

Section N. GENERAL HEALTH HABITS		RT72
		3-4
Sample Person Number _____		
<b>N1</b>	1 <input type="checkbox"/> Callback required (Hhld. page) 2 <input type="checkbox"/> Noninterview (Cover page) 3 <input type="checkbox"/> Available (1)	5
Read to respondent: These questions are about general health practices.		6
1. How often do you eat breakfast – almost every day, sometimes, rarely or never?	1 <input type="checkbox"/> Almost every day 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely or never	
2. Including evening snacks, how often do you eat between meals – almost every day, sometimes, rarely or never?	1 <input type="checkbox"/> Almost every day 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely or never	7
3. When you visit a doctor or other health professional for routine care, is eating proper foods discussed often, sometimes, rarely or never?	1 <input type="checkbox"/> Often 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely or never 4 <input type="checkbox"/> Don't visit for routine care	8
<b>N2</b>	Refer to page 46 or 47, item R, of HIS-1.	9
4a. About how tall are you without shoes?	_____ Feet _____ Inches	10-12
b. About how much do you weigh without shoes?	_____ Pounds	13-15
Hand Card N1 or read responses for telephone interview.		16
5. In your opinion which of these are the TWO best ways to lose weight?	1 <input type="checkbox"/> Don't eat at bedtime 2 <input type="checkbox"/> Eat fewer calories 3 <input type="checkbox"/> Take diet pills 4 <input type="checkbox"/> Increase physical activity 5 <input type="checkbox"/> Eat NO fat 6 <input type="checkbox"/> Eat grapefruit with each meal	17
6. Are you now trying to lose weight?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (9)	18
7. Are you eating fewer calories to lose weight?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	19
8. Have you increased your physical activity to lose weight?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	20
9a. Do you consider yourself overweight, underweight, or just about right?	1 <input type="checkbox"/> Overweight 2 <input type="checkbox"/> Underweight 3 <input type="checkbox"/> About right } (10)	21
b. Would you say you are very overweight, somewhat overweight, or only a little overweight?	1 <input type="checkbox"/> Very overweight 2 <input type="checkbox"/> Somewhat overweight 3 <input type="checkbox"/> Only a little overweight	22
10. On the average, how many hours of sleep do you get in a 24-hour period?	_____ Hours	23-24
FOOTNOTES		

**Section N. GENERAL HEALTH HABITS -- Continued**

<b>11. Is there a particular clinic, health center, doctor's office, or other place that you usually go to if you are sick or need advice about your health?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (14)	25
<b>12. What kind of place is it -- a clinic, a health center, a hospital, a doctor's office, or some other place?</b>  IF HOSPITAL: Is this an outpatient clinic or the emergency room?  IF CLINIC: Is this a hospital outpatient clinic, a company clinic, or some other kind of clinic?	1 <input type="checkbox"/> Doctor's office (group practice or doctor's clinic) 2 <input type="checkbox"/> Hospital outpatient clinic 3 <input type="checkbox"/> Sample person's home 4 <input type="checkbox"/> Hospital emergency room 5 <input type="checkbox"/> Company or industry clinic 6 <input type="checkbox"/> Health center 8 <input type="checkbox"/> Other (Specify) _____	26
<b>13. Is there ONE particular doctor you usually see at (place in 12)?</b>	1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } (N3)	27
Hand Card N2 or read reasons for telephone interview.  <b>14. Which of these is the MAIN reason you don't have a particular place you usually go?</b>	1 <input type="checkbox"/> Have two or more usual doctors or places depending on what is wrong 2 <input type="checkbox"/> Haven't needed a doctor 3 <input type="checkbox"/> Previous doctor no longer available 4 <input type="checkbox"/> Haven't been able to find the right doctor 5 <input type="checkbox"/> Recently moved to area 6 <input type="checkbox"/> Can't afford medical care 8 <input type="checkbox"/> Other reason (Specify) _____	28
<b>N3</b> Refer to sex.	1 <input type="checkbox"/> Male (Section O) 2 <input type="checkbox"/> Female (15)	29
<b>15. About how long has it been since you had a Pap smear test?</b>	_____ Years 98 <input type="checkbox"/> Never 00 <input type="checkbox"/> Less than 1 year	30-31
<b>16a. About how long has it been since you had a breast examination by a doctor or other health professional?</b>	_____ Years 98 <input type="checkbox"/> Never 00 <input type="checkbox"/> Less than 1 year	32-33
<b>b. Do you know how to examine your own breasts for lumps?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Section O)	34
<b>c. About how many times a year do you examine your own breasts for lumps?</b>	_____ Times per year 98 <input type="checkbox"/> Other (Specify) _____ 98 <input type="checkbox"/> Never	35-36
FOOTNOTES		

