

**Plan and Operation of the
HANES I Augmentation
Survey of Adults 25-74 Years**

United States, **1974-1975**

DHEW Publication No. (PHS) 78-1314

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Under the legislation establishing the National Health Survey, the Public Health Service is authorized to use, insofar as possible, the services or facilities of other Federal, State, or private agencies. In accordance with specifications established by the National Center for Health Statistics, the U.S. Bureau of the Census participated in the design and selection of the sample and carried out the household interview stage of the data collection and certain parts of the statistical processing.

The Center for Disease Control acted as laboratory consultants and performed a series of biochemical, hematological, and serological assessments on blood specimens of persons participating in the survey.

The U.S. Environmental Protection Agency supervised the chemical analyses of the water samples collected at each household.

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SYMBOLS

Data not available-----	- - -
Category not applicable-----	. . .
Quantity zero-----	-
Quantity more than 0 but less than 0.05-----	0.0
Figure does not meet standards of reliability or precision-----	*

PLAN AND OPERATION OF THE HANES I AUGMENTATION SURVEY OF ADULTS 25-74 YEARS

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INTRODUCTION

In the Health Examination Survey (HES), a major program of the National Center for Health Statistics (NCHS), data are collected by direct physical examination, tests, and measurements performed on the sample population studied. The National Health Survey was authorized under the National Health Survey Act of 1956 by the 84th Congress to be a continuous public health service activity to monitor the health status of the American population. Information has been obtained on the prevalence of certain medically defined illnesses and the distribution of a variety of physical, physiological, and psychological measurements. The Survey provides this information for the U.S. civilian noninstitutionalized population and simultaneously provides the demographic and socioeconomic data necessary for analysis. In recent years, procedures to measure either directly or indirectly the impact of the environment on individuals and to delineate met and unmet health care needs have been employed in the Survey.

The first three national surveys conducted between 1959 and 1970 had specific age groupings as their target populations. These were adults ages 18-79 years, children ages 6-11, and youths ages 12-17.¹⁻³ The fourth survey program, the first Health and Nutrition Examination Survey (HANES I) was conducted between April 1971 and June 1974 on a probability sample of the U.S. noninstitutionalized civilian

population, ages 1-74. An extensive nutrition examination and special examinations by ophthalmologists, dermatologists, and dentists were given to every sample person who was examined. Additional examination components focused on other aspects of health were administered to a subsample of adults (25-74 years), about one-fifth of all the examinees. These additional components were designated as the "detailed" components, in contrast with the somewhat simpler nutrition examinations.

A reduction in the magnitude of resources available for conducting the field operation made it necessary to cut back the number of field teams from three to two in January 1973. It had originally been anticipated that the detailed components would be continued into a second HANES program. Due to the reduction in field teams, HANES I required 3 years instead of 2. In order to speed up the availability of the data from detailed components, it was decided to devote the 15-month period, July 1974 through September 1975, to approximately double the number of people examined for the detailed health component. The larger sample size would facilitate analysis of the examination findings by smaller demographic groupings. In addition, the prolonged period of data collection would also provide more time for planning the design of the next projected Health and Nutrition Examination Survey (HANES II) so as to take greater advantage of information and experience gained from HANES I. This 15-month operation was referred to as the "Augmentation Survey" for the detailed component.

For the 15-month augmentation phase of the detailed component of HANES I, a number of changes were made in both the content of the examination and the sample design. The operation of the survey proceeded in roughly the same manner as it did in the first part of HANES I. The purpose of this report is to supplement the program description of HANES I⁴ by describing the modifications in procedures, program content, sampling, and other data collection activities that were made for the augmentation phase of HANES I. Stand sequencing, scheduling, professional and public relations, logistical arrangements, household interviewing, appointment procedures, quality control, examination procedures, and the composition of the field staff are described in the HANES I program report. Most of the components of the detailed examination were continued with little or no modification. For a detailed discussion of the components in the following listing, reference to the HANES I program description⁴ is advised. A description of the nutrition and special examinations given in HANES I and copies of the forms used in HANES I are also included. Copies of the forms used in the HANES I Augmentation Survey are found in appendix III of this report. Detailed instructions and procedures used in HANES I and the HANES I Augmentation Survey are described in the staff instruction manuals, which are available upon request.⁵⁻⁷

Components of the HANES I Detailed Examination Survey that were continued in the HANES I Augmentation Survey include:

1. A physician's examination.
2. Spirometry.
3. Single-breath carbon monoxide test for pulmonary diffusion.
4. A 12-lead electrocardiogram (ECG).
5. Pure-tone audiometry at 500, 1,000, 2,000, and 4,000 cycles.
6. Anthropometric measurements.
7. Medical History, General Medical History Supplement, Health Care Needs, Arthritis, Respiratory, and Cardiovascular questionnaires.

