) you now have in your (body part):	
	an infection	
	any healing problems	
	pain, other than discomfort	
	generally associated with surgery and healing	
	any defects or has it failed to operate properly	
	any other problems or complications with the device	
	what were they	1988
	How long had you had your (device) when this problem was first noticed:	
	less than 30 days	
	30 to 90 days	
	more than 90 days	1988
	Why did you need to get the (device) in the first place:	
	infection	
	injury	
	some other reason (specify)	1988

Mental Health

During the past 12 months, did anyone in the family have:

- schizophrenia
- paranoid or delusional disorder, other than schizophrenia

Topic	Questionnaire item	Year
Mental Health (continued)		
	manic episodes or manic depression, also called bipolar disorder	
	major depression	
	anti-social personality, obsessive compulsive personality, or any other severe personality disorder	
	Alzheimer's disease or another type of senile disorder	
	alcohol abuse disorder	
	drug abuse disorder	
	mental retardation	1989
	During the past 12 months, did anyone else have: (see previous list)	1989
	During the past 12 months, did anyone in the family have any other mental or emotional disorders (Include only those disorders which seriously interfere with a person's ability to work or attend school, or to manage their day-to-day activities.)	1989
	Who is this	1989
	What would you call the disorder (person) has	1989
	Does (disorder(s)) now entirely prevent (person) from working at a paid job or business	1989
	Because of (this disorder/any of these disorders), is (person) limited in the kind or amount of work (person) can do	1989
	Because of this disorder/any of these disorders, does (person) have trouble finding or keeping a job or doing job tasks	1989
	For how long has person (been unable to work/been limited in work/had trouble with work) because of this disorder/any of these disorders: less than 3 months 3 months, less than 1 year 1 year, less than 5 years 5 years or more don't know	1989
	Does (disorder) now entirely prevent person from attending regular school or college	1989
	Because of (this disorder/any of these disorders), does person have trouble with school attendance or school work	1989
	For how long has person been unable to attend school/had trouble with school because of this disorder/ any of these disorders	1989
	On own and without help, does person appropriately take care of own personal care needs, such as eating, dressing, bathing, and going to the toilet	1989
	Is this because of disorder/any of these mental disorders	1989
	For how long has (person) had trouble taking care of any of these needs: less than 3 months 3 months, less than 1 year 1 year, less than 5 years 5 years or more don't know	1989

Topic	Questionnaire item	Year
Mental Health (continued)		
	On (person's) own and without help, does (person) adequately handle routine matters such as:	
	managing money	
	doing every day household chores	
	shopping	
	getting around outside the home	1989
	Are these because of (person's) (disorder)/any of these mental disorders)	1989
	For how long has (person) had trouble taking care of any of these things:	
	less than 3 months	
	3 months, less than 1 year	
	1 year, less than 5 years	
	5 years or more	
	don't know	1989
	Because of (person's) (mental and emotional disorders), how much difficulty (no difficulty, some difficulty, a lot of difficulty, completely unable, don't know) does (person) now have:	
	forming friendships	
	keeping friendships	
	concentrating long enough to complete tasks	
	coping with day-to-day stresses	1989
	For how long has (person) had any of these difficulties:	
	less than 3 months	
	3 months, less than 1 year	
	1 year, less than 5 years	
	5 years or more	
	don't know	1989
	When did (person) last see or talk to a mental health professional about (person's) (mental and emotional disorders) (Include psychiatrists, psychologists, social workers, psychiatric nurses, and any other type of mental health professional.):	
	less than 2 weeks	
	2 weeks, less than 1 month	
	1 month, less than 3 months	
	3 months, less than 1 year	
	1 year, less than 5 years	
	5 years or more	
	never	
	don't know	1989
	What type of mental health professional was last seen	1989
	When did (person) last see or talk to a doctor or other health professional about (mental and emotional disorders):	
	less than 2 weeks	
	2 weeks, less than 1 month	
	1 month, less than 3 months	
	3 months, less than 1 year	
	1 year, less than 5 years	
	5 years or more	
	never	