Section O. INJURY CONTROL AND CHILD SAFETY AND HEALTH									
<b>01</b>	Refer to household composition.	1 <input type="checkbox"/> Children under 10 in family (1) 2 <input type="checkbox"/> No children under 10 in family (03)	37						
Read to respondent: These questions are about preventing injuries to children.			38						
<b>1a.</b>	Have you ever heard about POISON CONTROL CENTERS?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2)							
<b>b.</b>	Do you have the telephone number for a Poison Control Center in your area?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	39						
<b>2.</b>	There is a medication called IPECAC (ip' i kak) SYRUP which is sometimes taken to cause vomiting after something poisonous is swallowed. Do you now have any Ipecac Syrup in this household?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	40						
<b>02</b>	Refer to household composition.	1 <input type="checkbox"/> Children under 5 in family (3) 2 <input type="checkbox"/> No children under 5 in family (03)	41						
<b>3.</b>	Have you heard about child safety seats, sometimes called car safety carriers, which are designed to carry children while they are riding in a car?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (03)	42						
<b>4.</b>	Did a doctor or other health professional EVER tell you about the importance of using car safety seats for (your) children?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	43						
<b>03</b>	Refer to household composition.	1 <input type="checkbox"/> Children under 18 in family (04) 2 <input type="checkbox"/> No children under 18 in family (10)	44						
<b>04</b>	Enter person number and name of all children under 18; THEN mark box.	<table border="1"> <tr> <td>Person Number</td> <td>5-6</td> </tr> <tr> <td>First name</td> <td></td> </tr> <tr> <td>1 <input type="checkbox"/> Under 5 (5) 2 <input type="checkbox"/> 5-17 (7)</td> <td>7</td> </tr> </table>	Person Number	5-6	First name		1 <input type="checkbox"/> Under 5 (5) 2 <input type="checkbox"/> 5-17 (7)	7	RT73 3-4
Person Number	5-6								
First name									
1 <input type="checkbox"/> Under 5 (5) 2 <input type="checkbox"/> 5-17 (7)	7								
<b>5.</b>	When --- was brought home from the hospital following birth, was --- buckled in a car safety seat?	5. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Not born in hospital 4 <input type="checkbox"/> Didn't ride home in "car" 9 <input type="checkbox"/> DK	8						
<b>6a.</b>	Does --- now have a car safety seat?	6a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (7)	9						
<b>b.</b>	When riding in a car, is --- buckled in a car safety seat all or most of the time, some of the time, once in awhile, or never?	b. 1 <input type="checkbox"/> All or most of the time 2 <input type="checkbox"/> Some of the time 3 <input type="checkbox"/> Once in awhile 4 <input type="checkbox"/> Never 9 <input type="checkbox"/> DK } (7) (NP)	10						
<b>7.</b>	When riding in a car, does --- wear a seat belt all or most of the time, some of the time, once in awhile, or never?	7. 1 <input type="checkbox"/> All or most of the time 2 <input type="checkbox"/> Some of the time 3 <input type="checkbox"/> Once in awhile 4 <input type="checkbox"/> Never 5 <input type="checkbox"/> Uses child safety seat 9 <input type="checkbox"/> DK	11						
<b>05</b>	Refer to age.	05 1 <input type="checkbox"/> Under 5 (8) 8 <input type="checkbox"/> Other (06)	12						
Read to respondent: (These next questions are about breastfeeding.)			13						
<b>8.</b>	Was --- ever breastfed?	8. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (06)							
<b>9.</b>	How old was --- when --- COMPLETELY stopped breastfeeding?	9. 000 <input type="checkbox"/> Still breastfed Age { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	14-16						
<b>06</b>	Respondent	06 1 <input type="checkbox"/> Child's parent 8 <input type="checkbox"/> Other	17						

FORM HIS-1(SB) (1985) (4-25-85)

Section O. INJURY CONTROL AND CHILD SAFETY AND HEALTH — Continued		RT74
		3-4
		5
10. When driving or riding in a car, do you wear a seat belt all or most of the time, some of the time, once in awhile, or never?	<input type="checkbox"/> All or most of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Once in awhile <input type="checkbox"/> Never <input type="checkbox"/> Don't ride in car	
<i>Read to respondent:</i> The next questions are about this home.		6-7
11a. How many smoke detectors are installed in this home?	<input type="checkbox"/> Only 1 (11c) _____ Number (11b) <input type="checkbox"/> None } (12) <input type="checkbox"/> DK }	
b. How many of them are now working?	_____ Number (11d) <input type="checkbox"/> None (11f)	8-9
c. Is it now working?	<input type="checkbox"/> Yes <input type="checkbox"/> No } (11f) <input type="checkbox"/> DK }	10
d. How do you know [it is/they are] working?	<input type="checkbox"/> Tested it/them <input type="checkbox"/> It/they went off because of smoke <input type="checkbox"/> It/they went off while cooking <input type="checkbox"/> Changed the batteries <input type="checkbox"/> The light is on <input type="checkbox"/> Beeps when battery is low <input type="checkbox"/> Other (Specify) _____	11 12 13 14 15 16 17
e. Any other way?	<input type="checkbox"/> Yes (Reask 11d and e) <input type="checkbox"/> No	
f. [Is it/Are any of the smoke detectors] next to a sleeping area?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	18
12a. Do you know about what the hot water temperature is in this home?	<input type="checkbox"/> Yes <input type="checkbox"/> No (13)	19
b. About what temperature is the hot water?	_____ Temperature OR <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> Medium	20-22 23
c. How did you estimate the hot water temperature?	<input type="checkbox"/> The setting on hot water heater <input type="checkbox"/> Tested with thermometer <input type="checkbox"/> Guessed <input type="checkbox"/> Other (Specify) _____	24
13. In the past 12 months, have you (or has anyone in your household) used a thermometer to test the temperature of the hot water here?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	25
14. ABOVE what temperature will hot water cause scald injuries?	_____ Temperature <input type="checkbox"/> DK	26-28
FOOTNOTES		

FORM HD-100 (100) (100) (4-25-84)

