Section Q. CONDITIONS AND IMPAIRMENTS

3–4

Read to respondent — **Now tell me if you have any of these eye conditions, even if you have mentioned them before.**

1. Do you NOW have — 5

a. Cataracts?	1☐ Yes	2☐ No	9☐ DK	6
b. Glaucoma?	1☐ Yes	2☐ No	9☐ DK	7
c. Color blindness?	1☐ Yes	2☐ No	9☐ DK	8
d. A detached retina or any other condition of the retina? *Circle appropriate condition*	1☐ Yes	2☐ No	9☐ DK	9
e. Blindness in one or both eyes? *If "Yes," ask:* **Which — one or both?**	Yes 0☐ One 1☐ Both *(Q1)*	2☐ No	9☐ DK	10
f. Any other trouble seeing with one or both eyes EVEN when wearing glasses?	1☐ Yes	2☐ No	9☐ DK	11

Q1 *Refer to answers in 1a–f*

1☐ All "No" or "DK" in 1a–f *(2)*
8☐ Other — *Enter "Yes" responses in EYE LTR box on Condition Summary Chart, THEN Q2*

12

Q2 *Blindness in BOTH eyes reported in 1e*

1☐ Yes *(4a THEN 9)*
2☐ No *(2)*

2a. Do you use eyeglasses? Include eyeglasses that just magnify.	1☐ Yes 2☐ No *(3)*	13
b. Were these eyeglasses prescribed for you?	1☐ Yes 2☐ No	14
3. Do you use contact lenses?	1☐ Yes 2☐ No	15
4a. Have you ever had an operation for cataracts?	1☐ Yes 2☐ No *(5)*	16
b. Do you have a lens implant?	1☐ Yes 2☐ No	17
5. Do you use a magnifying glass to read or to do other close work?	1☐ Yes 2☐ No	18

Read to respondent — **The next few questions are about how well you can see (wearing your [glasses/(or) contact lenses] if that's how you see best).**

6a. Can you see well enough to recognize the features of people if they are within two or three feet?	1☐ Yes 2☐ No	19
b. Can you see well enough to watch T.V. 8 to 12 feet away?	1☐ Yes 2☐ No	20
c. Can you see well enough to read newspaper print?	1☐ Yes 2☐ No	21
7a. Can you see well enough to step off a curb or down a step?	1☐ Yes 2☐ No	22
b. Can you see well enough to recognize a friend walking on the other side of the street?	1☐ Yes 2☐ No	23
8. Which statement best describes your vision (wearing [glasses/(or) contact lenses]) — no trouble seeing, a little trouble, or a lot of trouble?	1☐ No trouble 2☐ Little trouble 3☐ Lot of trouble	24

FORM HIS-1 (SB) (1984) (3-13-84)

Section Q. CONDITIONS AND IMPAIRMENTS, Continued

Read to respondent — **These next questions are about hearing.** — 25

9. Do you NOW have —

a. Tinnitus or ringing in the ears? *Circle appropriate condition.*
1 ☐ Yes 2 ☐ No 9 ☐ DK

b. Deafness in one or both ears? — 26
Yes
0 ☐ One 2 ☐ No 9 ☐ DK
If "Yes," ask: **Which — one or both?**
1 ☐ Both *(Q3)*

c. Any other trouble hearing with one or both ears? — 27
1 ☐ Yes 2 ☐ No 9 ☐ DK

Q3 *Refer to answers in 9a—c* — 28
1 ☐ All "No" or "DK" in 9a—c *(10)*
8 ☐ Other — *Enter "Yes" responses in EAR LTR box on Condition Summary Chart. THEN 10*

10a. Do you use a hearing aid? — 29
1 ☐ Yes
2 ☐ No

b. (With your hearing aid) Can you hear MOST of the things people say? — 30
1 ☐ Yes *(11)*
2 ☐ No

c. (With your hearing aid) Can you hear ONLY A FEW WORDS people say or LOUD noises? — 31
1 ☐ Yes
2 ☐ No

11. Which statement best describes your hearing (with your hearing aid) — no trouble hearing, a little trouble, or a lot of trouble? — 32
1 ☐ No trouble
2 ☐ Little trouble
3 ☐ Lot of trouble

Read to respondent — **Please tell me if you have EVER had any of the following conditions, even if you have mentioned them before.**