Topic	Questionnaire item	Year
Mental Health (continued)		
	don't know	1989
	When did a doctor or other health professional first give a diagnosis of (mental and emotional disorders) for (person):	
	less than 1 year	
	1 year, less than 5 years	
	5 years or more	
	never	
	don't know	1989
	Did the doctor call the (mental and emotional disorders) by a more technical or specific name	1989
	What did he or she call it	1989
	Has a doctor or other health professional ever given this disorder a technical or specific name	1989
	What did he or she call it	1989
	When did a doctor first call this disorder (name of disorder):	
	less than 1 year	
	1 year, less than 5 years	
	5 years or more	
	never	
	don't know	1989
	Does (person) now take any prescription medication for (mental and emotional disorders)	1989
	During the past 12 months, did (person) take any prescription medication for (this disorder/any of these disorders)	1989
	How many different medications (does (person) take/ did (person) take) during the past 12 months for (this disorder/any of these disorders)	1989
	(May I (interviewer) see/Would you please bring to the telephone) the container(s) for the medication(s) you just told me about	1989
	What (is/are) the name(s) of the medication(s)	1989
	Does (person) now receive a disability payment through any government program because of (mental and emotional disorders)	1989
	Is this payment through Social Security Disability Insurance, called "SSDI"; through Supplemental Security Income, called "SSI"; through the Veteran's Administration; or through some other program	1989
Orofacial Pain		
	During the past 6 months, did you have a toothache more than once, when biting or chewing	1989
	Did you first have this pain more than 6 months ago	1989
	During the past 6 months, did you have painful sores or irritations around the lips or on the tongue, cheeks, or gums more than once	1989

Topic	Questionnaire item	Year
Orofacial Pain (continued)		
	Did you first have the sores or irritations more than 6 months ago	1989
	During the past 6 months, did you have prolonged, unexplained burning sensation in your tongue or any other part of your mouth more than once	1989
	When you have this sensation, does it come and go or is it continuous and uninterrupted	1989
	During how many different months in the past 6 months did you have this sensation	1989
	How many total days in the past 6 months did you have this sensation:	
	1-3 days	
	4-10 days	
	11-15 days	
	16-30 days	
	31-45 days	
	46 or more days	
	every day	
	don't know	1989
	Did you first have this sensation more than 6 months ago	1989
	During the past 6 months, did you have pain in the jaw joint or in front of the ear more than once	1989
	When you have this pain, does it come and go or is it continuous and uninterrupted	1989
	During how many different months in the past 6 months, did you have this pain	1989
	How many total days in the past 6 months did you have this pain:	
	1-3 days	
	4-10 days	
	11-15 days	
	16-30 days	
	31-45 days	
	46 or more days	
	every day	
	don't know	1989
	Did you first have this pain more than 6 months ago	1989
	During the past 6 months, did you have a dull, aching pain across your face or cheek more than once (do not count sinus pain)	1989
	On a scale of 1-10, where 1 is mild and 10 is severe, how would you rate this pain at its worst	1989
	In the past 6 months, did you see or talk to a dentist for the pain we just discussed	1989
	How many times during the last 6 months did you see or talk to a dentist about the pain	1989
	In the past 6 months, did you see or talk to a medical doctor about the pain	1989
	How many times (in the past 6 months) did you see or talk to any other type of health professional about the pain	1989

Topic	Questionnaire item	Year
<u>Orofacial Pain (continued)</u>		
	In the past 6 months, did you see or talk to any other type of health professional about the pain	1989
	What kind of health professional	1989
	How many times during the past 6 months did you see or talk to the (health professional)	1989
	In the past 6 months, did you worry about the health of your teeth and gums because of the pain	1989
	In the past 6 months, did you worry about the health of your body because of the pain	1989
	Here is a list of things people do when they have teeth, mouth, or face pain. Please tell me (interviewer) the things you did for the pain during the past 6 months:	
	use a hot or cold compress	
	take a prescription drug	
	take an over-the-counter drug	
	drink some liquor or wine	
	because of the pain	
	take time off work	
	stay home more than usual	
	avoid family and friends	
	anything else (specify)	
	none of the above	
	don't know	1989
<u>Pain (see Orofacial Pain, Abdominal Pain, and Work Injuries)</u>		
<u>Physical Activity (see also Exercise)</u>		
	How many times in past 2 weeks did you (play/go/do) particular activity	1985
	On the average about how many minutes did you actually spend doing particular activity	1985
	What usually happened to your heart rate or breathing when you did (particular activity)	1985
	Did you have a small, moderate, or large increase, or no increase at all in your heart rate or breathing	1985
	Would you say that you are physically more active, less active or about as active as other persons your age	1985
	Is that (a lot more or a little more/a lot less or a little less) active	1985
<u>Poisoning</u>		
	Have you ever heard about Poison Control Centers	1985
	Do you have the telephone number for a Poison Control Center in your area	1985
	Do you now have any Ipecac Syrup in this household	1985