Section P. HIGH BLOOD PRESSURE						RT75 3-4
<p><b>1. I am going to read a list of things which may or may not affect a person's chances of getting HEART DISEASE.</b></p> <p><i>Hand Card P</i></p> <p>After I read each one, tell me if you think it definitely increases, probably increases, probably does not, or definitely does not increase a person's chances of getting heart disease. First —</p>						
	DEFINITELY INCREASES	PROBABLY INCREASES	PROBABLY DOES NOT INCREASE	DEFINITELY DOES NOT INCREASE	DK/NO OPINION	
a. Cigarette smoking? (Give me a number from the card.)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	5
b. Worry or anxiety?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	6
c. High blood pressure?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	7
d. Diabetes?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	8
e. Being VERY overweight?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	9
f. Overwork?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	10
g. Drinking coffee with caffeine?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	11
h. Eating a diet high in animal fat?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	12
i. Family history of heart disease?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	13
j. High cholesterol?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	14
2. The following conditions are related to having a STROKE. In your opinion, which of these conditions MOST increases a person's chances of having a stroke — diabetes, high blood pressure, or high cholesterol?	1 <input type="checkbox"/> Diabetes 2 <input type="checkbox"/> High blood pressure 3 <input type="checkbox"/> High cholesterol 9 <input type="checkbox"/> DK					15
3. Which one of the following substances in food is MOST often associated with HIGH BLOOD PRESSURE — sodium, cholesterol or sugar?	1 <input type="checkbox"/> Sodium 2 <input type="checkbox"/> Cholesterol 3 <input type="checkbox"/> Sugar 9 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> DK					16
4. Have you EVER been told by a doctor or other health professional that you had hypertension, sometimes called high blood pressure?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (12) 3 <input type="checkbox"/> Only during pregnancy (12)					17
5. Were you told two or more DIFFERENT times that you had hypertension or high blood pressure?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK					18
6. Are you NOW taking any medicine prescribed by a doctor for your hypertension or high blood pressure?	1 <input type="checkbox"/> Yes (8) 2 <input type="checkbox"/> No					19
7a. Was any medicine EVER prescribed by a doctor for your hypertension or high blood pressure?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (8)					20
b. Did a doctor advise you to stop taking the medicine?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					21
FOOTNOTES						

**Section P. HIGH BLOOD PRESSURE – Continued**

<b>8. Because of your hypertension or high blood pressure, has a doctor or other health professional EVER advised you to –</b>	<b>a. Diet to lose weight?</b> 1 <input type="checkbox"/> Yes (9) <span style="float:right">22</span> 2 <input type="checkbox"/> No (8b)	<b>b. Cut down on salt or sodium in your diet?</b> 1 <input type="checkbox"/> Yes (9) <span style="float:right">23</span> 2 <input type="checkbox"/> No (8c)	<b>c. Exercise?</b> 1 <input type="checkbox"/> Yes (9) <span style="float:right">24</span> 2 <input type="checkbox"/> No (11)
<b>9. Have you EVER followed this advice?</b>	1 <input type="checkbox"/> Yes (10) <span style="float:right">25</span> 2 <input type="checkbox"/> No (8b)	1 <input type="checkbox"/> Yes (10) <span style="float:right">26</span> 2 <input type="checkbox"/> No (8c)	1 <input type="checkbox"/> Yes (10) <span style="float:right">27</span> 2 <input type="checkbox"/> No (11)
<b>10. Are you NOW following this advice?</b>	1 <input type="checkbox"/> Yes } (8b) <span style="float:right">28</span> 2 <input type="checkbox"/> No }	1 <input type="checkbox"/> Yes } (8c) <span style="float:right">29</span> 2 <input type="checkbox"/> No }	1 <input type="checkbox"/> Yes } (11) <span style="float:right">30</span> 2 <input type="checkbox"/> No }
<b>11a. Do you still have hypertension or high blood pressure?</b>	1 <input type="checkbox"/> Yes (12) <span style="float:right">31</span> 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK		
<b>b. Is this condition completely cured or is it under control?</b>	1 <input type="checkbox"/> Cured <span style="float:right">32</span> 2 <input type="checkbox"/> Under control 9 <input type="checkbox"/> DK		
<b>12a. ABOUT how long has it been since you LAST had your blood pressure taken by a doctor or other health professional?</b>	Number { 2 <input type="checkbox"/> Days 3 <input type="checkbox"/> Weeks 4 <input type="checkbox"/> Months 5 <input type="checkbox"/> Years 999 <input type="checkbox"/> DK } (13) 000 <input type="checkbox"/> Never		
<b>b. Blood pressure is usually given as one number over another. Were you told what your blood pressure was, in NUMBERS?</b>	1 <input type="checkbox"/> Yes <span style="float:right">35</span> 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (12d)		
<b>c. What was your blood pressure, in NUMBERS?</b>	_____ / _____ <span style="float:right">37-39</span> 999 999 <input type="checkbox"/> DK		
<b>d. At that time, was your blood pressure high, low, or normal?</b>	1 <input type="checkbox"/> High <span style="float:right">40-42</span> 2 <input type="checkbox"/> Low 3 <input type="checkbox"/> Normal 8 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> DK <span style="float:right">43</span>		
<b>13. Do you NOW have diabetes or sugar diabetes?</b>	1 <input type="checkbox"/> Yes <span style="float:right">44</span> 2 <input type="checkbox"/> No 8 <input type="checkbox"/> Other (Specify) _____		
<b>14. Have you ever been told by a doctor or other health professional that you had high cholesterol?</b>	1 <input type="checkbox"/> Yes <span style="float:right">45</span> 2 <input type="checkbox"/> No		
<b>15. Do you have any kind of heart condition or heart trouble?</b>	1 <input type="checkbox"/> Yes <span style="float:right">46</span> 2 <input type="checkbox"/> No		
<b>16. Have you ever had a stroke?</b>	1 <input type="checkbox"/> Yes <span style="float:right">47</span> 2 <input type="checkbox"/> No		
FOOTNOTES			

