Table I – ILLNESSES, IMPAIRMENTS, AND INJURIES

Line number	Col. No. of person (a)	Question No. (b)	Did you ever AT ANY TIME talk to a doctor about your . . .? (c)	If condition is on Card C, enter condition without asking columns (d-1) through (d-4) and go to columns (e)–(f). For all other illnesses and present effects of "old" injuries — – If doctor talked to, ask: What did the doctor say it was – did he give it a medical name? – If doctor NOT talked to, record original entry and ask (d-2) – (d-4) as required. For all injuries which happened LAST WEEK OR THE WEEK BEFORE, ask: What part of the body was hurt? What kind of injury was it? (For injuries or accidents which happened before the past 2 weeks, enter the present effects.) (d-1)	CAUSE If the entry in col. (d-1) is An IMPAIRMENT or a SYMPTOM or came from Question 9 or 11, ask: What was the cause of . . .? (If "Cause" is an injury, enter "Accident" or "Injury" and fill Table A.) (d-2)	KIND For any entry in col. (d-1) or col. (d-2) that includes the words: Allergy* Tumor Asthma "Condition" Cyst "Disease" Growth "Trouble" Stroke* ask: What kind of . . . is it? *For an ALLERGY or STROKE, ask: How does the allergy (stroke) affect you? (d-3)	PART OF BODY Ask only for: IMPAIRMENTS, "CURRENT" INJURIES, and PRESENT EFFECTS OF "OLD" INJURIES And for: Abscess, Ache (except headache), Bleeding, Blood clot, Boil, Cancer, Cyst, Growth, Hemorrhage, Infection, Inflammation, Neuralgia, Neuritis, Pain, Sore, Soreness, Tumor, Ulcer, Weak, Weakness What part of the body is affected? Show detail for: Ear or eye - (one or both) Head - (skull, scalp, face) Back - (upper, middle, lower) Arm - (shoulder, upper, elbow, lower, wrist, hand; one or both) Leg - (hip, upper, knee, lower, ankle, foot; one or both) (d-4)	LAST WEEK OR THE WEEK BEFORE did your . . . cause you to cut down on the things you usually do? (Check one) No (Go to col. m) (e) Yes → (f)	Did you have to cut down for as much as a day? (Check one) No (Go to col. m) (g) Yes → (h)
6			☐ Yes ☐ No		x	x	x		
7			☐ Yes ☐ No		x	x	x		
8			☐ Yes ☐ No		x	x	x		

Table II – HOSPITALIZATIONS

T

INTERVIEWER: Enter TOTAL number of hospitalizations recorded in question 13.

(Number)

Fill one line of Table II for each hospital stay reported. If no hospitalizations reported, check the "None" box.

☐ None

Line number	Col. No. of person (a)	Question No. (b)	USE YOUR CALENDAR You said that you were in the hospital (once, twice, etc.) during the past year — When did you enter the hospital (the last time)? *(Enter month, day and year; if exact date not known, obtain estimate.)* (c)	How many nights were you in the hospital? *(If exact number not known, accept best estimate.)* (d)	Complete from entries in cols. (c) and (d); or, if not clear ask the questions. How many of these – – nights were in the past 12 months? (e)	How many of these – – nights were last week or the week before? (f)	Were you still in the hospital last Sunday night? (g)	For what condition did you enter the hospital – – do you know the medical name? (If medical name not known, enter respondent's description.) (Entry must show CAUSE, KIND, AND PART OF BODY in same detail as required in Table I) (h)
1			Month / Day / Year	Nights	Nights	Nights	☐ Yes ☐ No	
2			Month / Day / Year	Nights	Nights	Nights	☐ Yes ☐ No	
3			Month / Day / Year	Nights	Nights	Nights	☐ Yes ☐ No	

Table A - ACCIDENTS AND INJURIES

Line No. from Table I

Accident happened last week or week before *(Go to Q. 3)* ☐

1. When did the accident happen?

Year

(If 1963, 1964, or 1965 also enter month):

Month

2. 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 (injuries)

3. a. Was a car, truck, bus or other motor vehicle involved in the accident in any way? ☐ Yes ☐ No *(Go to Q. 4)*

b. Was more than one motor vehicle involved? ☐ Yes (More than one) ☐ No

c. Was it (either one) moving at the time? ☐ Yes ☐ No

4. a. Where did the accident happen — at home or some other place?