12. Have you EVER had — — 33

a. Osteoporosis, sometimes called fragile or soft bones? (os tee o po ro' sis)
1 ☐ Yes 2 ☐ No 9 ☐ DK

b. A broken hip? — 34
1 ☐ Yes 2 ☐ No 9 ☐ DK

c. Hardening of the arteries or arteriosclerosis? — 35
Circle appropriate condition
1 ☐ Yes 2 ☐ No 9 ☐ DK

d. Hypertension, sometimes called high blood pressure? — 36
1 ☐ Yes 2 ☐ No 9 ☐ DK

e. Rheumatic fever? — 37
1 ☐ Yes 2 ☐ No 9 ☐ DK

f. Rheumatic heart disease? — 38
1 ☐ Yes 2 ☐ No 9 ☐ DK

g. Coronary heart disease? — 39
1 ☐ Yes 2 ☐ No 9 ☐ DK

h. Angina pectoris? (pek' to ris) — 40
1 ☐ Yes 2 ☐ No 9 ☐ DK

i. A myocardial infarction? — 41
1 ☐ Yes 2 ☐ No 9 ☐ DK

j. Any other heart attack? — 42
1 ☐ Yes 2 ☐ No 9 ☐ DK

k. A stroke or a cerebrovascular accident? (ser' a-bro vas ku lar) — 43
Circle appropriate condition
1 ☐ Yes 2 ☐ No 9 ☐ DK

l. Alzheimer's disease? (al' zī mers) — 44
1 ☐ Yes 2 ☐ No 9 ☐ DK

m. Cancer of any kind? — 45
1 ☐ Yes 2 ☐ No 9 ☐ DK

Q4 *Refer to answers in 12a—m* — 46
1 ☐ All "No" or "DK" in 12a—m *(13)*
8 ☐ Other — *Enter "Yes" responses in EVER LTR box on Condition Summary Chart, THEN 13*

FORM HIS-115B(1984) (3-13-84)

Section Q. CONDITIONS AND IMPAIRMENTS, Continued

13. During the PAST 12 MONTHS, did you have —

47

a. Arthritis of any kind or rheumatism?
Circle appropriate condition
1 ☐ Yes 2 ☐ No 9 ☐ DK

48

b. Diabetes?
1 ☐ Yes 2 ☐ No 9 ☐ DK

49

c. An aneurysm?
(an' yoo rizm)
1 ☐ Yes 2 ☐ No 9 ☐ DK

50

d. Any blood clots?
1 ☐ Yes 2 ☐ No 9 ☐ DK

51

e. Varicose veins?
1 ☐ Yes 2 ☐ No 9 ☐ DK

52

Q5 *Refer to answers in 13a—e*
1 ☐ All "No" or "DK" in 13a—e *(14)*
9 ☐ Other — *Enter "Yes" responses in 12-MO LTR box on Condition Summary Chart, THEN 14*

53

14a. During the past 12 months, that is, since *(12-month date)* **a year ago, have you fallen?**
1 ☐ Yes
2 ☐ No *(14d)*

54

b. How many times?
1 ☐ One
2 ☐ More than one

55

c. [Did you fall/Were any of these falls] because you felt dizzy?
1 ☐ Yes *(14e)*
2 ☐ No

56

d. Do you sometimes have trouble with dizziness?
1 ☐ Yes
2 ☐ No *(15)*

57

e. Does dizziness prevent you in any way from doing things you otherwise could do?
1 ☐ Yes
2 ☐ No

58

15. Do you have trouble biting or chewing any kinds of food, such as firm meat or apples?
If asked — includes wearing false teeth/dentures.
1 ☐ Yes
2 ☐ No

RT 69
3—4

Read to respondent — **In order to determine how health practices and conditions are related to how long people live, we would like to refer to statistical records maintained by the National Center for Health Statistics.**

5—11

16a. I have your date of birth as *(birthdate from item 3 on HIS-1 Household Composition page)*. **Is that correct?**

Date of birth

Month	Date	Year

12—13

b. In what State or country were you born?

99 ☐ DK

Write in the full name of the State or mark the appropriate box if the sample person was not born in the United States.

_____ State

01 ☐ Puerto Rico
02 ☐ Virgin Islands
03 ☐ Guam
04 ☐ Canada
05 ☐ Cuba
06 ☐ Mexico
98 ☐ All other countries

14—33

c. To verify the spelling, what is your full name, including middle initial?

Last

34—48

First

49

Middle initial

50—69

Verify for males; ask for females.

d. What was your father's LAST name?
Verify spelling. DO NOT write "Same."