Section Q. STRESS		48		
<p><i>Read to respondent:</i></p> <p><b>These next questions are about stress.</b></p> <p><b>1. During the past 2 weeks, would you say that you experienced a lot of stress, a moderate amount of stress, relatively little stress, or almost no stress at all?</b></p>		<p>1 <input type="checkbox"/> A lot</p> <p>2 <input type="checkbox"/> Moderate</p> <p>3 <input type="checkbox"/> Relatively little</p> <p>4 <input type="checkbox"/> Almost none</p> <p>5 <input type="checkbox"/> DK what stress is (3)</p>		
<p><b>2. In the past year, how much effect has stress had on your health — a lot, some, hardly any or none?</b></p>		<p>1 <input type="checkbox"/> A lot</p> <p>2 <input type="checkbox"/> Some</p> <p>3 <input type="checkbox"/> Hardly any or none</p>		
<p><b>3a. In the past year, did you think about seeking help for any personal or emotional problems from family or friends?</b></p>		<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>		
<p><b>b. from a helping professional or a self-help group?</b></p>		<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>		
<b>Q1</b>	Refer to 3a and b.	<p>1 <input type="checkbox"/> "No" in 3a and 3b (Section R)</p> <p>8 <input type="checkbox"/> Other (4)</p>		
<p><b>4a. Did you actually seek any help?</b></p>		<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No (Section R)</p>		
<p><b>b. From whom did you seek help?</b></p> <p><i>Number up to four items in the order mentioned.</i></p> <p><i>Do not read list.</i></p>		<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <p>Family member or relative <b>54</b></p> <p>Friend <b>55</b></p> <p>Psychologist <b>56</b></p> <p>Psychiatrist <b>57</b></p> <p>Psychiatric social worker <b>58</b></p> <p>Other mental health professional <b>59</b></p> <p>Medical doctor <b>60</b></p> <p>Religious counselor <b>61</b></p> <p>Alcoholics Anonymous <b>62</b></p> </td> <td style="width: 50%; border: none;"> <p>Gamblers Anonymous <b>63</b></p> <p>Weight Watchers <b>64</b></p> <p>Counselor at work <b>65</b></p> <p>Counselor at school <b>66</b></p> <p>Probation officer <b>67</b></p> <p>Other (Specify) <b>68</b></p> <p>_____ <b>69</b></p> <p>_____ <b>70</b></p> </td> </tr> </table>	<p>Family member or relative <b>54</b></p> <p>Friend <b>55</b></p> <p>Psychologist <b>56</b></p> <p>Psychiatrist <b>57</b></p> <p>Psychiatric social worker <b>58</b></p> <p>Other mental health professional <b>59</b></p> <p>Medical doctor <b>60</b></p> <p>Religious counselor <b>61</b></p> <p>Alcoholics Anonymous <b>62</b></p>	<p>Gamblers Anonymous <b>63</b></p> <p>Weight Watchers <b>64</b></p> <p>Counselor at work <b>65</b></p> <p>Counselor at school <b>66</b></p> <p>Probation officer <b>67</b></p> <p>Other (Specify) <b>68</b></p> <p>_____ <b>69</b></p> <p>_____ <b>70</b></p>
<p>Family member or relative <b>54</b></p> <p>Friend <b>55</b></p> <p>Psychologist <b>56</b></p> <p>Psychiatrist <b>57</b></p> <p>Psychiatric social worker <b>58</b></p> <p>Other mental health professional <b>59</b></p> <p>Medical doctor <b>60</b></p> <p>Religious counselor <b>61</b></p> <p>Alcoholics Anonymous <b>62</b></p>	<p>Gamblers Anonymous <b>63</b></p> <p>Weight Watchers <b>64</b></p> <p>Counselor at work <b>65</b></p> <p>Counselor at school <b>66</b></p> <p>Probation officer <b>67</b></p> <p>Other (Specify) <b>68</b></p> <p>_____ <b>69</b></p> <p>_____ <b>70</b></p>			
<p><b>c. Anyone else?</b></p>		<p><input type="checkbox"/> Yes (Reask 4b and c)</p> <p><input type="checkbox"/> No</p>		
Section R. EXERCISE		RT76		
<p><b>R1</b></p>		3-4		
<p><i>Read to respondent:</i></p> <p><b>These next questions are about physical exercise. Hand calendar.</b></p> <p><b>1a. In the past 2 weeks (outlined on that calendar), beginning Monday (date) and ending this past Sunday (date), have you done any exercises, sports, or physically active hobbies?</b></p>		<p>1 <input type="checkbox"/> SP is physically handicapped (Describe in footnotes. THEN 1)</p> <p>8 <input type="checkbox"/> Other (2)</p>		
<p><b>b. What were they?</b></p> <p><i>Record on next page, THEN 1c.</i></p>				
<p><b>c. Anything else?</b></p>		<p><input type="checkbox"/> Yes (Reask 1b and c)</p> <p><input type="checkbox"/> No (2b)</p>		
<p>FOOTNOTES</p>				