1 ☐ At home (inside house) 2 ☐ At home (adjacent premises) ☐ Some other place

If "Some other place," ask:

b. What kind of place was it?

3 ☐ Street and highway (includes roadway) 6 ☐ School (includes school premises)

4 ☐ Farm 7 ☐ Place of recreation and sports, except at school

5 ☐ Industrial place (includes premises) 8 ☐ Other *(Specify the place where accident happened)* _____

5. Were you at work at your job or business when the accident happened?

1 ☐ Yes 2 ☐ No 3 ☐ While in Armed Services 4 ☐ Under 17 at time of accident

INTERVIEWER: Return to Table I and complete the rest of this line.

Table I – ILLNESSES, IMPAIRMENTS, AND INJURIES – Continued

How many days did you have to cut down during that two week period? (i)	During that two week period, how many days did your . . . keep you in bed all or most of the day? (j)	If 6-16 years old, ask: How many days did your . . . keep you from school during that two week period? (k)	If "Yes" in Q. 5a or 5b, ask: How many days did your . . . keep you from work during that two week period? (l)	Did you first notice your . . . (did it happen) during the past 3 months or before that time? (Check one) Before 3 months (Go to col. (p)) (m)	During 3 mos. → (n)	Did you first notice it (did it happen) during the past 2 weeks or before that time? If "During past 2 weeks," ask: Which week, last week or the week before? (o)	If col. (m) is checked, ask: Did you first notice it during the past 12 months or before that time? (p)	To interviewer CONTINUE if col. (m) is checked, or the condition is on Card A or is an impairment; otherwise, STOP (aa)	ABOUT how many days during the past 12 months has your . . . kept you in bed all or most of the day? (q)	If 1 or more days in col. (q) and col. (j) is blank or checked "None," ask: Were any of these – – days during last week or the week before? If "Yes," ask: How many? (r)	If "Yes" to col. (c), ask: ABOUT how many times during the past 12 months have you seen or talked to a doctor about your . . .? (s)	Ask after completing last condition for each person. Please look at each statement on this card, Card – – (Show Card E, F, G, or H as appropriate) Then tell me which statement fits you best, in terms of health. (If "4", go to col. (v)) (t)	If "1", "2" or "3" in col. (t), ask: Is this because of any of the conditions you have told me about? If "Yes," ask: Which? (Enter X on line for each condition named.) (u)	Please look at the tan card, Card I. Which one of those statements fits you best, in terms of health. (v)	If "1"-"4" in col. (v), ask: Is this because of any of the conditions you told me about? If "Yes," ask: Which? (Enter X on line for each condition named.) (w)	Line number
Days	☐ Days or ☐ None	☐ Days or ☐ None	☐ Days or ☐ None			☐ Last week ☐ Week before ☐ Before 2 wks.	☐ 3-12 mos ☐ Before 12 mos.		☐ Days or ☐ None	☐ Days or ☐ None	☐ Times or ☐ None		☐ Yes ☐ No		☐ Yes ☐ No	6
Days	☐ Days or ☐ None	☐ Days or ☐ None	☐ Days or ☐ None			☐ Last week ☐ Week before ☐ Before 2 wks.	☐ 3-12 mos. ☐ Before 12 mos.		☐ Days or ☐ None	☐ Days or ☐ None	☐ Times or ☐ None		☐ Yes ☐ No		☐ Yes ☐ No	7
Days	☐ Days or ☐ None	☐ Days or ☐ None	☐ Days or ☐ None			☐ Last week ☐ Week before ☐ Before 2 wks.	☐ 3-12 mos. ☐ Before 12 mos.		☐ Days or ☐ None	☐ Days or ☐ None	☐ Times or ☐ None		☐ Yes ☐ No		☐ Yes ☐ No	8