8. A schedule for measuring psychological well-being.
9. Hand-wrist X-rays processed for bone density and cortical thickness and hip and knee X-rays assessed for the presence of arthritis.
10. Laboratory tests--Serum: Measurements of SCOT, alkaline phosphatase, bilirubin, uric acid, folates, cholesterol, calcium, phosphorus, and serology tests for measles, German measles, polio, tetanus, diphtheria, and amebiasis were performed. Whole **blood**: Hematocrit, hemoglobin, red and white cell counts, and white cell differential count were continued. Hemoglobinopathy screening that was instituted during the conduct of HANES I was also continued in the Augmentation Survey.

NEW PROCEDURES

Hearing Test for Speech

The purpose of this test was to provide a measure of the ability of the U.S. population to hear and understand conversational speech.

Recommendations for the addition of the test came from a number of speech and hearing authorities who attended an advisory meeting at NCHS. These included Hollowell Davis, Central Institute for the Deaf; Leo Doeffler, Stanley Zerling, and Ralph Nauton, University of Chicago; and Eldon Eagles, Associate Director for the National Institute of Neurological and Communicative Disorders and Stroke, National Institutes of Health.

The stimuli used in the test consisted of the revised Central Institute for the Deaf Sentences supplied by Dr. Davis. The material was developed by a working group of the Committee on Hearing and Bioacoustics of the National Research Council. The following criteria were followed in developing 10 lists of 10 sentences each:

Vocabulary appropriate to adults.

Words that appear with high frequency as cited in one or more of the well-known word counts of the English language.

Exclusion of proper names and proper nouns.

Free use of common nonslang idioms and constructions.

Avoidance of phonetic loading and tongue twisting.

High redundancy.

Low level of abstraction.

Grammatical construction that varies freely.

The sentences in each list contained 50 keywords (appendix III, forms Q and R). The keywords are shown in capital letters in each of the sentences. The recordings of the sentences made under contract at the University of Maryland by Dr. G. Donald Causey were examined at the National Bureau of Standards and judged to be of excellent technical quality.

In the test format, the initial list of sentences was presented at a level 10-15 decibels (dB) below the 100-cycle pure-tone threshold unless that threshold was 25 dB or lower. In that case, testing always began at the 20-dB level. Depending on the results of the initial presentation, the next list was presented at either 10 dB higher or 10 dB lower. The end-point for terminating the test was the correct identification of 90 percent of the keywords in a particular list. A different list was presented at each 10-dB level within the range of 20 dB to 80 dB, as determined by the degree of hearing loss.

Vision Testing

The inclusion of visual acuity tests in the HANES I Augmentation Survey was for the purpose of comparing objective tests of visual disability with a series of questions designed for the same purpose. The near-vision test used in the examination was designed to measure one's ability to read printed selections. Keeney and Sloan cards had different style typefaces and different reading selections. Using both Keeney and Sloan cards together provided a wide range of type sizes for testing near-vision acuity. An adaptation of the test provided some information on near vision for illiterate persons.

Distance visual acuity was measured in previous examination programs by using devices that

simulated the recommended 20-foot distance—by optical methods such as the use of mirrors. Since some inaccuracies are introduced by the use of distance simulation devices, it was decided to use Good-lite charts at an actual 20-foot distance. Carefully controlled direct and background lighting was used to ensure accuracy. Both binocular and monocular distance vision were tested.

Water Sample Collaborative Study (HANES-National Institutes of Health-Environmental Protection Agency)

This study was undertaken to evaluate the possible relationships among bulk constituents, hardness, and trace metals in household tap-water with certain risk factors of cardiovascular disease. Water samples were collected from taps or wells and from public water distribution supplies. The samples are being analyzed by the Environmental Protection Agency to measure their hardness, alkalinity, and the total amount of solute present. They are also being tested for the presence and concentration of sizable numbers of trace minerals. In addition to the water sample collection, a questionnaire (appendix III, form C) was administered to the sample persons detailing personal consumption of water and the source of the water supplied to the household. The water pipes under the sink were examined to determine their composition.