**Section R. EXERCISE – Continued**

NOTE – ASK ALL OF 2a BEFORE GOING TO 2b–d.		NOTE: ASK 2b–d FOR EACH ACTIVITY MARKED “YES” IN 2a.	
<p><i>Read to respondent: These next questions are about physical exercise. Hand calendar.</i></p> <p><b>2a. In the past 2 weeks (outlined on that calendar), beginning Monday, (date), and ending this past Sunday, (date), have you done any (of the following exercises, sports, or physically active hobbies) –</b></p> <p>(1) Walking for exercise? YES <input type="checkbox"/> NO <input type="checkbox"/></p>		<p><b>b. How many times in the past 2 weeks did you (play/go/doi (activity in 2a)?</b></p> <p>(1) _____ Times</p>	
<p><b>c. On the average, about how many minutes did you actually spend (activity in 2a) on each occasion?</b></p> <p>_____ Minutes</p>		<p><b>d. (What usually happened to your heart rate or breathing when you (activity in 2a)? Did you have a small, moderate, or large increase, or no increase at all in your heart rate or breathing?</b></p> <p>1 <input type="checkbox"/> Small 3 <input type="checkbox"/> Large 13 2 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> None</p>	
<b>R2</b>	Refer to age. <input type="checkbox"/> SP is 75+ (23) <input type="checkbox"/> Other (2)		
(2) Jogging or running?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 7	(2) _____ Times	_____ Minutes
(3) Hiking?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 15	(3) _____ Times	_____ Minutes
(4) Gardening or yard work?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 22	(4) _____ Times	_____ Minutes
(5) Aerobics or aerobic dancing?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 29	(5) _____ Times	_____ Minutes
(6) Other dancing?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 36	(6) _____ Times	_____ Minutes
(7) Callisthenics or general exercise?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 43	(7) _____ Times	_____ Minutes
(8) Golf?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 50	(8) _____ Times	_____ Minutes
(9) Tennis?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 57	(9) _____ Times	_____ Minutes
(10) Bowling?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 64	(10) _____ Times	_____ Minutes
(11) Biking?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 71	(11) _____ Times	_____ Minutes
(12) Swimming or water exercises?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 78	(12) _____ Times	_____ Minutes
(13) Yoga?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 85	(13) _____ Times	_____ Minutes
<b>R3</b>	Refer to age. <input type="checkbox"/> SP is 65–74 (23) <input type="checkbox"/> Other (14)		
(14) Weight lifting or training?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> RT77 3–4 5 6	(14) _____ Times	_____ Minutes
(15) Basketball?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 7–8	(15) _____ Times	_____ Minutes
(16) Baseball or softball?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9–11	(16) _____ Times	_____ Minutes
(17) Football?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 12–15	(17) _____ Times	_____ Minutes
(18) Soccer?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 16–18	(18) _____ Times	_____ Minutes
(19) Volleyball?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 20	(19) _____ Times	_____ Minutes
(20) Handball, racquetball, or squash?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 21–22	(20) _____ Times	_____ Minutes
(21) Skating?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 23–26	(21) _____ Times	_____ Minutes
(22) Skiing?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 27	(22) _____ Times	_____ Minutes
(23) Have you done any (other) exercises, sports, or physically active hobbies in the past 2 weeks (that I haven't mentioned)? Anything else?	<input type="checkbox"/> Yes – What were they? <input type="checkbox"/> No	(23) _____ Times	_____ Minutes
	69–70	71–72	73–75
	77–78	79–80	81–83



**Section R. EXERCISE – Continued**

3. Do you exercise or play sports regularly?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)	85
4. For how long have you exercised or played sports regularly?		Number $\left\{ \begin{array}{l} 1 \text{  Days} \\ 2 \text{  Weeks} \\ 3 \text{  Months} \\ 4 \text{  Years} \end{array} \right.$	86-88
5a. Would you say that you are physically more active, less active, or about as active as other persons your age?		1 <input type="checkbox"/> More active 2 <input type="checkbox"/> Less active 3 <input type="checkbox"/> About as active (R4) 4 <input type="checkbox"/> Other (Specify) _____ (R4)	89
b. Is that [a lot more or a little more/a lot less or a little less] active?		1 <input type="checkbox"/> A lot more 2 <input type="checkbox"/> A little more 3 <input type="checkbox"/> A lot less 4 <input type="checkbox"/> A little less	90
<b>R4</b>	Refer to "Wa/Wb" boxes in C1 on HIS-1.	1 <input type="checkbox"/> Wa or Wb box marked (6a) 2 <input type="checkbox"/> Other (6c)	91
6a. How much hard physical work is required on your job? Would you say a great deal, a moderate amount, a little, or none?		1 <input type="checkbox"/> Great deal 2 <input type="checkbox"/> Moderate amount 3 <input type="checkbox"/> A little } (7) 4 <input type="checkbox"/> None }	92
b. About how many hours per day do you perform hard physical work on your job?		_____ Hours (7)	93-94
c. How much hard physical work is required in your main daily activity? Would you say a great deal, a moderate amount, a little, or none?		1 <input type="checkbox"/> Great deal 2 <input type="checkbox"/> Moderate amount 3 <input type="checkbox"/> A little } (7) 4 <input type="checkbox"/> None }	95
d. About how many hours per day do you perform hard physical work in your main daily activity?		_____ Hours	96-97
Read to respondent: These next questions are about strengthening the heart and lungs through exercise.		_____ Days	98
7a. How many days a week do you think a person should exercise to strengthen the heart and lungs?		8 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> DK	99-101
b. For how many minutes do you think a person should exercise on EACH occasion so that the heart and lungs are strengthened?		_____ Minutes 999 <input type="checkbox"/> DK	102
Hand card R1 c. (During those (number in 7b) minutes), How fast do you think a person's heart rate and breathing should be to strengthen the heart and lungs? Do you think that the heart and breathing rate should be -- no faster than usual, a little faster than usual, a lot faster but talking is possible, so fast that talking is not possible?		1 <input type="checkbox"/> No faster than usual 2 <input type="checkbox"/> A little faster than usual 3 <input type="checkbox"/> A lot faster but talking is possible 4 <input type="checkbox"/> So fast that talking is not possible 9 <input type="checkbox"/> DK	
FOOTNOTES			