_____ Father's LAST name

70—78

Read to respondent — **We also need your Social Security Number. This information is voluntary and collected under the authority of the Public Health Service Act. There will be no effect on your benefits and no information will be given to any other government or nongovernment agency.**

Read if necessary — **The Public Health Service Act is title 42, United States Code, section 242k.**

999999999 ☐ DK

☐☐☐ – ☐☐ – ☐☐☐☐

Social Security Number

e. What is your Social Security Number?

Mark if number obtained from → 1 ☐ Memory 2 ☐ Records

79

FORM HIS-1(SB)(1984) 13-13-841

RT 70

Section R1. ACTIVITIES OF DAILY LIVING (ADL'S) 3–4

Read to respondent — **The next questions are about how well you are able to do certain activities — by yourself and without using special equipment.**

	(1) Bathing or showering? 5	(2) Dressing? 22	(3) Eating? 39
1. Because of a health or physical problem, do you have ANY difficulty — *Ask if "Doesn't do":* **Is this because of a HEALTH or PHYSICAL problem?** *If "Yes," mark box 1; if "No," mark box 3*	1 ☐ Yes 2 ☐ No 3 ☐ Doesn't do for other reason	1 ☐ Yes 2 ☐ No 3 ☐ Doesn't do for other reason	1 ☐ Yes 2 ☐ No 3 ☐ Doesn't do for other reason
Ask 2–5 for each ADL marked "Yes" in 1. **2. By yourself and without using special equipment, how much difficulty do you have (ADL), some, a lot, or are you unable to do it?**	6 1 ☐ Some 2 ☐ A lot 3 ☐ Unable	23 1 ☐ Some 2 ☐ A lot 3 ☐ Unable	40 1 ☐ Some 2 ☐ A lot 3 ☐ Unable
3. Do you receive help from another person in (ADL)?	7 1 ☐ Yes 2 ☐ No *(5)*	24 1 ☐ Yes 2 ☐ No *(5)*	41 1 ☐ Yes 2 ☐ No *(5)*
4a. Who gives this help? **Anyone else?** *Mark the S/C/P box without asking if ONLY help is from spouse/children/parents.* **b. Is this help paid for?** *Ask if necessary:* **Which helpers are paid?**	**4a.** Source of help 8–11 / **4b.** Paid 12–15 HH member 1 ☐ Relative . . . . 2 ☐ Nonrelative . . 0 ☐ S/C/P *(5)* 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Non-HH member 3 ☐ Relative . . . . 4 ☐ Nonrelative . . 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	**4a.** Source of help 25–28 / **4b.** Paid 29–32 HH member 1 ☐ Relative . . . . 2 ☐ Nonrelative . . 0 ☐ S/C/P *(5)* 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Non-HH member 3 ☐ Relative . . . . 4 ☐ Nonrelative . . 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	**4a.** Source of help 42–45 / **4b.** Paid 46–49 HH member 1 ☐ Relative . . . . 2 ☐ Nonrelative . . 0 ☐ S/C/P *(5)* 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Non-HH member 3 ☐ Relative . . . . 4 ☐ Nonrelative . . 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
5a. Do you use any special equipment or aids in (ADL)?	16 1 ☐ Yes 2 ☐ No *(2 for next ADL with "Yes" in 1)*	33 1 ☐ Yes 2 ☐ No *(2 for next ADL with "Yes" in 1)*	50 1 ☐ Yes 2 ☐ No *(2 for next ADL with "Yes" in 1)*
b. What special equipment or aids do you use? **Anything else?**	Special equipment or aids 17–18 19–20	Special equipment or aids 34–35 36–37	Special equipment or aids 51–52 53–54

Ask 6 if any ADL marked "Yes" in 1.

6a. What (other) condition causes the trouble in (read ADL(s))?

Ask if injury or operation: **When did [the (injury) occur? / you have the operation?]** *Enter injury if over 3 months ago.*

Ask or reask 6b, if 0–3 months injury or operation.

Ask if operation over 3 months ago: **For what condition did you have the operation?** *Enter condition.*

☐ Old age *(6c)*

b. Besides (condition), is there any other condition which causes this trouble in (read ADL(s))?

☐ Yes *(Reask 6a and b)*
☐ No *(6d)*

c. Is this trouble in (read ADL(s)) caused by any (other) specific condition?

