

BD	Mark box(es) from item C.	BD 1 <input type="checkbox"/> 1+ Bed Days 2 <input type="checkbox"/> 1+ Hospital Stays 3 <input type="checkbox"/> No Bed Days
45. During the past 12 months (that is since _____ (date) a year ago), ABOUT how many days did illness or injury keep -- in bed all or most of the day? (Include the days in the past 2 weeks.) (Include the days while a patient in a hospital.) (Was it more than 7 days or less than 7 days?) (Was it more than 30 days or less than 30 days?) (Was it more than half the year or less than half the year?)		45. 0 <input type="checkbox"/> None 1 <input type="checkbox"/> 1-7 2 <input type="checkbox"/> 8-30 3 <input type="checkbox"/> 31-180 (6 months) 4 <input type="checkbox"/> 181+ (6 months +)

Table SA																																											
46a. Does anyone in the family now use (any of the following special aids) -	Yes	No																																									
1. An artificial arm?			<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;">Person No.</th> <th style="width:10%;">Type of aid</th> <th style="width:20%;">If 1-6 in (b), ASK: Does he use one or two ____ (at a time)?</th> <th style="width:60%;">If 3-10 in (b), ASK: For what condition does he need this ____? (Item C) If "brace," Ask: On what part of the body is the brace worn? (d)</th> </tr> <tr> <th>(a)</th> <th>(b)</th> <th>(c)</th> <th></th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> Other</td> <td></td> </tr> <tr> <td></td> <td></td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> Other</td> <td></td> </tr> <tr> <td></td> <td></td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> Other</td> <td></td> </tr> <tr> <td></td> <td></td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> Other</td> <td></td> </tr> <tr> <td></td> <td></td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> Other</td> <td></td> </tr> <tr> <td></td> <td></td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> Other</td> <td></td> </tr> <tr> <td></td> <td></td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> Other</td> <td></td> </tr> <tr> <td></td> <td></td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> Other</td> <td></td> </tr> </tbody> </table>	Person No.	Type of aid	If 1-6 in (b), ASK: Does he use one or two ____ (at a time)?	If 3-10 in (b), ASK: For what condition does he need this ____? (Item C) If "brace," Ask: On what part of the body is the brace worn? (d)	(a)	(b)	(c)				1 <input type="checkbox"/> 2 <input type="checkbox"/> Other				1 <input type="checkbox"/> 2 <input type="checkbox"/> Other				1 <input type="checkbox"/> 2 <input type="checkbox"/> Other				1 <input type="checkbox"/> 2 <input type="checkbox"/> Other				1 <input type="checkbox"/> 2 <input type="checkbox"/> Other				1 <input type="checkbox"/> 2 <input type="checkbox"/> Other				1 <input type="checkbox"/> 2 <input type="checkbox"/> Other				1 <input type="checkbox"/> 2 <input type="checkbox"/> Other	
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2. An artificial leg?																																											
3. A brace of any kind?																																											
4. Crutches?																																											
5. A cane or walking stick?																																											
6. Special shoes?																																											
7. A wheel chair?																																											
8. A walker?																																											
9. Guide dog?																																											
10. Any other kind of aid for getting around?																																											
If "Yes," specify: _____ <div style="text-align: center;">Enter in Table SA</div>																																											
b. Who is this? c. Anyone else?																																											

FOOTNOTES

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Table SA - Continued

Is the _____ used all of the time, most of the time or only occasionally? (e)	How long has he used _____? (f)	How was the _____ obtained? Was it purchased, rented, borrowed or a gift? (g)
1 <input type="checkbox"/> All 2 <input type="checkbox"/> Most 3 <input type="checkbox"/> Occasionally	<input type="checkbox"/> Less than 1 month ____ Months ____ Years	1 <input type="checkbox"/> Purchased 2 <input type="checkbox"/> Rented 3 <input type="checkbox"/> Borrowed 4 <input type="checkbox"/> Gift
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