Additional Questionnaire Material

During the Health Interview Survey (HIS), conducted annually by NCHS, approximately 40,000 households are interviewed to obtain a wide variety of health information. Sets of questions on vision and hearing developed for HIS were included in the HANES exam. This would enable HIS to provide a better basis for interpretation of the relationship of a person's answers to questionnaires in these fields to clinical findings. In short, the questionnaire items provide a scaled index of impairment for hearing, distance visual acuity, and reading ability (appendix III, form B).

A portion of the 1975 HIS schedule on hypertension was included so that it could be correlated with the clinical data obtained in the HANES I Augmentation Survey. A final addition

was a 20-question depression scale that the National Institute of Mental Health recommended to be included. This scale had been used in two large community studies. Since depression is an exceedingly common and important condition for study, the epidemiological relationship of it to various other health factors is of considerable interest.

Additional Laboratory Procedures

Because of continuous interest in monitoring the prevalence of venereal disease in the U.S. population, serological tests for syphilis were added to the survey. These tests, performed at the Center for Disease Control consisted of the ART, VDRL, and FTA. Another study subject was hemoglobinopathies. Tests for hemoglobinopathies were actually begun on a special pilot basis at the 37th location of HANES I. Although considerable information is available from local studies, interest was shown in developing estimates for the U.S. population. The laboratory procedure performed involved the phenotyping of red cells. On the SMA 12/60, the additional determinations of blood urea nitrogen (BUN), creatinine, sodium, and potassium were done. The BUN and serum creatinine levels served as indicators of kidney impairment in the population.

SAMPLE DESIGN

The sample design for the HANES I Augmentation Survey of Adults had two basic requirements: The sample of persons selected for examination in locations 66-100 would constitute a national probability sample of the target population and, when considered jointly with those receiving the detailed examination in HANES I locations 1-65, the sample would be a 100-PSU (primary sampling unit), national probability sample. All 100 of the HANES sample locations are listed in appendix II by geographic region and probability design. As indicated in appendix II, 10 of the PSU's were included in both the Augmentation Survey sample and in the initial 65-PSU design, so that actually there were only 90 distinct sample PSU's. The sample design specifications, selection procedures, and

data collection procedures for the first 65 PSU's are described elsewhere.⁴ Definitions relating to the sample design and selection of locations remained constant throughout the 100 survey locations.

The HANES I Augmentation Survey sample was designed to meet the following goals:

1. To examine a national probability sample of adults 25-74 years of age which represents the civilian noninstitutionalized population of the contiguous United States, excluding those living on lands set aside for use by American Indians.
2. To complete the survey of approximately 4,300 sample persons in a 12- to 15-month period.
3. To sample the target population in proportion to its representation in the population-with no oversampling of special groups.
4. To produce two kinds of estimates from the survey: (a) distributions of the population by specified characteristics such as blood pressure and selected biochemical determinations; and (b) prevalence in the population of selected chronic conditions, particularly arthritic, respiratory, and cardiovascular conditions.
5. To set maximum tolerances for variability for these key statistics permitting a general analysis by broad geographic regions and by other major demographic subgroups such as income, race, age, and sex.

Selection of Primary Sampling Units

The program description of HANES I⁴ describes the contiguous United States as divided into 1,900 geographic areas or PSU's. These 1,900 PSU's were collapsed into 357 strata for HIS and collapsed again into 40 superstrata for HANES. Of these 40 superstrata, 15 are composed of only 1 very large metropolitan area of more than 2 million people and were drawn into the HANES 65-PSU design with certainty. However, in the Augmentation Survey only five of

them were drawn into the sample with certainty :

Essex, Morris, Union, Somerset, Hudson, Middlesex, N. J.

Essex, Middlesex, Norfolk, Plymouth, Suffolk, Mass.

Allegheny, Beaver, Washington, Westmoreland, Pa.

Macomb, Oakland, Wayne, Mich.

Alameda, Contra-Costa, San Mateo, San Francisco, Solano, Calif.

The other 10 superstrata that were drawn into the 65-PSU design with certainty were collapsed into 5 groups of two each, only 1 of which was chosen for the Augmentation Survey with a probability of 0.5:

Nassau, Queens, Suffolk, N.Y.