Topic	Questionnaire item	Year
<u>Poliomyelitis</u>		
	Ever told by doctor or health care professional that you had poliomyelitis or polio	1987
	Ever have paralysis caused by polio	1987
	Do you now have paralysis or any health impairment or health problem caused by polio	1987
<u>Pregnancy (see also Birth, Smoking, Vitamin and Mineral Intake, and Cancer)</u>		
	Any women 18–44 years old now pregnant	1985
	Does cigarette smoking during pregnancy definitely increase, probably increase, probably not or definitely not increase the chances of:	
	miscarriage	
	stillbirth	
	premature birth	
	low birth weight of the newborn	1985
	Smoke during this pregnancy	1985
	On average how many cigarettes a day did you smoke before you found out you were pregnant/this time	1985
	On average how many cigarettes a day did you smoke after you found out you were pregnant/this time	1985
	Would you say you smoked cigarettes during most of that pregnancy	1985
<u>Sleep</u>		
	Sleep, number of hours nightly	1985
	On the average, how many hours of sleep do you get in a 24-hour period	1985
<u>Smoke Detectors</u>		
	How many smoke detectors are installed in this home	1985
	How many of them (smoke detectors) are now working	1985
	Is it (smoking detector) now working	1985
	How do you know (it is/they are) working (smoke detectors):	
	tested it/them	
	it/they went off because of smoke	
	it/they went off while cooking	
	changed the batteries	
	the light is on	
	beeps when battery is low	
	other (specify)	1985
	Is/Are any of smoke detectors next to a sleeping area	1985
<u>Smoking (see also Cancer and Diabetes)</u>		
	Have you smoked at least 100 cigarettes in your entire life	1985, 1987, 1988
	About how old were you when you first started	

Topic	Questionnaire item	Year
Smoking (continued)		
	smoking cigarettes fairly regularly:	
	number of days	
	number of weeks	
	number of months	
	number of years	
	never smoked regularly	1985, 1988
	Do you smoke cigarettes now	1985, 1988, 1989
	About how many cigarettes do you smoke per day	1989
	About how long has it been since you last smoked	
	cigarettes fairly regularly:	
	never smoked regularly	
	number of days	
	number of weeks	
	number of months	
	number of years	1985, 1988
	Did you smoke cigarettes at all during the 12 months before your last child was born	1985
	On the average, about how many cigarettes a day do/did you smoke	1985, 1988
	Do you think cigarette smoking definitely increases, probably increases, probably does not or definitely does not increase a person's chances of getting the following problems:	
	emphysema	
	bladder cancer	
	cancer of larynx or voice box	
	cataracts	
	cancer of the esophagus	
	chronic bronchitis	
	gallstones	
	lung cancer	1985
	Did a doctor ever advise you to quit or cut down on smoking	1985
	Do you live with anyone who smokes cigarettes	1988
	Do they regularly smoke in the home	1988
	Is smoking allowed in your place of work other than in designated areas	1988
	Do you find that cigarette smoke in the work place causes you:	
	no discomfort	
	some discomfort	
	moderate discomfort	
	great discomfort	1988

Social Relationships (see Personal/Emotional Problems)

Stress/Stroke

During the past 2 weeks, would you say that you experienced stress:

