

		PERSON ①	
1. a. What is the name of the head of this household? (Enter name in column for Person 01) b. What are the names of all other persons who live here? (List all persons who live here) c. I have listed (read names). Is there anyone else staying here now such as friends, relatives, or roomers? <input type="checkbox"/> Yes* <input type="checkbox"/> No d. Have I missed anyone who USUALLY lives here but is now away from home? <input type="checkbox"/> Yes* <input type="checkbox"/> No e. Do any of the people in this household have a home anywhere else? <input type="checkbox"/> Yes* <input type="checkbox"/> No If any adult males listed, ask: f. Are any of the persons in this household now on full-time active duty with the Armed Forces of the United States? <input type="checkbox"/> Yes (Delete) <input type="checkbox"/> No		LAST NAME FIRST NAME	
2. How is -- related to -- (head of household)?		RELATIONSHIP Head	
3. How old was -- on his last birthday? (Also mark Race and Sex)		AGE	RACE <input type="checkbox"/> White <input type="checkbox"/> Negro <input type="checkbox"/> Other
If 17 years old or over, ask: 4. Is -- now married, widowed, divorced, separated, or never married? (Mark one box for each person) If persons under 17 are or have been married mark the "Und. 17" box and give marital status in a footnote.		<input type="checkbox"/> Und. 17 <input type="checkbox"/> Married <input type="checkbox"/> Widowed	<input type="checkbox"/> Never married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated
If 17 years old or over, ask: 5. What was -- doing most of the past 12 months -- (for males) working or doing something else? (for females) keeping house, working or doing something else?		<input type="checkbox"/> Under 17 <input type="checkbox"/> Working <input type="checkbox"/> Keeping house <input type="checkbox"/> Something else	
H	If related persons 19 years old or over are listed in addition to the respondent, say: We would like to have all adults who are at home take part in the interview. Is your --, etc., at home now? If other eligible respondents are at home, ask: Would you please ask --, --, etc., to join us?	<input type="checkbox"/> At home (Interview for self) <input type="checkbox"/> Under 19 <input type="checkbox"/> Not at home	
	This survey covers all kinds of illnesses. These first questions refer to LAST WEEK AND THE WEEK BEFORE, that is, the 2-week period outlined in red on this calendar. (Hand calendar)		<input type="checkbox"/> Yes <input type="checkbox"/> No
6. a. Was -- sick at any time LAST WEEK OR THE WEEK BEFORE? (the 2 weeks shown on that calendar?)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. What was the matter?			
c. Did -- have anything else during that 2-week period?			
7. a. LAST WEEK OR THE WEEK BEFORE, did -- take any medicine or treatment for any condition (besides . . . which you told me about)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. For what condition?			
c. Did -- take any medicine for any other condition?			
8. a. LAST WEEK OR THE WEEK BEFORE, did -- have any accidents or injuries?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. What were they?			
c. Did -- have any other accidents or injuries during that 2-week period?			
9. a. Did -- EVER have on (any other) accident or injury that still bothers him or affects him in anyway?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. In what way does it bother him? (Record present effects)			
Open your Flashcard Booklet to Card A. 10. Read both sides of Card A, condition by condition; record in his column any conditions mentioned for the person.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Turn to Card B. 11. Read both sides of Card B, condition by condition; record in his column any conditions mentioned for the person.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. a. Does -- have any other ailments, conditions, or problems with his health?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. What is the condition? (Record condition itself if still present; otherwise record present effects.)			
c. Any other problems with his health?			