Section S. SMOKING		RT78
<b>S1</b>	Refer to "Smoking asked" box on HIS-1.	1 <input type="checkbox"/> "Smoking asked" box marked (4) 8 <input type="checkbox"/> Other (1)
Read to respondent: These next questions are about smoking cigarettes.		
1. Have you smoked at least 100 cigarettes in your entire life?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (4)	6
2a. Do you smoke cigarettes now?	1 <input type="checkbox"/> Yes (3) 2 <input type="checkbox"/> No	7
b. About how long has it been since you last smoked cigarettes fairly regularly?	<input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years (4) _____ Number	8-10
	999 <input type="checkbox"/> Never smoked regularly (4)	
3. On the average, about how many cigarettes a day do you now smoke?	00 <input type="checkbox"/> Less than 1 per day _____ Number	11-12
4. [These next questions are about smoking cigarettes.] (Hand Card S) Tell me if you think CIGARETTE SMOKING definitely increases, probably increases, probably does not, or definitely does not increase a person's chances of getting the following problems. First --	DEFINITELY INCREASES    PROBABLY INCREASES    PROBABLY DOES NOT INCREASE    DEFINITELY DOES NOT INCREASE    DK/NO OPINION	
a. Emphysema? (Give me a number from the card.)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/>	13
b. Bladder cancer?	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/>	14
c. Cancer of the larynx (lar'inks) or voice box?	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/>	15
d. Cataracts?	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/>	16
e. Cancer of the esophagus?	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/>	17
f. Chronic bronchitis?	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/>	18
g. Gallstones?	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/>	19
h. Lung cancer?	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/>	20
<b>S2</b>	Refer to age.	1 <input type="checkbox"/> SP is under 45 (4i) 2 <input type="checkbox"/> SP is 45+ (S3)
Read to respondent: Does cigarette smoking during pregnancy definitely increase, probably increase, probably not or definitely not increase the chances of --		
i. Miscarriage?	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/>	22
j. Stillbirth?	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/>	23
k. Premature birth?	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/>	24
l. Low birth weight of the newborn?	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/>	25
5a. If a woman takes birth control pills, is she more likely to have a stroke if she smokes than if she does not smoke?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (S3)	26
b. Is she much more likely or somewhat more likely to have a stroke?	1 <input type="checkbox"/> Much more 2 <input type="checkbox"/> Somewhat more	27
<b>S3</b>	Refer to 1.	1 <input type="checkbox"/> "Yes" in 1 (6) 8 <input type="checkbox"/> Other (Section T)
6. Did a doctor EVER advise you to quit or cut down on smoking?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	29

**Section T. ALCOHOL USE**

<p><i>Read to respondent:</i></p> <p><b>These next questions are about drinking alcoholic beverages. Included are liquor such as whiskey, rum, gin, or vodka, and beer, and wine, and any other type of alcoholic beverage.</b></p>		30
<p><b>1a. In YOUR ENTIRE LIFE have you had at least 12 drinks of ANY kind of alcoholic beverage?</b></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (1d)</p>	31
<p><b>b. In ANY ONE YEAR have you had at least 12 drinks of ANY kind of alcoholic beverage?</b></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (1d)</p>	32
<p><b>c. Have you had at least one drink of beer, wine, or liquor during the PAST YEAR?</b></p>	<p>1 <input type="checkbox"/> Yes (2) 2 <input type="checkbox"/> No</p>	33-34
<p><b>d. What is your MAIN reason for not drinking (in the past year)?</b></p>	<p>00 <input type="checkbox"/> No need/not necessary 01 <input type="checkbox"/> Don't care for/dislike it 02 <input type="checkbox"/> Medical/health reasons 03 <input type="checkbox"/> Religious/moral reasons 04 <input type="checkbox"/> Brought up not to drink 05 <input type="checkbox"/> Costs too much 06 <input type="checkbox"/> Family member an alcoholic or problem drinker 07 <input type="checkbox"/> Infrequent drinker 08 <input type="checkbox"/> Other (Specify) _____</p> <p align="right">(9)</p>	
<p><b>2. In the past 2 WEEKS (outlined on that calendar), beginning Monday (date) and ending this past Sunday (date), on how many days did you drink any alcoholic beverages, such as beer, wine, or liquor?</b></p> <p><i>Use list to probe, if necessary.</i></p>	<p>01 <input type="checkbox"/> 14 (Every day)      12 <input type="checkbox"/> 8-9      23 <input type="checkbox"/> 3 02 <input type="checkbox"/> 13-14      13 <input type="checkbox"/> 8      24 <input type="checkbox"/> 2-3 03 <input type="checkbox"/> 13      14 <input type="checkbox"/> 7-8      25 <input type="checkbox"/> 2 04 <input type="checkbox"/> 12-13      15 <input type="checkbox"/> 7      26 <input type="checkbox"/> 1-2 05 <input type="checkbox"/> 12      16 <input type="checkbox"/> 6-7      27 <input type="checkbox"/> 1 06 <input type="checkbox"/> 11-12      17 <input type="checkbox"/> 6      28 <input type="checkbox"/> None/Never (4) 07 <input type="checkbox"/> 11      18 <input type="checkbox"/> 5-6      29 <input type="checkbox"/> DK 08 <input type="checkbox"/> 10-11      19 <input type="checkbox"/> 5 09 <input type="checkbox"/> 10      20 <input type="checkbox"/> 4-5 10 <input type="checkbox"/> 9-10      21 <input type="checkbox"/> 4 11 <input type="checkbox"/> 9      22 <input type="checkbox"/> 3-4</p>	35-36
<p><b>3. On the (number in 2) days that you drank alcoholic beverages, how many drinks did you have per day, on the average?</b></p> <p><i>Use list to probe, if necessary.</i></p>	<p>01 <input type="checkbox"/> Twelve or more      08 <input type="checkbox"/> Three or four 02 <input type="checkbox"/> Seven to eleven      09 <input type="checkbox"/> Three 03 <input type="checkbox"/> Six      10 <input type="checkbox"/> Two or three 04 <input type="checkbox"/> Five or six      11 <input type="checkbox"/> Two 05 <input type="checkbox"/> Five      12 <input type="checkbox"/> One or two 06 <input type="checkbox"/> Four or five      13 <input type="checkbox"/> One 07 <input type="checkbox"/> Four      99 <input type="checkbox"/> DK</p>	37-38
<p><b>4a. Was the amount of your drinking during that 2-WEEK period typical of your drinking during the past 12 months?</b></p>	<p>1 <input type="checkbox"/> Yes (5) 2 <input type="checkbox"/> No</p>	39
<p><b>b. Was the amount of your drinking during that 2-WEEK period more or less than your drinking during the past 12 months?</b></p>	<p>1 <input type="checkbox"/> More 2 <input type="checkbox"/> Less</p>	40
<p><b>5. During the past 12 months, in how many MONTHS did you have at least one drink of ANY alcoholic beverage?</b></p>	<p>_____ Months</p>	41-42
<p><b>6. During (that month/those months), on how many DAYS did you have 9 or more drinks of ANY alcoholic beverage?</b></p>	<p>_____ Days 000 <input type="checkbox"/> None or never</p>	43-45
<p><b>7. During (that month/those months), on how many DAYS did you have 5 or more drinks of ANY alcoholic beverage? (Include the (number in 6) days you had 9 or more drinks.)</b></p>	<p>_____ Days 000 <input type="checkbox"/> None or never</p>	46-48
<p><b>8. During the past year, how many times did you drive when you had perhaps too much to drink?</b></p>	<p>_____ Times 000 <input type="checkbox"/> None 998 <input type="checkbox"/> Don't drive</p>	49-51
<p><b>FOOTNOTES</b></p>		