Bronx, N.Y.

Bucks, Chester, Delaware, Montgomery, Philadelphia, Pa.

Lake, Porter, Cook, Will, Kane, Ill.

Orange, Los Angeles, Calif.

However, when these five locations are considered as part of the 100-PSU design they are selected with certainty.

In each of the 25 remaining noncertainty strata, defined as they were for the HANES I 65-PSU design," a selection of a PSU was made with probability proportional to size in a controlled selection procedure, independent of its selection status in the 65-PSU design. Only two PSU's in the noncertainty strata were included in both surveys:

St. Bernard, Jefferson, Orleans, La.

Hancock, Hamblen, Hawkins, Claiborne, Tenn.

Sample Selection Within Primary Sampling Units

Within PSU's, using 1970 census data, enumeration districts (ED's) were divided into segments of an expected eight housing units each.

In urban areas where listing units were well defined in 1970, this division was quite accurate, since the sampling frame was comprised of listings that resulted from the 1970 census. For ED's not covered by the listing books, area sampling was employed, and consequently, some variation in segment size occurred. To make the sample representative of the current population of the United States, the listed segments were supplemented by a sample of housing units that had been constructed since 1970. Then a systematic sample of segments in each PSU was selected. Randomly selected reserve segments were drawn to provide a minimum of 105 sample persons per PSU.

After the sample segments had been identified, a list of all current addresses within the segment boundaries was made, and the household interviews were conducted to determine the age of each household member, as well as to obtain other demographic and socioeconomic information required for the survey. After listing the household members according to specified rules of relationship to the head of the household, those 25-74 years of age were then added to the appropriate Sample Person Selection Sheet (figure 1) from which one of every two eligible persons was selected for participation in the survey. The sheet illustrates one of two possible sampling patterns with selection of the first listed person in the segment, third, and so forth. The patterns were randomly assigned to segments in order to effectively remove sampling bias from the selection process. The census interviewer proceeded to arrange an examination appointment for all sample persons who indicated a willingness to be examined.

Logistical arrangements, household interviewing procedures, appointment and transportation procedures, and general mobile examination center procedures are described elsewhere.⁴

DATA COLLECTION

Census interviewers replaced Health Examination Representatives in administering most of the material in the medical history forms as a part of the initial household interview phase of the survey. Because of this change in interviewers, the task of asking certain "sensitive" questions (e.g., those relating to kidney and

<small>FORM HES-28A (Cycle IV) (5-13-74)</small>	<small>U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS</small>	a. HES Stand Name	b. HES Stand Number
SAMPLE PERSON SELECTION SHEET HEALTH EXAMINATION SURVEY		c. Interviewer's Name	

Part I - SAMPLE PERSON SELECTION

Line No. (1)	HH EP's Line No. (2)	Serial No. (3)	Segment No. (4)	Line No. (1)	HH EP's Line No. (2)	Serial No. (3)	Segment No. (4)	Line No. (1)	HH EP's Line No. (2)	Serial No. (3)	Segment No. (4)
1				15				29			
2				16				30			
3				17				31			
4				18				32			
5				19				33			
6				20				34			
7				21				35			
8				22				36			
9				23				37			
10				24				38			
11				25				39			
12				26				40			
13				27				41			
14				28				42			

Part II - CALL BACK HOUSEHOLDS (Cross off when household is interviewed)

Segment No. (1)	Serial No. (2)	EP's (Est.) (3)	Segment No. (1)	Serial No. (2)	EP's (Est.) (3)	Segment No. (1)	Serial No. (2)	EP's (Est.) (3)	Remarks

Figure 1. Sample Person Selection Sheet

bowel function) was given to the examining physician. There were also small modifications in the mobile units, such as the installation of 'special lighting and recording equipment. In place of scheduling 10 examinees (2 for the detailed and 8 for the nutrition exams scheduled for each of the 2 daily sessions of HANES I), 6 examinees, all for the detailed, were scheduled for each session. The average number of examinees scheduled at each location in the Augmentation Survey was 120. The lengths of time spent in different locations were roughly equal, in contrast to HANES I in which some locations had a much larger sample size than others and so required a longer stay. Because of the dropping of the dental, dermatological, and ophthalmological exams, none of the personnel responsible for these parts of the exam was present in the detailed Augmentation Survey. Nutritionists were also not needed, since the Augmentation Survey did not include a dietary history.