13. a. Has -- been in a hospital at any time since _____ a year ago?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes," ask: b. How many times was -- in a hospital during that period?		No. of times _____	
(Examine ages in question 3 for babies 1 year old or under. For each child 1 year old or under, ask 14a.)		Month _____ Day _____ Year _____	
14. a. When was -- born? (If on or after the date stamped in 13a, ask 14b.)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Was -- born in a hospital? { If "Yes," and no hospitalizations entered in his column, enter "1" in 13b } { If "Yes," and a hospitalization is reported for the mother and baby, ask 14c }		<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Is this hospitalization included in the number you gave me for --? (If "No," correct entry for mother and baby)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
R	For persons 19 years old or over, show who responded for (or was present during the asking of) Q. 6-14. If persons responded for self, show whether entirely or partly. For persons under 19 show who responded for them. If eligible respondent is "at home" but did not respond for self, enter the reason in a footnote.	<input type="checkbox"/> Responded for self-entirely <input type="checkbox"/> Responded for self-partly Person _____ was respondent	
	Q. 6-14		

<p>Card A</p> <p>A-1 Now I'm going to read a list of conditions—Please tell me if you, your _____, etc., have had any of these conditions DURING THE PAST 12 MONTHS?</p> <ol style="list-style-type: none"> 1. Asthma? 2. CHRONIC bronchitis? 3. REPEATED attacks of sinus trouble? 4. TROUBLE with varicose veins? 5. Hemorrhoids or piles? 6. Hay fever? 7. Tumor, cyst, or growth? 8. CHRONIC gallbladder or liver trouble? 9. Stomach ulcer? 10. Any other CHRONIC stomach trouble? 11. Kidney stones or CHRONIC kidney trouble? 	<p>A-2 Have you, your _____, etc., had any of these conditions DURING THE PAST 12 MONTHS?</p> <ol style="list-style-type: none"> 12. Thyroid trouble or goiter? 13. Any allergy? 14. CHRONIC nervous trouble? 15. CHRONIC skin trouble? 16. Hernia or rupture? 17. Prostate trouble? 18. Palsy? 19. Paralysis of any kind? 20. REPEATED trouble with back or spine? 21. Cleft palate? 22. Any speech defect? 	<p>Card E</p> <p>For: Workers and other persons except Housewives and Children</p> <ol style="list-style-type: none"> 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. 	<p>Card G</p> <p>For: Children from 6 through 16 years old</p> <ol style="list-style-type: none"> 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. 	<p>Card I</p> <p>For: Mobility</p> <ol style="list-style-type: none"> 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. Does not need the help of another person or a special aid but has trouble in getting around freely. 6. Not limited in any of the above ways.
<p>Card B</p> <p>B-1 Have you, your _____, etc., EVER had any of these conditions?</p> <ol style="list-style-type: none"> 1. Tuberculosis? 2. Hardening of the arteries? 3. High blood pressure? 4. Cancer? 5. Heart trouble? 6. Stroke? 7. Rheumatic fever? 8. Arthritis or rheumatism? 9. Mental illness? 10. Diabetes? 11. Epilepsy? 	<p>B-2 Do you, your _____, etc., HAVE any of these conditions?</p> <ol style="list-style-type: none"> 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. Missing fingers, hand or arm— toes, foot or leg? 4. Missing lung or kidney (or breast)? 5. Club foot? 6. PERMANENT stiffness or any deformity of foot, leg, fingers, arm or back? 	<p>Card F</p> <p>For: Housewife</p> <ol style="list-style-type: none"> 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. 	<p>Card H</p> <p>For: Children under 6 years old</p> <ol style="list-style-type: none"> 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. 3. Able to play with other children but limited in amount or kind of play. 4. Not limited in any of the above ways. 	<p>Card J</p> <p>For: Total combined family income during past 12 months</p> <p>Under \$500 (including loss) . . . Group A</p> <p>\$500— \$999 Group B</p> <p>\$1,000— \$1,999 Group C</p> <p>\$2,000— \$2,999 Group D</p> <p>\$3,000— \$3,999 Group E</p> <p>\$4,000— \$4,999 Group F</p> <p>\$5,000— \$6,999 Group G</p> <p>\$7,000— \$9,999 Group H</p> <p>\$10,000—\$14,999 Group I</p> <p>\$15,000 and over Group J</p>