- a lot
- moderate
- relatively little

Topic	Questionnaire Item	Year
<u>Stress/Stroke (continued)</u>		
	almost none don't know what stress is	1985
	In the past year, how much effect has stress had on your health: a lot some hardly any none	1985
	Have you ever had a stroke	1985
	The following conditions are related to having a stroke; in your opinion, which of these conditions most increases a person's chances of having a stroke: diabetes high blood pressure high cholesterol don't know	1985
<u>Tobacco Use (see Smoking and Cancer)</u>		
<u>Usual Source of Care/Place of Care (see also Cancer Control and Doctor Visit)</u>		
	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	1985
	What kind of place is it: a doctor's office hospital outpatient clinic sample person's home hospital emergency room company or industry clinic health center other (specify)	1985
	Which of these is the main reason you don't have a particular place you usually go: have two or more usual doctors or places depending on what is wrong haven't needed a doctor previous doctor no longer available haven't been able to find the right doctor recently moved to area can't afford medical care other reason	1985
<u>Vitamin and Mineral Intake</u>		
	During the past 2 weeks (outlined on calendar), did (child/adult) take any vitamin, mineral, or fluoride products	1986
	How many different vitamin, mineral, or fluoride products did (child/adult) take during the past 2 weeks	1986
	What is the product name	1986

Topic	Questionnaire item	Year
Vitamin and Mineral Intake (continued)		
	What is the manufacturer's or distributor's name	1986
	In what form did (child/adult) take this product: capsules, tablets, or pills wafers teaspoon(s) tablespoon(s) drops/droppers some other form (specify) don't know	1986
	How many (see list above) must (child/adult) take to obtain the amount of nutrients listed on the label	1986
	During the past 2 weeks , on how many days did (child/ adult) take the vitamin or mineral	1986
	On the days when (child/adult) took the vitamin or mineral, how many did (child/adult) take per day	1986
	For how long has (child/adult) been taking this type of product : number of days number of weeks number of months number of years	1986
	Did (child/adult) have a doctor's prescription to obtain this product	1986
	Were you pregnant during the past 2 weeks	1986
	Were you breastfeeding a baby during the past 2 weeks	1986
Work Injuries (see also Employment and Work Risks)		
	During the past 12 months, that is, since a year ago, have you had : repeated trouble with neck, back or spine a condition affecting the wrist and hand, called carpal tunnel syndrome a condition affecting the fingers and/or toes, called Raynaud's phenomenon a condition affecting the tendons called tendonitis hepatitis skin cancer lung cancer asthma chronic bronchitis emphysema any dust disease of the lungs, such as silicosis, asbestosis, brown lung, or black lung disease	1988
	Do you now have : deafness in one or both ears any other trouble hearing in one or both ears	1988
	Were you ever told by a doctor or other medical person that your condition was related to any job you ever had	1988
	Was a worker's compensation claim ever filed for your condition	1988

Topic	Questionnaire item	Year
Work Injuries (continued)		
	Did you ever report to your employer or to other company personnel that your condition was related to your job	1988
	Did you ever tell a doctor or other medical person that your condition was related to any job you ever had	1988
	During the past 12 months, were you told by your doctor or employer to stay home from work temporarily because of your condition	1988
	During the past 12 months, did your employer transfer you to another job, either temporarily or permanently, because of your condition	1988
	During the past 12 months, did your employer give you lighter work or excuse you from certain duties at work because of your condition	1988
	Did you ever stop working at a job or change jobs because of your condition	1988
	What kind of work did you do that was related to your condition	1988
	What were your most important activities or duties at this job	1988
	In what kind of business or industry did you work the longest as:	
	an employee of a private company, business or individual for wages, salary or commission	
	a member of the Armed Forces	
	a Federal government employee	
	a State government employee	
	a local government employee	
	self-employed in own business	
	professional practice, or farm	
	is the business incorporated	
	working without pay in family business or farm	1988
	During the past 12 months, have you had any on-the-job injuries	1988
	How many times have you been injured on the job during the past 12 months	1988
	On what date your (most recent injury/injury before that) happened	1988
	At the time of your injury (date) were you working as a (name of occupation) for (name of employer)	1988
	For whom did you work when the injury happened	1988
	What kind of business or industry is this	1988
	What kind of work did you do at that job	1988
	What were your most important activities or duties at that job	1988
	Were you:	
	an employee of a private company, business or individual for wages, salary, or commission	
	a member of the Armed Forces	
	a Federal government employee	
	a State government employee	
	a local government employee	

