

1. Name of condition _____

Mark "2-wk. ref. pd." box without asking if "DV" or "HS" in C2 as source.

2. When did [---/anyone] last see or talk to a doctor or assistant about --- (condition)?

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

3a. (Earlier you told me about --- (condition)) Did the doctor or assistant call the (condition) by a more technical or specific name?

1 Yes 2 No 9 DK

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

b. What did he or she call it? _____ Specify

1 Color Blindness (NC) 2 Cancer (3a)
 3 Normal pregnancy, normal delivery, vasectomy } (5)
 4 Old age (NC)
 5 Other (3c)

c. What was the cause of --- (condition in 3b)? (Specify) _____

Mark box if accident or injury. 0 Accident/injury (S)

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

1 Yes (S) 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 ---? (Specify) _____

For Stroke, fill remainder of this condition page for the first present effect. Enter in item C2 and complete a separate condition page for each additional present effect.

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

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

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:

h. 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?

Infection Sore Soreness

Specify _____

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

Tumor Cyst Growth

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

1 Malignant 2 Benign 9 DK

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

1 2-wk. 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

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

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?)

K1	Refer to RD and C2. <input type="checkbox"/> "Yes" in "RD" box AND more than 1 condition in C2 (6) <input type="checkbox"/> Other (K2)	13. Is this (condition in 3b) the result of the same accident you already told me about? <input type="checkbox"/> Yes (Record condition page number where accident questions first completed.) → _____ (NC) Page No. <input type="checkbox"/> No						
	6a. During the 2 weeks outlined in red on that calendar, did -- (condition) cause -- to cut down on the things -- usually does? <input type="checkbox"/> Yes <input type="checkbox"/> No (K2) b. During that period, how many days did -- cut down for more than half of the day? 00 <input type="checkbox"/> None (K2) _____ Days	14. 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 and public sidewalk) 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) _____						
	7. During those 2 weeks, how many days did -- stay in bed for more than half of the day because of this condition? 00 <input type="checkbox"/> None _____ Days	Mark box if under 18. <input type="checkbox"/> Under 18 (16) 15a. Was -- under 18 when the accident happened? 1 <input type="checkbox"/> Yes (16) <input type="checkbox"/> No						
	8. During those 2 weeks, how many days did -- miss more than half of the day from -- job or business because of this condition? 00 <input type="checkbox"/> None _____ Days Ask if "Wa/Wb" box marked in C1: 9. During those 2 weeks, how many days did -- miss more than half of the day from school because of this condition? 00 <input type="checkbox"/> None _____ Days	b. Was -- in the Armed Forces when the accident happened? 2 <input type="checkbox"/> Yes (16) <input type="checkbox"/> No c. Was -- at work at -- job or business when the accident happened? 3 <input type="checkbox"/> Yes 4 <input type="checkbox"/> No						
K2	<input type="checkbox"/> Condition has "CL LTR" in C2 as source (10) <input type="checkbox"/> Condition does not have "CL LTR" in C2 as source (K4)	16a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (17) b. Was more than one vehicle involved? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No c. Was [it/either one] moving at the time? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	10. About how many days since (12-month date) a year ago, has this condition kept -- in bed more than half of the day? (Include days while an overnight patient in a hospital.) 000 <input type="checkbox"/> None _____ Days 11. Was -- ever hospitalized for -- (condition in 3b)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	17a. At the time of the accident what part of the body was hurt? What kind of injury was it? Anything else? <table border="1" data-bbox="829 766 1085 850"> <thead> <tr> <th>Part(s) of body *</th> <th>Kind of injury</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </tbody> </table>	Part(s) of body *	Kind of injury				
Part(s) of body *	Kind of injury							
K3	<input type="checkbox"/> Missing extremity or organ (K4) <input type="checkbox"/> Other (12) 12a. Does -- still have this condition? 1 <input type="checkbox"/> Yes (K4) <input type="checkbox"/> No b. Is this condition completely cured or is it under control? 2 <input type="checkbox"/> Cured 3 <input type="checkbox"/> Other (Specify) _____ (K4) 3 <input type="checkbox"/> Under control (K4) c. About how long did -- have this condition before it was cured? <input type="checkbox"/> Less than 1 month OR _____ Number { <input type="checkbox"/> Months <input type="checkbox"/> Years d. Was this condition present at any time during the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Ask if box 3, 4, or 5 marked in Q.5: b. What part of the body is affected now? How is -- (part of body) affected? Is -- affected in any other way? <table border="1" data-bbox="829 924 1085 1008"> <thead> <tr> <th>Part(s) of body *</th> <th>Present effects **</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </tbody> </table>	Part(s) of body *	Present effects **				
Part(s) of body *	Present effects **							
K4	<input type="checkbox"/> Not an accident/injury (NC) 1 <input type="checkbox"/> First accident/injury for this person (14) 2 <input type="checkbox"/> Other (13)	* Enter part of body in same detail as for 3g. ** If multiple present effects, enter in C2 each one that is not the same as 3b or C2 and complete a separate condition page for it.						