**Section T. ALCOHOL USE -- Continued**

<p><b>9. (Hand Card T) Tell me if you think HEAVY ALCOHOL DRINKING definitely increases, probably increases, probably does not, or definitely does not increase a person's chances of getting the following problems. First --</b></p>		DEFINITELY INCREASES	PROBABLY INCREASES	PROBABLY DOES NOT INCREASE	DEFINITELY DOES NOT INCREASE	DK/NO OPINION	
<p><b>a. Throat cancer? (Give me a number from the card.)</b></p>		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>52</b>
<p><b>b. Cirrhosis of the liver?</b></p>		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>53</b>
<p><b>c. Bladder cancer?</b></p>		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>54</b>
<p><b>d. Cancer of the mouth?</b></p>		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>55</b>
<p><b>e. Arthritis?</b></p>		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>56</b>
<p><b>f. Blood clots?</b></p>		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>57</b>
<b>T1</b>	Refer to age.	<p>1 <input type="checkbox"/> SP is under 45 (9g) 2 <input type="checkbox"/> SP is 45 + (Section U)</p>					<b>58</b>
<p><i>Read to respondent :</i></p> <p><b>Does heavy drinking during pregnancy definitely increase, probably increase, probably not or definitely not increase the chances of --</b></p>		DEFINITELY INCREASES	PROBABLY INCREASES	PROBABLY DOES NOT INCREASE	DEFINITELY DOES NOT INCREASE	DK/NO OPINION	
<p><b>g. Miscarriage?</b></p>		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>59</b>
<p><b>h. Mental retardation of the newborn?</b></p>		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>60</b>
<p><b>i. Low birth weight of the newborn?</b></p>		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>61</b>
<p><b>j. Birth defects?</b></p>		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	<b>62</b>
<p><b>10a. Have you ever heard of FETAL ALCOHOL SYNDROME?</b></p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Section U)</p>					<b>63</b>
<p><b>b. In your opinion, which ONE of the following best describes Fetal Alcohol Syndrome -- a baby is born drunk, or born addicted to alcohol, or born with certain birth defects?</b></p>		<p>1 <input type="checkbox"/> Drunk 2 <input type="checkbox"/> Addicted to alcohol 3 <input type="checkbox"/> With certain birth defects</p>					<b>64</b>
<p>FOOTNOTES</p>							

**Section U. DENTAL CARE**

1. This next question is about preventing TOOTH DECAY. Hand Card U. After I read each of the following, tell me if you think it is definitely important, probably important, probably not, or definitely not important in preventing TOOTH DECAY. First —	DEFINITELY IMPORTANT	PROBABLY IMPORTANT	PROBABLY NOT IMPORTANT	DEFINITELY NOT IMPORTANT	DK/NO OPINION	
a. Seeing a dentist regularly? (Give me a number from the card.)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	65
b. Drinking water with fluoride from early childhood?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	66
c. Regular brushing and flossing of the teeth?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	67
d. Using fluoride toothpaste or fluoride mouth rinse?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	68
e. Avoiding between-meal sweets?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	69
2. Now I'm going to ask about preventing GUM DISEASE. In your opinion, how important or not important is each of the following in preventing GUM DISEASE? First —						
a. Seeing a dentist regularly?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	70
b. Drinking water with fluoride from early childhood?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	71
c. Regular brushing and flossing of the teeth?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	72
d. Using fluoride toothpaste or fluoride mouth rinse?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	73
e. Avoiding between-meal sweets?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>	74
3. In your opinion, which of the following is the MAIN cause of tooth loss in CHILDREN — tooth decay, gum disease, or injury to the teeth?						
4. In your opinion, which of the following is the MAIN cause of tooth loss in ADULTS — tooth decay, gum disease, or injury to the teeth?						
5a. Have you ever heard of DENTAL SEALANTS?						
b. Which of the following BEST describes the purpose of dental sealants — to prevent gum disease, to prevent tooth decay, or to hold dentures in place?						
FOOTNOTES						