Quality control measures were in general similar to those outlined in *Plan and Operation of the Health and Nutrition Examination Survey*, Series 1, No. 10a.⁴ Some additional procedures had been worked out during HANES I and were applied in the detailed exam for the Augmentation Survey sample as follows:

1. **X-ray technique:** Chest X-ray films were reviewed by a supervisory technician who furnished a checklist of particular errors of technique (figure 2). These were used for further instruction of the technicians. The hip and knee X-rays were graded for quality by one of the expert readers at the same time the film was being examined for pathology. In addition, listings of errors in technique in hip and knee films and in the hand-wrist X-ray films were also provided by the respective contractors on a regular

POSTERIOR-ANTERIOR CHEST FILM															
Stand _____	Date	Tech number	Apices not shown or cut off	Costophrenic angles not shown or cut off	Rotation of examinee	Exposure not on full inspir. (no 10 ribs)	Underexposed	Overexposed	Movement or breathing	Artifacts	Marker not shown or number incorrect	2 films taken	3 films taken	WORKSHEET A For Chief Health Technician COMMENTS	Technician signature
Sample number															
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
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16															
17															
18															

Figure 2. Quality control review form

basis. Field evaluations of the X-ray units included checking the horizontal accuracy of the X-ray beams at the beginning of a stand and using metal wedges and bone phantoms for checking the calibration of the X-ray machines for the hand and wrist bone density determinations.

2. **Spirometry:** The spirometry output was monitored on an oscilloscope. Based on morphology and reproducibility of the forced expiration trials, various corrective actions were undertaken by the technician. About 4 months after the continuation exams began, the acquisition of two-channel Gould Records provided the means of ensuring a more accurate check on the quality of the recordings.
3. **Carbon monoxide (CO) diffusion test:** The tracings from the test were reviewed to determine whether the trials were acceptable. The trials were reviewed for such items as inspiration time, breath-holding time, inspired volume/vital capacity ratio, minimum dead space washout, minimum volume of gas collected, presence of inhalation artifacts.
4. **ECG tracings:** These tracings were checked for "noise," correct lead placement, machine problems, calibration standards, and baseline shift in the field, and also on a spot basis at headquarters.
5. **Body measurements:** Body measurements were replicated as in the first 65 locations of HANES I. In addition, a random assignment of examinees to technicians within a field team was coupled with computer monitoring to compare results among technicians for body measurements.
6. **Audiometry:** The random assignment of examinees to technicians and the monitoring of technician differences were also used to compare pure-tone audiometry results. In addition, the results of the speech test were reviewed at headquarters for each stand on a regular basis

and compared with the results of the pure-tone audiometry.

7. **Leg length measurements:** This X-ray determination was part of the arthritis exam. In order to ensure the accuracy of leg length determinations by X-ray, a metal stand on which the examinee stood was verified as level every day by means of two spirit levels. A computer program was used for monitoring this by comparing left and right leg measurements for each stand.
8. **General Well-Being Schedule:** Each copy of the General Well-Being (GWB) questionnaire was reviewed at headquarters. In addition, every form was checked in the field, and an examiner's observation sheet was filled out giving reasons for not obtaining a full, acceptable GWB. Also included was the interviewer's impression of the degree of comprehension of the interviewee in filling out the GWB.
9. **Laboratory procedures:** Generally, a 10-percent nonrandom sample of blind duplicates was selected for all blood chemistries and serologies. The single exception was the T₃ T₄ determinations for which the 10-percent sample of blind duplicates was chosen in a random fashion. (The nonrandom selection was from the first batch of blood specimens in the first daily session.) The quality control procedures in hematology included the use of Coulter controls. Control results were plotted daily. Blood indices were calculated and used in quality control.

The data collection of the Augmentation Survey was completed in September 1975 with medical histories and household information completed on 94 percent of the 4,288 sample persons; 71 percent of sample persons were examined.

The nonexamined sample persons are of major concern in interpreting the results of the survey. The potential biasing effects of excluding information for nonexamined sample persons are evaluated in the development of each

report, and the findings are presented in published reports. In the development of national estimates, imputation procedures to estimate missing data are selected to minimize potential bias in the final results. Imputation procedures used on the data are presented in substantive reports to inform the user of the amount of missing data for which estimated values were substituted and how the values were estimated.

