

HOSPITAL PAGE		Person number	
<p>Enter month, day, year; if the exact date is not known, obtain the best estimate.</p> <p>USE YOUR CALENDAR</p>	<p>1. Person number</p> <p>Write in and mark <input type="text"/></p>	<p>WASHINGTON USE</p> <p>Month</p> <p>Jan <input type="radio"/> Feb <input type="radio"/> Mar <input type="radio"/> Apr <input type="radio"/> May <input type="radio"/> Jun <input type="radio"/> July <input type="radio"/> Aug <input type="radio"/> Sept <input type="radio"/> Oct <input type="radio"/> Nov <input type="radio"/> Dec <input type="radio"/></p> <p>Day</p> <p>Year</p> <p>Nights</p> <p>Q. No. 15 16 17 Hosp. Other</p> <p>Diag.</p> <p>Diagnosis surgically treated</p> <p>Operation 1</p> <p>Operation 2</p> <p>Operation 3</p> <p>Service</p> <p>Ownership</p> <p>IC or dum. code</p> <p>Footnotes:</p>	
	<p>YOU SAID THAT -- WAS IN THE (HOSPITAL/NURSING HOME) DURING THE PAST YEAR:</p> <p>2. WHEN DID -- ENTER THE (HOSPITAL/NURSING HOME) (THE LAST TIME)?</p> <p>Write in</p> <p>Month <input type="text"/></p> <p>Day <input type="text"/></p> <p>Year <input type="text"/></p> <p>Make sure the YEAR is correct. →</p>		
<p>Do not include any nights in interview week. If the exact number is not known, accept the best estimate.</p>	<p>3. HOW MANY NIGHTS WAS -- IN THE (HOSPITAL/NURSING HOME)?</p> <p>Total nights in hospital -- nursing home <input type="text"/></p>		
<p>Complete question 4 from entries in questions 2 and 3; if not clear, ask the questions.</p> <p>Do not include any nights in interview week.</p> <p>USE YOUR CALENDAR</p>	<p>4a. HOW MANY OF THESE -- NIGHTS WERE IN THE PAST 12 MONTHS?</p> <p>Nights past 12 months <input type="text"/></p> <p>4b. HOW MANY OF THESE -- NIGHTS WERE LAST WEEK OR THE WEEK BEFORE?</p> <p>Nights past 2 weeks <input type="text"/></p> <p>4c. WAS -- STILL IN THE (HOSPITAL/NURSING HOME) LAST SUNDAY NIGHT FOR THIS HOSPITALIZATION (STAY)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>If medical name not known, enter an adequate description.</p> <p>Entry must show CAUSE, KIND, and PART OF BODY in same detail as required for the Condition page.</p>	<p>5. FOR WHAT CONDITION DID -- ENTER THE (HOSPITAL/NURSING HOME) -- DO YOU KNOW THE MEDICAL NAME?</p> <p>For delivery ask: WAS THIS A NORMAL DELIVERY? If "No" ask: WHAT WAS THE MATTER?</p> <p>For newborn, ask: WAS THE BABY NORMAL AT BIRTH? Record in "Condition" box</p> <p>Condition <input type="text"/></p> <p>Cause <input type="text"/></p> <p>Kind <input type="text"/></p> <p>Part of body <input type="text"/></p>		
<p>If name of operation is not known, describe what was done.</p>	<p>6a. WERE ANY OPERATIONS PERFORMED ON -- DURING THIS STAY AT THE (HOSPITAL/NURSING HOME)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No - Go to 7</p> <p>b. WHAT WAS THE NAME OF THE OPERATION?</p> <p>Operation <input type="text"/></p> <p>c. ANY OTHER OPERATIONS? <input type="checkbox"/> Yes - Describe above <input type="checkbox"/> No</p>		
<p>Enter the full name of the hospital or nursing home; the street or highway on which it is located, and the city and State; if the city is not known, enter the county.</p>	<p>7. WHAT IS THE NAME AND ADDRESS OF THE (HOSPITAL/NURSING HOME)?</p> <p>Name of Hospital <input type="text"/></p> <p>Street <input type="text"/></p> <p>City (or county) <input type="text"/> State <input type="text"/></p>		

CONTINUED ON NEXT PAGE

HOSPITAL PAGE (CONT'D)	ASK QUESTIONS 8-10 FOR ALL COMPLETED HOSPITALIZATIONS	Mark one circle →	"Yes" in Q. 4c - Go to 14 "No" in Q. 4c - Ask 8-10																																		
<p>Ask if "No" marked in question 4c:</p> <p>8. WHAT WAS THE TOTAL AMOUNT OF THE (HOSPITAL/NURSING HOME) BILL FOR THIS STAY? DO NOT INCLUDE DOCTORS' OR SURGEONS' BILLS.</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align: center;">Dollars</td> <td style="width:50%; text-align: center;">Cents</td> </tr> <tr> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> </table>	Dollars	Cents			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;">WASHINGTON USE</td> </tr> <tr> <td colspan="2">Tot. Amount</td> </tr> <tr> <td colspan="2" style="height: 40px;"></td> </tr> <tr> <td colspan="2">10. Source 1</td> </tr> <tr> <td colspan="2" style="text-align: center;">A B C D E F G H I D K</td> </tr> <tr> <td>Amount</td> <td style="text-align: right;">BL DK</td> </tr> </table>		WASHINGTON USE		Tot. Amount				10. Source 1		A B C D E F G H I D K		Amount	BL DK																		
