Table I - ILLNESSES, IMPAIRMENTS, AND INJURIES

<table>
<thead>
<tr>
<th>Col. No. of Person</th>
<th>Question</th>
<th>Did you ever have ANY TIME talk to a doctor about your...?</th>
<th>If condition is on Card C, enter condition without asking columns (d-1) through (d-4) and go to columns (e)-(f). Ask only for IMPAIRMENTS, &quot;CURRENT&quot; INJURIES, AND PRESENT EFFECTS OF &quot;OLD&quot; INJURIES for which you...</th>
<th>Cause</th>
<th>Kind</th>
<th>Part of Body</th>
<th>Last Week or the Week Before, did your...?</th>
<th>Did you have to cut down for any reason a day?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>(b)</td>
<td>(c)</td>
<td>(d-1)</td>
<td>(d-2)</td>
<td>(d-3)</td>
<td>(d-4)</td>
<td>(e)</td>
<td>(f)</td>
</tr>
<tr>
<td>6</td>
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</tbody>
</table>

Table II - HOSPITALIZATIONS

Table A - ACCIDENTS AND INJURIES
### Table I - ILLNESSES, IMPAIRMENTS, AND INJURIES - Continued

| How many days did you have to cut down during that two-week period? | During that two-week period, how many days did your . . . keep you in bed or most of the day? | How many days did you . . . keep you from school during that two-week period? | Did you first notice your . . . (did it happen) during the past 12 months or before that time? | To interviewer: CON- TINUE if col. (p) in Card A is checked or the condition is an impairment; otherwise, STOP. | About how many days during the past 12 months has your . . . kept you in bed all or most of the day? | If col. (n) is checked, ask: Did you first notice it during the past 12 months or before that time? | If col. (m) is checked, ask: How many times during the past 12 months have you seen or talked to a doctor about your . . .? | Please look at each statement on this card, Card B (Note: When any of the conditions you have told me about? If "Yes," ask: Which? (Enter X on line for each condition named.)) | Ask after completing last condition for each person. |
|---|---|---|---|---|---|---|---|---|---|---|
| (i) | (j) | (k) | (l) | (m) | (n) | (o) | (p) | (q) | (r) | (s) |
| Days or None | Days or None | Days or None | Days or None | Days or None | Days or None | Days or None | Days or None | Days or None | Days or None | Days or None |
| Days | Week before | Before 2 wks | Before 12 mos | Days | Week before | Before 2 wks | Before 12 mos | Days | Week before | Before 2 wks |
| Times | Time | Hour | Hour |
| Yes | No | Yes | No |
| Yes | No | Yes | No |
| Yes | No | Yes | No |

### Table II - HOSPITALIZATIONS

<table>
<thead>
<tr>
<th>Were any operations performed on you during this stay at the hospital?</th>
<th>What is the name and address of the hospital you were in?</th>
<th>After completing Table II for all persons, carry each condition in col. (b) or col. (i) back to Table I if it does not already appear there and there are &quot;Yes&quot; for more than one condition in col. (b) or col. (i) is an &quot;Impairment&quot; OR a condition on Card A.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Name of hospital</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Street</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Street</td>
</tr>
</tbody>
</table>

(Enter full name of hospital, street or highway on which it is located, city and state; if city not known, enter country.)
### 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. Hemia or rupture  
28. Prostate trouble

### Card B

**Check List of Selected Impairments**

1. Deafness or serious trouble hearing with one of 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 C

**Check List of 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