☐ Yes *(Reask 6a and b)*
☐ No

If multiple conditions, including old age, are listed in 6a, ask 6d for each ADL with a "Yes" in 1. Otherwise, mark appropriate box or transcribe the only listed condition for each ADL.

d. Which of these conditions, that is (read conditions in 6a) would you say is the MAIN cause of the trouble in (ADL)?

(1) 21	(2) 38	(3) 55
1 ☐ 0–3 month Inj/Op ONLY 2 ☐ Old age	1 ☐ 0–3 month Inj/Op ONLY 2 ☐ Old age	1 ☐ 0–3 month Inj/Op ONLY 2 ☐ Old age
Ask 6d for next ADL with "Yes" in 1	*Ask 6d for next ADL with "Yes" in 1*	*Ask 6d for next ADL with "Yes" in 1*
3 ☐ _____ Condition — *Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.*	3 ☐ _____ Condition — *Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.*	3 ☐ _____ Condition — *Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.*

FOOTNOTES

FORM HIS-1 (58) (1984) (3-13-84)

Section R1. ACTIVITIES OF DAILY LIVING (ADL'S), Continued

Reask 1 (4) [56] **Getting in and out of bed or chairs?**	(5) [73] **Walking?**	(6) [90] **Getting outside?**	(7) [5] **Using the toilet, including getting to the toilet?**
1 ☐ Yes 2 ☐ No 3 ☐ Doesn't do for other reason	1 ☐ Yes 2 ☐ No 3 ☐ Doesn't do for other reason	1 ☐ Yes 2 ☐ No 3 ☐ Doesn't do for other reason	1 ☐ Yes 2 ☐ No 3 ☐ Doesn't do for other reason
[57] 1 ☐ Some 2 ☐ A lot 3 ☐ Unable	[74] 1 ☐ Some 2 ☐ A lot 3 ☐ Unable	[91] 1 ☐ Some 2 ☐ A lot 3 ☐ Unable	[6] 1 ☐ Some 2 ☐ A lot 3 ☐ Unable
[58] 1 ☐ Yes 2 ☐ No *(5)*	[75] 1 ☐ Yes 2 ☐ No *(5)*	[92] 1 ☐ Yes 2 ☐ No *(5)*	[7] 1 ☐ Yes 2 ☐ No *(5)*
4a. Source of help [59–62] / **4b.** Paid [63–66] HH member — 0 ☐ S/C/P *(5)* 1 ☐ Relative .... 1 ☐ Yes 2 ☐ No 2 ☐ Nonrelative . 1 ☐ Yes 2 ☐ No Non-HH member 3 ☐ Relative .... 1 ☐ Yes 2 ☐ No 4 ☐ Nonrelative . 1 ☐ Yes 2 ☐ No	**4a.** Source of help [76–79] / **4b.** Paid [80–83] HH member — 0 ☐ S/C/P *(5)* 1 ☐ Relative .... 1 ☐ Yes 2 ☐ No 2 ☐ Nonrelative . 1 ☐ Yes 2 ☐ No Non-HH member 3 ☐ Relative .... 1 ☐ Yes 2 ☐ No 4 ☐ Nonrelative . 1 ☐ Yes 2 ☐ No	**4a.** Source of help [93–96] / **4b.** Paid [97–100] HH member — 0 ☐ S/C/P *(5)* 1 ☐ Relative .... 1 ☐ Yes 2 ☐ No 2 ☐ Nonrelative . 1 ☐ Yes 2 ☐ No Non-HH member 3 ☐ Relative .... 1 ☐ Yes 2 ☐ No 4 ☐ Nonrelative . 1 ☐ Yes 2 ☐ No	**4a.** Source of help [8–11] / **4b.** Paid [12–15] HH member — 0 ☐ S/C/P *(5)* 1 ☐ Relative .... 1 ☐ Yes 2 ☐ No 2 ☐ Nonrelative . 1 ☐ Yes 2 ☐ No Non-HH member 3 ☐ Relative .... 1 ☐ Yes 2 ☐ No 4 ☐ Nonrelative . 1 ☐ Yes 2 ☐ No
[67] 1 ☐ Yes 2 ☐ No *(2 for next ADL with "Yes" in 1)*	[84] 1 ☐ Yes 2 ☐ No *(2 for next ADL with "Yes" in 1)*	[101] 1 ☐ Yes 2 ☐ No *(2 for next ADL with "Yes" in 1)*	[16] 1 ☐ Yes 2 ☐ No *(6)*
Special equipment or aids ______ [68–69] ______ [70–71]	Special equipment or aids ______ [85–86] ______ [87–88]	Special equipment or aids ______ [102–103] ______ [104–105]	Special equipment or aids ______ [17–18] ______ [19–20]
(4) [72] 1 ☐ 0–3 month Inj/Op ONLY 2 ☐ Old age *Ask 6d for next ADL with "Yes" in 1* 3 ☐ ______ Condition — *Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.*	(5) [89] 1 ☐ 0–3 month Inj/Op ONLY 2 ☐ Old age *Ask 6d for next ADL with "Yes" in 1* 3 ☐ ______ Condition — *Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.*	(6) [106] 1 ☐ 0–3 month Inj/Op ONLY 2 ☐ Old age *Ask 6d for next ADL with "Yes" in 1* 3 ☐ ______ Condition — *Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.*	(7) [21] 1 ☐ 0–3 month Inj/Op ONLY 2 ☐ Old age } *(Next page)* 3 ☐ ______ Condition — *Enter in ADL box on Condition Summary Chart, THEN next page.*