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<p>9a. DID (WILL) HEALTH INSURANCE PAY ANY PART OF THIS BILL? <input type="checkbox"/> Yes <input type="checkbox"/> No - Go to 10</p> <p>b. WHAT IS THE NAME OF THE INSURANCE PLAN? →</p> <p>c. DID (WILL) ANY OTHER HEALTH INSURANCE PLAN PAY PART OF THIS (HOSPITAL/NURSING HOME) BILL?</p> <p style="font-size: small;">If "Yes" Reask 9b</p> <p style="font-size: x-small;">For each Health Insurance Plan named, ask:</p> <p>d. WHAT WAS (WILL BE) THE AMOUNT PAID BY (Name of Plan)?</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align: center;">Name of Insurance Plan</td> <td style="width:25%; text-align: center;">Dollars</td> <td style="width:25%; text-align: center;">Cents</td> </tr> <tr> <td style="height: 40px;"></td> <td style="height: 40px;"></td> <td style="height: 40px;"></td> </tr> </table>	Name of Insurance Plan	Dollars	Cents				<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="2">10. Source 2</td> </tr> <tr> <td colspan="2" style="text-align: center;">A B C D E F G H I D K</td> </tr> <tr> <td>Amount</td> <td style="text-align: right;">BL DK</td> </tr> <tr> <td colspan="2">10. Source 3</td> </tr> <tr> <td colspan="2" style="text-align: center;">A B C D E F G H I D K</td> </tr> <tr> <td>Amount</td> <td style="text-align: right;">BL DK</td> </tr> <tr> <td colspan="2">10. Source 4</td> </tr> <tr> <td colspan="2" style="text-align: center;">A B C D E F G H I D K</td> </tr> <tr> <td>Amount</td> <td style="text-align: right;">BL DK</td> </tr> </table>		10. Source 2		A B C D E F G H I D K		Amount	BL DK	10. Source 3		A B C D E F G H I D K		Amount	BL DK	10. Source 4		A B C D E F G H I D K		Amount	BL DK										
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<p>10a. WHO PAID (WILL PAY) THE (REMAINDER OF THE) HOSPITAL BILL? Mark each category mentioned</p> <p>b. DID ANY OTHER PERSON OR AGENCY PAY ANY OTHER PART OF THE HOSPITAL BILL?</p> <p><input type="checkbox"/> Yes - Ask 10c <input type="checkbox"/> No - Go to 10d</p> <p>c. WHO WAS THIS? Mark each category mentioned</p> <p>d. WHAT WAS THE AMOUNT PAID BY --?</p> <p style="font-size: x-small;">Enter amount paid opposite appropriate category.</p> <p>INTERVIEWER: Add amounts entered (include any amount paid by health insurance) and enter in TOTAL box, then mark one of the following boxes.</p> <p><input type="checkbox"/> Total amount paid (to be paid) agrees with amount of hospital bill - Go to Q. 11</p> <p><input type="checkbox"/> Total amount paid (to be paid) does NOT agree with amount of hospital bill - Resolve difference with respondent.</p>	<p>Enter total amount paid by health insurance in line A →</p> <p>Enter ANY amount paid by Social Security Medicare in line B →</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">A <input type="checkbox"/> Health insurance - All plans - exclude Medicare</td> <td style="width:25%; text-align: center;">Dollars</td> <td style="width:25%; text-align: center;">Cents</td> </tr> <tr> <td>B <input type="checkbox"/> Social Security Medicare</td> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> <tr> <td>C <input type="checkbox"/> Self and/or Family</td> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> <tr> <td>D <input type="checkbox"/> Relative not in household</td> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> <tr> <td>E <input type="checkbox"/> Friend</td> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> <tr> <td>F <input type="checkbox"/> Kerr Mills or other Fed. Plans</td> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> <tr> <td>G <input type="checkbox"/> Armed Forces Medicare</td> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> <tr> <td>H <input type="checkbox"/> State or Local Welfare Agency</td> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> <tr> <td>I <input type="checkbox"/> Other Specify</td> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> <tr> <td colspan="3" style="text-align: center;">TOTAL OF ABCVE - include amount paid by health insurance →</td> </tr> </table>	A <input type="checkbox"/> Health insurance - All plans - exclude Medicare	Dollars	Cents	B <input type="checkbox"/> Social Security Medicare			C <input type="checkbox"/> Self and/or Family			D <input type="checkbox"/> Relative not in household			E <input type="checkbox"/> Friend			F <input type="checkbox"/> Kerr Mills or other Fed. Plans			G <input type="checkbox"/> Armed Forces Medicare			H <input type="checkbox"/> State or Local Welfare Agency			I <input type="checkbox"/> Other Specify			TOTAL OF ABCVE - include amount paid by health insurance →			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="2">Under 55 - Go to 14</td> <td colspan="2">55 or over - Ask 11a</td> </tr> </table>		Under 55 - Go to 14		55 or over - Ask 11a	
