

CONDITION PAGE 1	1. Person number	Name of condition																															
Enter person number and "Name of condition."	_____	_____																															
Ask for all conditions	2. Did -- ever at any time talk to a doctor about his . . . ?																																
Examine "Name of condition" entry in item 1 and mark	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No <input type="checkbox"/> Accident or injury (4) <input type="checkbox"/> On Card C (10) <input type="checkbox"/> Neither (3a)																																
If "Doctor talked to," ask: If "Doctor not talked to," record adequate description of condition or illness.	3a. What did the doctor say it was? Did he give it a medical name?																																
Do not ask for Cancer or Arthritis	b. What was the cause of . . . ?																																
If the entry in 3a or 3b includes the words:	<input type="checkbox"/> Accident or injury (4)																																
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%;">Arthritis</td> <td style="width: 25%;">Measles</td> <td style="width: 25%;">Ailment</td> <td style="width: 25%;">Disease</td> <td rowspan="5" style="width: 5%; vertical-align: middle;">} Ask!</td> </tr> <tr> <td>Asthma</td> <td>Rupture</td> <td>Attack</td> <td>Disorder</td> </tr> <tr> <td>Cyst</td> <td>Tumor</td> <td>Condition</td> <td>Trouble</td> </tr> <tr> <td>Growth</td> <td>Ulcer</td> <td>Defect</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>	Arthritis	Measles	Ailment	Disease	} Ask!	Asthma	Rupture	Attack	Disorder	Cyst	Tumor	Condition	Trouble	Growth	Ulcer	Defect						c. What kind of . . . is it?											
Arthritis	Measles	Ailment	Disease	} Ask!																													
Asthma	Rupture	Attack	Disorder																														
Cyst	Tumor	Condition	Trouble																														
Growth	Ulcer	Defect																															
For allergy or stroke, ask:	d. How does the allergy (stroke) affect him?																																
For any entry that includes the words:	e. What part of the body is affected? (Specify) _____																																
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%;">Abscess</td> <td style="width: 25%;">Damage</td> <td style="width: 25%;">Paralysis</td> <td rowspan="10" style="width: 5%; vertical-align: middle;">} Ask!</td> </tr> <tr> <td>Ache (except headache)</td> <td>Growth</td> <td>Rupture</td> </tr> <tr> <td>Bleeding</td> <td>Hemorrhage</td> <td>Sore</td> </tr> <tr> <td>Blood clot</td> <td>Infection</td> <td>Soreness</td> </tr> <tr> <td>Boil</td> <td>Inflammation</td> <td>Tumor</td> </tr> <tr> <td>Cancer</td> <td>Neuralgia</td> <td>Ulcer</td> </tr> <tr> <td>Cramps (except menstrual)</td> <td>Neuritis</td> <td>Varicose veins</td> </tr> <tr> <td>Cyst</td> <td>Pain</td> <td>Weak</td> </tr> <tr> <td></td> <td>Palsy</td> <td>Weakness</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>	Abscess	Damage	Paralysis	} Ask!	Ache (except headache)	Growth	Rupture	Bleeding	Hemorrhage	Sore	Blood clot	Infection	Soreness	Boil	Inflammation	Tumor	Cancer	Neuralgia	Ulcer	Cramps (except menstrual)	Neuritis	Varicose veins	Cyst	Pain	Weak		Palsy	Weakness				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	
Abscess	Damage	Paralysis	} Ask!																														
Ache (except headache)	Growth	Rupture																															
Bleeding	Hemorrhage	Sore																															
Blood clot	Infection	Soreness																															
Boil	Inflammation	Tumor																															
Cancer	Neuralgia	Ulcer																															
Cramps (except menstrual)	Neuritis	Varicose veins																															
Cyst	Pain	Weak																															
	Palsy	Weakness																															

FILL QUESTIONS 4-9 FOR ALL ACCIDENTS OR INJURIES

<p>4a. Did the accident happen during the past 2 years or before that time? <input type="checkbox"/> During the past 2 years (4b) <input type="checkbox"/> Before 2 years (5a)</p> <p>b. When did the accident happen? <input type="checkbox"/> Last week <input type="checkbox"/> 3-12 months <input type="checkbox"/> Week before <input type="checkbox"/> 1-2 years <input type="checkbox"/> 2 weeks-3 months</p> <p>Ask for all accidents or injuries: 5a. At the time of the accident what part of the body was hurt? What kind of injury was it? Anything else?</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Part(s) of body</td> <td style="width:50%;">Kind of injury</td> </tr> <tr> <td> </td> <td> </td> </tr> </table> <p>If accident happened BEFORE 3 months, ask: b. What part of the body is affected now? How is his -- affected? Is he affected in any other way?</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Part(s) of body</td> <td style="width:50%;">Present effects</td> </tr> <tr> <td> </td> <td> </td> </tr> </table> <p>6a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way? <input type="checkbox"/> Yes <input type="checkbox"/> No (7)</p> <p>b. Was more than one vehicle involved? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Was it (either one) moving at the time? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	Part(s) of body	Kind of injury			Part(s) of body	Present effects			<p>7. Where did the accident happen? 1 <input type="checkbox"/> At home (inside house) 2 <input type="checkbox"/> At home (adjacent premises) 3 <input type="checkbox"/> Street and highway (includes roadway) 4 <input type="checkbox"/> Farm 5 <input type="checkbox"/> Industrial place (includes premises) 6 <input type="checkbox"/> School (includes premises) 7 <input type="checkbox"/> Place of recreation and sports, except at school 8 <input type="checkbox"/> Other (Specify the place where accident happened)</p> <p>8. Was -- at work at his job or business when the accident happened? 1 <input type="checkbox"/> Yes <input type="checkbox"/> While in Armed Services 2 <input type="checkbox"/> No <input type="checkbox"/> Under 17 at time of accident</p> <p>Ask for all accidents that happened during the past 2 weeks except those involving moving motor vehicles.</p> <p>9. We are interested in the objects that caused this accident and injury. How did the accident happen?</p> <p>Footnotes</p>
Part(s) of body	Kind of injury								
Part(s) of body	Present effects								