FOOTNOTES

FORM HIS-1 (SB) (1984) (3-13-84)

Section R1. ACTIVITIES OF DAILY LIVING (ADL'S), Continued

7a. Do you have difficulty controlling your bowels? — 22
1☐ Yes
2☐ No *(7c)*

b. How frequently do you have this difficulty — daily, several times a week, once a week, or less than once a week? — 23
1☐ Daily
2☐ Several times a week
3☐ Once a week
4☐ Less than once a week
9☐ DK

c. Do you have a colostomy or a device to help control bowel movements? — 24
1☐ Yes
2☐ No *(8)*

d. Do you need help from another person in taking care of this device? — 25
1☐ Yes
2☐ No

8a. Do you have difficulty controlling urination? — 26
1☐ Yes
2☐ No *(8c)*

b. How frequently do you have this difficulty — daily, several times a week, once a week, or less than once a week? — 27
1☐ Daily
2☐ Several times a week
3☐ Once a week
4☐ Less than once a week
9☐ DK

c. Do you have a urinary catheter or a device to help control urination? — 28
1☐ Yes
2☐ No *(R1)*

d. Do you need help from another person in taking care of this device? — 29
1☐ Yes
2☐ No

R1 *Mark first appropriate box* — 30
1☐ Respondent is a proxy
2☐ Sample person has only been seen in a bed or chair
3☐ Telephone interview
8☐ All other *(Next page)*
} *(9)*

Mark if known — 31

9. Because of a health or physical problem, do you usually —

a. Stay in bed all or most of the time?
1☐ Yes *(10)*
2☐ No

b. Stay in a chair all or most of the time? — 32
1☐ Yes *(10)*
2☐ No *(Next page)*

10a. What (other) condition causes you to stay in [bed/a chair]?
☐ Old age *(10c)*

Ask if injury or operation:
When did [the (injury) occur? / you have the operation?]
Enter injury if over 3 months ago.

Ask or reask 10b, if 0—3 months injury or operation.

Ask if operation over 3 months ago:
For what condition did you have the operation?
Enter condition.

b. Besides (condition), is there any other condition which causes this?
☐ Yes *(Reask 10a and b)*
☐ No *(10d)*

c. Is this caused by any (other) specific condition?
☐ Yes *(Reask 10a and b)*
☐ No

Ask if multiple conditions, including old age, are listed in 10a. Otherwise, mark appropriate box or transcribe the only listed condition. — 33

d. Which of these conditions, that is (read conditions in 10a) would you say is the MAIN cause of your staying in [bed/a chair] all or most of the time?
1☐ 0—3 month Inj/Op ONLY
2☐ Old age
} *(Next page)*
3☐ _____
Condition — *Enter "9" in ADL box on Condition Summary Chart, THEN next page.*

FORM HIS-1 (SB) (1984) (3-13-84)

Section R2. INCIDENTAL ACTIVITIES OF DAILY LIVING (IADL'S)

Read to respondent — **Now I will ask about some other activities. Tell me about doing them by yourself.**