Table II – HOSPITALIZATIONS

Were any operations performed on you during this stay at the hospital? If "Yes," ask: a. What was the name of the operation? b. Any other operations? (i)	What is the name and address of the hospital you were in? (Enter full name of hospital, street or highway on which it is located, city and State; if city not known, enter county.) (j)	Line number
☐ Yes ☐ No	Name of hospital Street / City and State	1
☐ Yes ☐ No	Name of hospital Street / City and State	2
☐ Yes ☐ No	Name of hospital Street / City and State	3

INTERVIEWER: After completing Table II for all persons, carry each condition in col. (h) or col. (i) back to Table I if it does not already appear there and there are "1" or more nights in col. (f) OR the entry in col. (h) or col. (i) is an "Impairment" OR a condition on Card A.

Card A

Check List of Chronic Conditions

1. Asthma
2. Tuberculosis
3. Chronic bronchitis
4. Repeated attacks of sinus trouble
5. Rheumatic fever
6. Hardening of the arteries
7. High blood pressure
8. Heart trouble
9. Stroke
10. Trouble with varicose veins
11. Hemorrhoids or piles
12. Hay fever
13. Tumor, cyst or growth
14. Chronic gallbladder or liver trouble
15. Stomach ulcer
16. Any other chronic stomach trouble
17. Kidney stones or chronic kidney trouble
18. Mental illness
19. Arthritis or rheumatism
20. Diabetes
21. Thyroid trouble or goiter
22. Any allergy
23. Epilepsy
24. Chronic nervous trouble
25. Cancer
26. Chronic skin trouble
27. Hernia or rupture
28. Prostate trouble

Card B

Check List of Selected Impairments

1. Deafness or serious trouble hearing with one or both ears
2. Serious trouble seeing with one or both eyes even when wearing glasses
3. Cleft palate
4. Any speech defect
5. Missing fingers, hand, or arm --- toes, foot, or leg
6. Palsy
7. Paralysis of any kind
8. Repeated trouble with back or spine
9. Club foot
10. Permanent stiffness or any deformity of the foot, leg, fingers, arm, or back
11. Any condition present since birth

Card E

For:
Workers and other persons except Housewives and Children

1. Not able to work at all.
2. Able to work but limited in amount of work or kind of work.
3. Able to work but limited in kind or amount of other activities.
4. Not limited in any of the above ways.

Card F

For: Housewife

1. Not able to keep house at all.
2. Able to keep house but limited in amount or kind of housework.
3. Able to keep house but limited in kind or amount of other activities.
4. Not limited in any of the above ways.

Card G

For:
Children from 6 through 16 years old

1. Not able to go to school at all.
2. Able to go to school but limited to certain types of schools or in school attendance.
3. Able to go to school but limited in other activities.
4. Not limited in any of the above ways.

Card H

For: Children under 6 years old

1. Not able to take part at all in ordinary play with other children.
2. Able to play with other children but limited in amount or kind of play.
4. Not limited in any of the above ways.

Card I

For: Mobility

1. Must stay in bed all or most of the time.
2. Must stay in the house all or most of the time.
3. Need the help of another person in getting around inside or outside the house.
4. Need the help of some special aid, such as a cane or wheelchair, in getting around inside or outside the house.
5. Not limited in any of the above ways.

Card K

For: Total combined family income during past 12 months

Group A. Under $500 (Including loss)
Group B. $500 - $999
Group C. $1,000 - $1,999
Group D. $2,000 - $2,999
Group E. $3,000 - $3,999
Group F. $4,000 - $4,999
Group G. $5,000 - $6,999
Group H. $7,000 - $9,999
Group I. $10,000 - $14,999
Group J. $15,000 and over

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