Topic	Questionnaire item	Year
Work Injuries (continued)		
	self-employed in own business, professional practice or farm is the business incorporated	1988
	working without pay in family business or farm	1988
	At the time of this injury, what part of your body was hurt, what kind of injury was it	1988
	Did you lose consciousness as a result of the injury	1988
	What were you doing at the time of the injury	1988
	How did the injury happen	1988
	Was the activity you were doing at the time of the injury a new or unfamiliar job task	1988
	Was the activity you were doing at the time of the injury part of your usual job tasks	1988
	Did you see or talk to a medical doctor, nurse, chiropractor, physician's assistant, nurse practitioner or other medical person as a result of this injury	1988
	Where did you first see or talk to a medical person about this injury:	
	work-site health unit	
	doctor's office (group practice or doctor's clinic)	
	emergency room	
	walk-in clinic	
	hospital outpatient clinic	
	other (specify)	1988
	Were you wearing eye protection equipment over your eyes at the time of the injury	1988
	What type of eye protection equipment were you wearing:	
	welding goggles	
	other goggles	
	glasses with side shields	
	glasses without side shields	
	welding helmet	
	face shield	
	other	1988
	Did you miss more than half of the day from work on the day of the injury	1988
	Other than the day of the injury, how many full days of scheduled work did you miss as a result of the injury	1988
	Did you miss any other scheduled time from work (other) than the day of the injury	1988
	How many days did you miss more than half of the day from work as a result of the injury	1988
	Were you temporarily transferred to another job because of the injury	1988
	Were you temporarily assigned lighter work or excused from certain duties at work other than the day of the injury	1988
	Did you report this injury to your employer	1988
	Was a worker's compensation claim filed as a result of this injury	1988
	Did you change employers as a result of this injury	1988

Topic	Questionnaire item	Year
Work Injuries (continued)		
	Was your salary lower, higher or the same after your change of employers	1988
	Were you as satisfied, less satisfied or more satisfied with your new employer as with your employer prior to the injury	1988
	Did you change the kind of work you do as a result of the injury	1988
	Was your salary lower, higher or the same after your job change	1988
	Were you as satisfied, less satisfied or more satisfied with your new job as with your job prior to the injury	1988
	Did you make a permanent change in your work activities because of this injury	1988
	Did you permanently change your off-the-job activities because of this injury	1988
	During the past 12 months have you had dermatitis, eczema, or any other red, inflamed skin rash	1988
	During the past 12 months, on about how many days altogether did you have a skin condition (include days when you used treatment for the condition)	1988
	What parts of your body were affected by this skin condition: hands arms head, face or neck other body area (specify) don't know	1988
	During the past 12 months, did you miss at least a full day from work because of your skin condition	1988
	Did any skin condition you had in the past 12 months result from chemicals or other substances which you got on your skin	1988
	What chemicals or other substances were these	1988
	Did you get these substances on your skin during the past 12 months	1988
	Was this at your job	1988
	Were you at work at your job or business when you got these substances on your skin	1988
	During the past 12 months, did you use any prescription medications or other treatments prescribed by a doctor for your skin condition	1988
	Did you use any over-the-counter or non-prescription medications or treatments for your skin condition	1988
	How long has it been since you last saw or talked to a dermatologist or skin specialist about your skin condition: number of days number of weeks number of months number of years never	1988