	(1)	(2)
11. Because of a health or physical problem, do you have ANY difficulty — *Ask if "Doesn't do":* **Is this because of a HEALTH or PHYSICAL problem?** *If "Yes," mark box 1; if "No," mark box 3.*	34 **Preparing your own meals?** 1 ☐ Yes 2 ☐ No 3 ☐ Doesn't do for other reason	46 **Shopping for personal items, (such as toilet items or medicines)?** 1 ☐ Yes 2 ☐ No 3 ☐ Doesn't do for other reason
Ask 12—14 for each IADL marked "Yes" in 11. **12. By yourself, how much difficulty do you have (IADL), some, a lot, or are you unable to do it?**	35 1 ☐ Some 2 ☐ A lot 3 ☐ Unable	47 1 ☐ Some 2 ☐ A lot 3 ☐ Unable
13. Do you receive help from another person in (IADL)?	36 1 ☐ Yes 2 ☐ No *(12 for next IADL with "Yes" in 11)*	48 1 ☐ Yes 2 ☐ No *(12 for next IADL with "Yes" in 11)*

	Source of help 14a.	Paid 14b.	Source of help 14a.	Paid 14b.
14a. Who gives this help? **Anyone else?** *Mark the S/C/P box without asking if ONLY help is from spouse, children/ parents. THEN 12 for next IADL with "Yes" in 11.* **b. Is this help paid for?** *Ask if necessary:* **Which helpers are paid?**	37—40 HH member 1 ☐ Relative . . . . 2 ☐ Nonrelative . . Non-HH member 3 ☐ Relative . . . . 4 ☐ Nonrelative . .	41—44 0 ☐ S/C/P 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	49—52 HH member 1 ☐ Relative . . . . 2 ☐ Nonrelative . . Non-HH member 3 ☐ Relative . . . . 4 ☐ Nonrelative . .	53—56 0 ☐ S/C/P 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No

Ask 15 if any IADL marked "Yes" in 11. **15a. What (other) condition causes the trouble in (read IADL(s))?** *Ask if injury or operation:* **When did [the (injury) occur? / you have the operation?]** *Enter injury if over 3 months ago.* *Ask or reask 15b, if 0—3 months injury or operation.* *Ask if operation over 3 months ago:* **For what condition did you have the operation?** *Enter condition.*	☐ Old age *(15c)*	
b. Besides (condition), is there any other condition which causes the trouble in (read IADL(s))?	☐ Yes *(Reask 15a and b)* ☐ No *(15d)*	
c. Is the trouble in (read IADL(s)) caused by any (other) specific condition?	☐ Yes *(Reask 15a and b)* ☐ No	
If multiple conditions, including old age, are listed in 15a, ask 15d for each IADL with a "Yes" in 11. Otherwise, mark appropriate box or transcribe the only listed condition. **d. Which of these conditions, that is (read conditions in 15a) would you say is the MAIN cause of the trouble in (IADL)?**	(1) 45 1 ☐ 0—3 month Inj/ Op ONLY 2 ☐ Old age *Ask 15d for next IADL with "Yes" in 11* 3 ☐ _____ Condition — *Enter in IADL box on Condition Summary Chart, THEN ask 15d for next IADL with "Yes" in 11.*	(2) 57 1 ☐ 0—3 month Inj/ Op ONLY 2 ☐ Old age *Ask 15d for next IADL with "Yes" in 11* 3 ☐ _____ Condition — *Enter in IADL box on Condition Summary Chart, THEN ask 15d for next IADL with "Yes" in 11.*