Section V. OCCUPATIONAL SAFETY AND HEALTH		RT79
		3-4
<b>V1</b>	Refer to "Wa/Wb" boxes in C1 on HIS-1.	1 <input type="checkbox"/> Wa or Wb box marked (1) 8 <input type="checkbox"/> Other (Cover page)
<b>Read to respondent:</b> <b>These questions are about your present job.</b>		5
<b>1a. In your present job, are you exposed to any SUBSTANCES that could endanger your health, such as chemicals, dusts, fumes, or gases?</b>		6
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (2) 9 <input type="checkbox"/> DK }		
<b>b. What substances are you exposed to that could endanger your health?</b> Enter each substance in a separate column. <b>Any others?</b>		
Ask 1c for each response in 1b.		
<b>c. How can (response in 1b) endanger your health?</b> Record verbatim response(s). <b>Any other way?</b>		
		RT80
<b>2a. In your present job, are you exposed to any WORK CONDITIONS that could endanger your health, such as loud noise, extreme heat or cold, physical or mental stress, or radiation?</b>		3-4
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (3) 9 <input type="checkbox"/> DK }		5
<b>b. What work conditions are you exposed to that could endanger your health?</b> Enter each work condition in a separate column. <b>Any others?</b>		
Ask 2c for each response in 2b.		
<b>c. How can (response in 2b) endanger your health?</b> Record verbatim response(s). <b>Any other way?</b>		
		66
<b>3a. In your present job are you exposed to any risks of accidents or injuries?</b>		67-68
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Cover Page) 9 <input type="checkbox"/> DK }		
<b>b. What (other) risks of accidents or injuries are you exposed to?</b> Record verbatim response(s).		
<b>c. Any others?</b>		
		66

**CARD R**

- 1. Aleut, Eskimo, or American Indian**
- 2. Asian or Pacific Islander**
- 3. Black**
- 4. White**

FORM HS 501 (1985) (10-2-84)

**CARD O**

- 1. Puerto Rican**
- 2. Cuban**
- 3. Mexican/Mexicano**
- 4. Mexican American**
- 5. Chicano**
- 6. Other Latin American**
- 7. Other Spanish**

Card R  
Card O

Containing Subpart 1

FORM HS 501 (1985) (10-2-84)

**CARD I**

- U .... \$20,000 – \$24,999**
- V .... \$25,000 – \$29,999**
- W ... \$30,000 – \$34,999**
- X .... \$35,000 – \$39,999**
- Y .... \$40,000 – \$44,999**
- Z .... \$45,000 – \$49,999**
- ZZ... \$50,000 and over**

FORM HS 501 (1985) (10-2-84)

**CARD J**

- A ..... Less than \$1,000 (including loss)**
- B ..... \$1,000 – \$1,999**
- C ..... \$2,000 – \$2,999**
- D ..... \$3,000 – \$3,999**
- E ..... \$4,000 – \$4,999**
- F ..... \$5,000 – \$5,999**
- G ..... \$6,000 – \$6,999**
- H ..... \$7,000 – \$7,999**
- I ..... \$8,000 – \$8,999**
- J ..... \$9,000 – \$9,999**
- K ..... \$10,000 – \$10,999**
- L ..... \$11,000 – \$11,999**
- M ..... \$12,000 – \$12,999**
- N ..... \$13,000 – \$13,999**
- O ..... \$14,000 – \$14,999**
- P ..... \$15,000 – \$15,999**
- Q ..... \$16,000 – \$16,999**
- R ..... \$17,000 – \$17,999**
- S ..... \$18,000 – \$18,999**
- T ..... \$19,000 – \$19,999**

Card I  
Card J

Containing Subpart 1

FORM HS 501 (1985) (10-2-84)

**CARD N1**

**Choose two**

- 1. Don't eat at bedtime**
- 2. Eat fewer calories**
- 3. Take diet pills**
- 4. Increase physical activity**
- 5. Eat NO fat**
- 6. Eat grapefruit with each meal**

FORM HS 501 (1985) 10 2 84

**CARD N2**

- 1. Have two or more usual doctors or places depending on what is wrong**
- 2. Haven't needed a doctor**
- 3. Previous doctor no longer available**
- 4. Haven't been able to find the right doctor**
- 5. Recently moved to area**
- 6. Can't afford medical care**
- 8. Other reason — Specify**

Card N1  
Card N2

Cut along broken line

FORM HS 501 (1985) 10 2 84

**CARD P**

- 1. Definitely increases the chances of heart disease**
- 2. Probably increases the chances of heart disease**
- 3. Probably does not increase the chances of heart disease**
- 4. Definitely does not increase the chances of heart disease**
- 9. Don't know or no opinion**

FORM HS 501 (1985) 10 2 84

**CARD R1**

- 1. No faster than usual**
- 2. A little faster than usual**
- 3. A lot faster but talking is possible**
- 4. So fast that talking is not possible**

Card P  
Card R1

Cut along broken line

FORM HS 501 (1985) 10 2 84



**CARD S**

***Cigarette smoking —***

- 1. Definitely increases the chances**
- 2. Probably increases the chances**
- 3. Probably does not increase the chances**
- 4. Definitely does not increase the chances**
- 9. Don't know or no opinion.**

FORM HS 501 (1985) (10-2-84)

**CARD T**

***Heavy alcohol drinking —***

- 1. Definitely increases the chances**
- 2. Probably increases the chances**
- 3. Probably does not increase the chances**
- 4. Definitely does not increase the chances**
- 9. Don't know or no opinion**

FORM HS 501 (1985) (10-2-84)

Card S  
Card T

(Cut along this line)

**CARD U**

- 1. Definitely important**
- 2. Probably important**
- 3. Probably not important**
- 4. Definitely not important**
- 9. Don't know or no opinion**

FORM HS 501 (1985) (10-2-84)