Topic	Questionnaire item	Year
Work Injuries (continued)		
	How long has it been since you last saw or talked to any other type of medical person about your skin condition:	
	number of days	
	number of weeks	
	number of months	
	number of years	
	never	1988
	During the past 12 months, have you stopped working at a job or changed jobs because of your skin condition	1988
	During the past 12 months did you make a major change in your work activities because of your skin condition	1988
	During the past 12 months, did you report your skin condition to your employer as a work-related illness or injury	1988
	During the past 12 months, was a worker's compensation claim filed for your skin condition	1988
	During the past 2 weeks, have you had any episodes of itchy, irritated or watery eyes	1988
	On how many days during the past 2 weeks did you have itchy, irritated or watery eyes	1988
	Do you wear contact lenses	1988
	What type of contact lenses do you wear:	
	hard lens(es) (include polycarbonate)	
	soft lens(es), daily wear	
	soft lens(es), extended wear	
	intraocular lens(es)	
	other (specify)	
	don't know	1988
	During the past 2 weeks, have you had any episodes of stuffy, blocked, itchy, or runny nose	1988
	On how many days during the past 2 weeks did you have stuffy, blocked, itchy, or runny nose	1988
	During the past 2 weeks, have you had any episodes of sore or dry throat	1988
	On how many days during the past 2 weeks, did you have sore or dry throat	1988
	Were these symptoms due to:	
	cold or flu	
	hay fever	
	allergies (other allergies)	
	something else (specify)	1988
	Did you have these symptoms while you were at work	1988
	When you were away from work, did these symptoms:	
	increase	
	decrease	
	stay the same	1988
	During the past 2 weeks when you had these symptoms, did you also have a fever	1988
	At any time during the past 12 months, that is since (12-month date) a year ago, did you have back pain every day for a week or more	1988

Topic	Questionnaire item	Year
Work Injuries (continued)		
	Did you have back pain only at the time of your monthly period	1988
	During the past 12 months, on about how many days altogether did you have back pain	1988
	During the past 12 months, how many full days did you miss from work because of back pain	1988
	When you had this back pain, what part of your back bothered you the most—the upper back, the middle back or the lower back	1988
	During the past 12 months, did the back pain ever spread to your: buttocks thighs lower leg or foot	1988
	Did any of the back pain you had in the past 12 months result from a single accident or injury (some examples are slipping, falling, twisting, lifting something, or being in a car accident)	1988
	When did the accident or injury happen	1988
	Were you at work at your job or business when the accident or injury happened	1988
	Was this at your job as a (name of occupation) for (name of employer)	1988
	For whom did you work when the accident or injury happened	1988
	Was any of the back pain you had in the past 12 months brought on by repeated activities such as lifting, pushing, pulling, bending, twisting, or reaching	1988
	Where did you perform the activities that brought on your back pain: at work at home recreational site other (specify)	1988
	Was this at your job as a (name of occupation) for (name of employer)	1988
	What caused your back pain	1988
	Has your back bothered you today	1988
	How many days, weeks, or months ago did you last have back pain	1988
	For how many consecutive days, weeks, or months (did your back bother you that time/has your back been bothering you)	1988
	In what year did you first have an episode of back pain that lasted for a week or more: 1987 1988 1989 earlier year (specify)	1988
	Counting (reported year), in how many different years have you had episodes of back pain lasting for a week or more	1988

Topic	Questionnaire item	Year
Work Injuries (continued)		
	What was the longest period of time that you had back pain every day:	
	less than 1 month	
	1 month, less than 3 months	
	3 months, less than 6 months	
	6 months, less than 12 months	
	1 year, less than 5 years	
	5 or more years	1988
	Have you ever stopped working at a job or changed jobs because of back pain	1988
	Have you ever made a major change in your work activities because of back pain	1988
	Are you left handed, right handed or able to use both hands equally well	1988
	Which hand do you use the most at work:	
	left	
	right	
	use both hands equally	1988
	During the past 12 months, that is, since (12 month date) a year ago, have you had discomfort in your hands, wrists, or fingers (discomfort can mean pain, burning, stiffness, numbness or tingling)	1988
	Was this discomfort due entirely to an injury, such as a cut, sprain or broken bone	1988
	During the past 12 months, on about how many days altogether did you have discomfort in your hands, wrists, or fingers	1988
	During the past 12 months, did you have the discomfort every day for a week or more	1988
	In which hand did you have this discomfort:	
	left	
	right	
	both	1988
	Was your discomfort worse when you were trying to sleep or did it awaken you from sleep	1988
	In the past 12 months, did your hands or fingers often feel clumsy, that is, did you often have difficulty picking up or holding things	1988
	Has your hand(s) bothered you today	1988
	How many days, weeks, or months ago did you last have this discomfort	1988
	For how many consecutive days, weeks, or months (did your hand(s) bother you that time/has your hand(s) been bothering you)	1988
	In what year did you first notice this hand discomfort:	
	1987	
	1988	
	1989	
	earlier year (specify)	1988