FOOTNOTES

Section R2. INCIDENTAL ACTIVITIES OF DAILY LIVING (IADL'S), Continued

(3) 58	(4) 70	(5) 82	(6) 94
Managing your money, (such as keeping track of expenses or paying bills)? 1 ☐ Yes 2 ☐ No 3 ☐ Doesn't do for other reason	*Reask 11* **Using the telephone?** 1 ☐ Yes 2 ☐ No 3 ☐ Doesn't do for other reason	**Doing heavy housework, (like scrubbing floors, or washing windows)?** 1 ☐ Yes 2 ☐ No 3 ☐ Doesn't do for other reason	**Doing light housework, (like doing dishes, straightening up, or light cleaning)?** 1 ☐ Yes 2 ☐ No 3 ☐ Doesn't do for other reason
59 1 ☐ Some 2 ☐ A lot 3 ☐ Unable	71 1 ☐ Some 2 ☐ A lot 3 ☐ Unable	83 1 ☐ Some 2 ☐ A lot 3 ☐ Unable	95 1 ☐ Some 2 ☐ A lot 3 ☐ Unable
60 1 ☐ Yes 2 ☐ No *(12 for next IADL with "Yes" in 11)*	72 1 ☐ Yes 2 ☐ No *(12 for next IADL with "Yes" in 11)*	84 1 ☐ Yes 2 ☐ No *(12 for next IADL with "Yes" in 11)*	96 1 ☐ Yes 2 ☐ No *(15)*
Source of help 14a. 61–64 / Paid 14b. 65–68	Source of help 14a. 73–76 / Paid 14b. 77–80	Source of help 14a. 85–88 / Paid 14b. 89–92	Source of help 14a. 97–100 / Paid 14b. 101–104
HH member 1 ☐ Relative . . . . 2 ☐ Nonrelative . . Non-HH member 3 ☐ Relative . . . . 4 ☐ Nonrelative . .	0 ☐ S/C/P 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	HH member 1 ☐ Relative . . . . 2 ☐ Nonrelative . . Non-HH member 3 ☐ Relative . . . . 4 ☐ Nonrelative . .	0 ☐ S/C/P 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
HH member 1 ☐ Relative . . . . 2 ☐ Nonrelative . . Non-HH member 3 ☐ Relative . . . . 4 ☐ Nonrelative . .	0 ☐ S/C/P 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	HH member 1 ☐ Relative . . . . 2 ☐ Nonrelative . . Non-HH member 3 ☐ Relative . . . . 4 ☐ Nonrelative . .	0 ☐ S/C/P 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
(3) 69 1 ☐ 0–3 month Inj/ Op ONLY 2 ☐ Old age *Ask 15d for next IADL with "Yes" in 11* 3 ☐ _____ Condition – *Enter in IADL box on Condition Summary Chart, THEN ask 15d for next IADL with "Yes" in 11.*	(4) 81 1 ☐ 0–3 month Inj/ Op ONLY 2 ☐ Old age *Ask 15d for next IADL with "Yes" in 11* 3 ☐ _____ Condition – *Enter in IADL box on Condition Summary Chart, THEN ask 15d for next IADL with "Yes" in 11.*	(5) 93 1 ☐ 0–3 month Inj/ Op ONLY 2 ☐ Old age *Ask 15d for next IADL with "Yes" in 11* 3 ☐ _____ Condition – *Enter in IADL box on Condition Summary Chart, THEN ask 15d for next IADL with "Yes" in 11.*	(6) 105 1 ☐ 0–3 month Inj/ Op ONLY 2 ☐ Old age *Next page* 3 ☐ _____ Condition – *Enter in IADL box on Condition Summary Chart, THEN next page.*

FOOTNOTES

FORM HIS 1 (58)-(1984)-3 13 84

RT 73

Section U. SUPPLEMENT CONDITION PAGES

CONDITION A

3–4
5–6

1. Name of condition

2. **When did you last see or talk to a doctor or assistant about your** *(condition)*? 7

0 ☐ Interview week *(Reask 2)*
1 ☐ 2-wk. ref. pd.
2 ☐ Over 2 weeks, less than 6 mos.
3 ☐ 6 mos., less than 1 yr.
4 ☐ 1 yr., less than 2 yrs.
5 ☐ 2 yrs., less than 5 yrs.
6 ☐ 5 yrs. or more
7 ☐ Dr. seen, DK when
8 ☐ DK if Dr. seen } *(3b)*
9 ☐ Dr. never seen }

3a. Did the doctor or assistant call the *(condition)* **by a more technical or specific name?** 8

1 ☐ Yes 2 ☐ No 9 ☐ DK

Ask 3b if "Yes" in 3a, otherwise transcribe condition name from item 1 without asking: 9–12

b. What did he or she call it? *(Specify)*

1 ☐ Color Blindness *(NC)*
2 ☐ Cancer *(3e)*
3 ☐ Vasectomy *(5)*
8 ☐ Other *(3c)*
13

c. What was the cause of your *(condition in 3b)*? *(Specify)*

Mark box if accident or injury 0 ☐ Accident/injury *(5)* 14

d. Did the *(condition in 3b)* **result from an accident or injury?**

1 ☐ Yes *(5)* 2 ☐ No

Ask 3e if the condition name in 3b includes any of the following words:

Ailment	Cancer	Disease	Problem
Anemia	Condition	Disorder	Rupture
Asthma	Cyst	Growth	Trouble
Attack	Defect	Measles	Tumor
Bad			Ulcer

e. What kind of *(condition in 3b)* **is it?** *(Specify)*

Ask 3f only if allergy or stroke in 3b—e:

f. How does the [allergy/stroke] NOW affect you? *(Specify)*

For Stroke, fill remainder of this condition page for the first present effect. If additional present effects, enter in Condition Summary Chart each one that is not already in the Condition Summary Chart. (If in C2 in HIS-1, enter condition number and transcribe when editing; if not, fill additional supplement page(s) during interview.)