Mark for all conditions	10. <input type="checkbox"/> Not an eye cond. (11) <input type="checkbox"/> First eye cond. (10a) <input type="checkbox"/> Under 6 (11) <input type="checkbox"/> Not first eye cond. (11)	10a. Can -- see well enough to read ordinary newspaper print with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
11. During the past two weeks, did his ... cause him to cut down on the things he usually does?		<input type="checkbox"/> Yes <input type="checkbox"/> No (16a)	
12. During that period, how many days did he cut down for as much as a day?		___ Days 00 <input type="checkbox"/> None (16a)	
13. During that 2-week period, how many days did his ... keep him in bed all or most of the day?		___ Days 00 <input type="checkbox"/> None	
14. Ask if 17+ years: How many days did his ... keep him from work during that 2-week period? (For females): not counting work around the house?		___ Days (16a) 00 <input type="checkbox"/> None (16a)	
15. Ask if 6-16 years: How many days did his ... keep him from school during that 2-week period?		___ Days 00 <input type="checkbox"/> None	
16a. When did he first notice his ...? - Was it during the past 3 months or before that time?		<input type="checkbox"/> During 3 mos. <input type="checkbox"/> More than 3 mos. ago (17)	
b. Did he first notice it during the past two weeks or before that time?		<input type="checkbox"/> Past 2 weeks <input type="checkbox"/> More than 2 wks. ago (AA)	
c. Which week, last week or the week before?		1 <input type="checkbox"/> Last week } (AA) 2 <input type="checkbox"/> Week before }	
17. Did -- first notice it during the past 12 months or before that time?		5 <input type="checkbox"/> 3-12 months 6 <input type="checkbox"/> More than 12 mos. ago	

AA	Continue if { reported in probe Q. 17, 28 or 36 or Card A } otherwise, go to next condition { Do not continue for missing extremities }		
INTERVIEWER CHECK ITEM	<input type="checkbox"/> Doctor seen (19)	<input type="checkbox"/> Doctor not seen (18)	
18. During the past 12 months what did -- do or take for his ...? Anything else? Write in _____		(25)	
19. After -- first noticed something was wrong, about how long was it before he talked to a doctor about it? (Probe: Was it a matter of days, weeks, or months?)		0 <input type="checkbox"/> Discovered by doctor (21) 2 ___ Days 4 ___ Months 3 ___ Weeks 5 ___ Years	
20. Before -- talked to a doctor about his ... , what did he do or take for this condition? Anything else? Write in _____		0 <input type="checkbox"/> Nothing	
21a. Does -- NOW take any medicine or treatment for his ... ?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (22)	
b. Was any of this medicine or treatment recommended by a doctor?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
22. Has he ever had surgery for this condition?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
23. Was he ever hospitalized for this condition?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
24. During the past 12 months, about how many times has -- seen or talked to a doctor about his ... ? (Do not count visits while a patient in a hospital.)		___ Times 000 <input type="checkbox"/> None	
25. About how many days during the past 12 months has this condition kept him in bed all or most of the day?		___ Days 000 <input type="checkbox"/> None	
26a. How often does his ... bother him - all of the time, often, once in a while, or never? 1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Often 3 <input type="checkbox"/> Once in a while 4 <input type="checkbox"/> Never (26c) 4 <input type="checkbox"/> Other _____ (Specify) _____ (26b)			
b. When it does bother him, is he bothered a great deal, some, or very little? 1 <input type="checkbox"/> Great deal (NC) 2 <input type="checkbox"/> Some (NC) 3 <input type="checkbox"/> Very little (NC) 4 <input type="checkbox"/> Other (Specify) _____ (NC)			
c. Does -- still have his ... ?		1 <input type="checkbox"/> Yes (Next condition) <input type="checkbox"/> No (26d)	
d. Is this condition completely cured or is it under control? _____ (NC)		2 <input type="checkbox"/> Cured (26e) 3 <input type="checkbox"/> Und. cont. (NC) 4 <input type="checkbox"/> Other (Specify)	
e. About how long did -- have this condition before it was cured?		0 <input type="checkbox"/> Less than one month ___ Months ___ Years	