Topic	Questionnaire item	Year
Work Injuries (continued)		
	Counting (reported year), in how many different years has your hand(s) bothered you	1988
	During the past 12 months, were you away from work for more than 1 week for any reason	1988
	When you were away from work for more than 1 week, did your hand discomfort: increase decrease stay the same	1988
	During the past 12 months, did you miss at least a full day from work because of your hand discomfort	1988
	Have you ever stopped working at a job or changed jobs because of your hand discomfort	1988
	Have you ever made a major change in your work activities because of your hand discomfort	1988
	How long has it been since you last saw or talked to a medical doctor, chiropractor, physical therapist or other medical person about your hand discomfort: never saw a medical person number of days number of weeks number of months number of years	1988
	What did the medical person call your hand discomfort	1988
	Even if you have mentioned it before, please tell me (interviewer) if you ever had any of the following conditions: arthritis of the hand, wrist, or fingers a broken bone in your hand, wrist, or fingers a condition affecting the wrist and hand called carpal tunnel syndrome	1988
Work Risks (see also Employment, Smoking, and Work Injuries)		
	In your present job, are you exposed to any work conditions that could endanger your health, such as loud noise, extreme heat or cold, physical or mental stress, or radiation	1985
	What work conditions are you exposed to that could endanger your health	1985
	How can (work condition) endanger your health	1985
	In your present job are you exposed to any risks of accidents or injuries	1985
	What risks of accidents or injuries are you exposed to	1985
	In your present job are you exposed to any substances that could endanger your health, such as chemicals, dusts, fumes or gases	1985
	What substances are you exposed to that could endanger your health	1985
	How can (substance) endanger your health	1985

Topic	Questionnaire item	Year
Work Risks (continued)		
	Did your job require you to do repeated strenuous physical activity such as lifting, pushing, or pulling heavy objects	1988
	During a typical work day, how many minutes or hours altogether did you spend doing strenuous physical activities	1988
	Did this job require you to do repeated bending, twisting or reaching	1988
	During a typical work day, how many minutes or hours altogether did you spend bending, twisting or reaching	1988
	Did this job require you to bend or twist your hands or wrists many times an hour	1988
	During a typical work day, how many minutes or hours altogether did you spend bending or twisting your hands or wrists	1988
	On this job, did you work with hand-held or hand-operated vibrating machinery	1988
	During a typical work day, how many minutes or hours did you spend working hand-held or hand-operated vibrating machinery	1988
	I (interviewer) am going to read a list of substances that people get on their skin at work. Tell me if you got any of these things on your hands or arms at your job as a (name of occupation) for (name of employer) during the past 12 months: did you get solvents or degreasers on your hands or arms petroleum products other than solvents, for example grease, oil, or fuel soaps, detergents, or cleaning and disinfecting solutions used in performing your job cutting oils, machine coolants, or metal working fluids paints, varnishes, lacquers, or other coatings glues, pastes, or other adhesives acids or alkalines pesticides, insecticides, herbicides, fungicides, or fumigants foods or food products handled as part of your job duties plants, trees or shrubs handled as part of your job duties did you get any other chemicals or substances on your hands or arms that could irritate the skin	1988

Vital and Health Statistics series descriptions

- SERIES 1. Programs and Collection Procedures**—These reports describe the data collection programs of the National Center for Health Statistics. They include descriptions of the methods used to collect and process the data, definitions, and other material necessary for understanding the data.
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- SERIES 5. International Vital and Health Statistics Reports**—These reports are analytical or descriptive reports that compare U.S. vital and health statistics with those of other countries or present other international data of relevance to the health statistics system of the United States.
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For answers to questions about this report or for a list of reports published in these series, contact:

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