Ask 3g if there is an impairment (refer to Card CP2) or any of the following entries in 3b—f:

Abscess	Cancer	Infection	Rupture
Ache (except head or ear)	Cramps (except menstrual)	Inflammation	Sore(ness)
		Neuralgia	Stiff(ness)
Bleeding (except menstrual)	Cyst	Neuritis	Tumor
	Damage	Pain	Ulcer
Blood clot	Growth	Palsy	Varicose veins
Boil	Hemorrhage	Paralysis	Weak(ness)

g. What part of the body is affected? *(Specify)*

Show the following detail:

Head ..... skull, scalp, face
Back/spine/vertebrae ..... upper, middle, lower
Side ..... left or right
Ear ..... inner or outer; left, right, or both
Eye ..... left, right, or both
Arm ..... shoulder, upper, elbow, lower or wrist; left, right, or both
Hand ..... entire hand or fingers only; left, right, or both
Leg ..... hip, upper, knee, lower, or ankle; left, right, or both
Foot ..... entire foot, arch, or toes only; left, right, or both

Except for eyes, ears, or internal organs, ask 3h if there are any of the following entries in 3b—f:

Infection **Sore** **Soreness**

3h. What part of the *(part of body in 3b—g)* **is affected by the [infection/sore/soreness] — the skin, muscle, bone, or some other part?** *(Specify)*

Ask if there are any of the following entries in 3b—f: 15

Tumor **Cyst** **Growth**

4. Is this [tumor/cyst/growth] malignant or benign?

1 ☐ Malignant 2 ☐ Benign 9 ☐ DK

5. a. When was your *(condition in 3b/3f)* **first noticed?** 16

b. When did you *(name of injury in 3b)*?

1 ☐ 2-week ref. pd.
2 ☐ Over 2 weeks to 3 months
3 ☐ Over 3 months to 1 year
4 ☐ Over 1 year to 5 years
5 ☐ Over 5 years

Ask probes as necessary:
(Was it on or since *(first date of 2-week ref. period)* **or was it before that date?)**
(Was it less than 3 months or more than 3 months ago?)
(Was it less than 1 year or more than 1 year ago?)
(Was it less than 5 years or more than 5 years ago?)

U1 (K3) 1 ☐ Missing extremity or organ in 3b/3f *(U2)* 8 ☐ Other *(12)* 17

12a. Do you still have this condition?

1 ☐ Yes *(U2)* ☐ No 18

b. Is this condition completely cured or is it under control?

2 ☐ Cured 8 ☐ Other *(Specify)* *(U2)*
3 ☐ Under control *(U2)*

c. About how long did you have this condition before it was cured? 19–21

ooo ☐ Less than 1 month **OR** Number { 1 ☐ Months 2 ☐ Years

d. Was this condition present at any time during the past 12 months? 22

1 ☐ Yes 2 ☐ No

U2 (K4) 23
1 ☐ Not an accident/injury *(NC)*
2 ☐ First accident/injury for this person *(17b)*
8 ☐ Other *(17b)*

Ask if box 3, 4, or 5 marked in item 5

17b. What part of the body is affected now?

How is your *(part of body)* **affected?** Same acc. as Cond. ____

Are you affected in any other way?

Part(s) of body *	Present effects **
	24

* Enter part of body in same detail as for 3g.

** If multiple present effects, enter in Condition Summary Chart each one that is not the same as 3b above or is not already in the Condition Summary Chart. (If in C2 in HIS-1, enter condition number and transcribe when editing; if not, fill additional supplement page(s) during interview.)

25

U3

a. *Indicate status of this condition page.* 1 ☐ Transcribed from HIS-1 2 ☐ Obtained in SOA Interview

b. *When editing, transcribe source data for this condition from the appropriate line in the Condition Summary Chart.*

EYE LTR	EAR LTR	EVER LTR	12 MO. LTR	ADL NUMBERS	IADL NUMBERS	CP
26	27	28	29	30–37	38–43	44–46

FORM HIS-1 (SB) (1984) (3-13-84)