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<p>11a. WHEN -- LEFT (Name of hospital/nursing home), DID HE RETURN HOME OR GO SOME OTHER PLACE?</p> <p><input type="checkbox"/> Home - Go to Question 12 <input type="checkbox"/> Some other place - Ask Question 11b</p> <p>b. WHAT KIND OF PLACE DID -- GO TO? Specify →</p> <p>INTERVIEWER: If the "Place" in 11b is a Hospital, Nursing Home or a similar place, was a Hospital Page filled for that stay? Mark one box.</p> <p><input type="checkbox"/> Hospital page filled - Stop <input type="checkbox"/> Hospital page not filled - Fill Hosp. page for unreported stay.</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;">WASHINGTON USE</td> </tr> <tr> <td colspan="2">Blank (incl 55)</td> </tr> <tr> <td colspan="2">page filled</td> </tr> <tr> <td colspan="2">none</td> </tr> <tr> <td colspan="2">Some other place</td> </tr> </table>			WASHINGTON USE		Blank (incl 55)		page filled		none		Some other place																									
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<p>12. AFTER LEAVING THE (HOSPITAL/NURSING HOME,) HOW MANY DAYS DID -- HAVE TO REMAIN IN BED ALL OR MOST OF THE DAY? Mark entry →</p> <p style="font-size: x-small;">Still in bed - Go to 14</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;"></td> <td style="width:50%; text-align: center;">None</td> </tr> <tr> <td style="text-align: center;">Dk</td> <td style="width:50%;"></td> </tr> </table>				None	Dk																															
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<p>13. (ALTOGETHER) HOW MANY DAYS WAS -- CONFINED TO THE HOUSE AFTER RETURNING HOME FROM THE (HOSPITAL/NURSING HOME)? Mark entry →</p> <p style="font-size: x-small;">Still confined to house</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;"></td> <td style="width:50%; text-align: center;">None</td> </tr> <tr> <td style="text-align: center;">Dk</td> <td style="width:50%;"></td> </tr> </table>				None	Dk																															
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<p>14. NOTE TO INTERVIEWER: If the condition in question 5 or 6 is on Card A (A-1, A-2) or B (B-1, B-2) or there is "1" or more nights in question 4b, the condition must have a completed Condition page. If the condition does not have a Condition page, fill one after completing all required Hospital pages.</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">• ■ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○</td> </tr> </table>			• ■ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○																																	
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<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. Palsy? 17. Paralysis of any kind? 18. REPEATED trouble with back or spine? 19. Cleft palate? 20. Any speech defect? 21. Hernia or rupture? 22. Prostate trouble? 	<p>Card D</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 F</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 H</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. Emphysema? 3. Hardening of the arteries? 4. High blood pressure? 5. Cancer? 6. Heart trouble? 7. Stroke? 8. Rheumatic fever? 9. Arthritis or rheumatism? 10. Mental illness? 11. Diabetes? 12. 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 E</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 G</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. 4. Not limited in any of the above ways. 	<p>Card I</p> <p>Which of the following income groups represents your total combined family income for the past 12 months? Include income from all sources such as wages, salaries, social security or retirement benefits, help from relatives, rents from property, and so forth.</p> <p>Under \$500 Group A \$500-- \$999 Group B \$1,000-- \$1,999 Group C \$2,000-- \$2,999 Group D \$3,000-- \$3,999 Group E \$4,000-- \$4,999 Group F \$5,000-- \$6,999 Group G \$7,000-- \$9,999 Group H \$10,000--\$14,999 Group I \$15,000 and over Group J</p>