PLANS FOR ANALYSIS AND PUBLICATION OF DATA

Analytical and descriptive reports published by NCHS on HANES findings are usually written by the analytical staff of the Division of Health Examination Statistics, often in collaboration with experts in particular fields.

Before the data are ready for analysis, several preliminary steps must be taken. In some cases, such as reading X-rays, further processing of a data unit is necessary. Data must then be reduced to machine-readable form. A considerable amount of time is usually spent editing data to detect errors in data collection and preparation. For example, examination of cholesterol data in HANES I revealed a large number of greatly elevated cholesterol values in one location. An extra serum vial for these

persons was used to repeat the tests; the original values were found to be erroneous, and the repeated tests values were used instead. Editing may also involve comparison of results for variables that are highly correlated, such as body measurements or hematocrit-hemoglobin determinations.

Because of the large amount of data available, it is to be expected that everything cannot be analyzed and published very soon after the end of the survey. Priorities for analyses are governed by such factors as the importance of the data, the necessity of timeliness of publication of particular data, the degree of interest of different groups in the data, and the relative difficulties involved in editing data. Some reports involving the relationships of several data items will require processing of all the involved items before analysis. Most of them should be published in the 5 years following completion of the survey. As in other HES cycles, a set of computer tapes containing the edited data is being prepared for the use of investigators at organizations other than NCHS, for example, universities and other Government agencies. In general, NCHS publishes the results in the Vital and Health Statistics Series 2 and 11 reports. To a lesser extent, information is made available in journal articles and in papers presented at professional meetings.

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APPENDIX I

TECHNICAL NOTES ON THE SAMPLE DESIGN

Definition of Terms

Standard metropolitan statistical area (SMSA).-An SMSA consists of a county or group of contiguous counties (except in New England) which contains at least one central city of 50,000 people or more, or "twin cities" with a combined population of at least 50,000 population. In addition, other contiguous counties are included in an SMSA if, according to certain criteria, they are socially and economically integrated with the central city. Definitions of SMSA's which identify the composition and structure of each appear in a U.S. Bureau of the Census publication.⁸

Geographic regions.-For purposes of HES, the 48 contiguous States and the District of Columbia are divided into 4 regions of about the same population size, shown in table I.

Controlled selection.-This term refers to a scheme that permits some element of subjective determination in obtaining a "better balanced" or "more representative" sample, while retaining all the elements of true probability sampling. The procedure is described in a number of publications.^{9,10} The control variables used for this sample design are "State groups" and "rate of population change" and are defined as follows:

Separate groups were formed within geographic regions, as shown in table I. To form the State groups, the HIS design strata were classified as belonging to the State in which the HIS sample PSU was located. If a sample PSU was within two States, it was put in the State with the greater proportion of the population.

NOTE: A list of references follows the text.

Table I. State groups by geographic region

Region	State group number	States in group
Northeast.....	1	New York
	2	Pennsylvania and New Jersey
	3	Maine, New Hampshire, Vermont, Massachusetts, Connecticut, and Rhode Island
Midwest.....	1	Ohio
	2	Michigan
	3	Indiana and Illinois
	4	Missouri
	5	Kansas, Nebraska, Iowa, and North Dakota
	6	Wisconsin and Minnesota
South.....	1	Maryland, Delaware, and District of Columbia
	2	Virginia and West Virginia
	3	Kentucky and Tennessee
	4	North Carolina and South Carolina
	5	Georgia
	6	Alabama and Mississippi
	7	Florida
	8	Arkansas, Louisiana, and Texas
West.....	1	California and Nevada
	2	Texas
	3	Washington, Oregon, Idaho, and Montana
	4	Oklahoma, Arkansas, and Louisiana
	5	Wyoming, Utah, Colorado, New Mexico, and Arizona
	6	North Dakota, South Dakota, Nebraska, Kansas, Minnesota, and Missouri

Rate of population change. -Groups were defined differently for each region as indicated in table II. In the Northeast Region, for example, PSU's with less than a 5-percent increase in population between 1950 and 1960 were classified in group 1, while this class in the Midwest

Table II. Ranges for rate-of-population-change control groups by geographic region, 1950-60

Rate-of-population-change group number	Region			
	Northeast	Midwest	South	West
	Percent population change, 1950-60			
1.....	3 and under	0 and under	-10 and under	-5 and under
2.....	5-11	1-15	-9-0	-2-0
3.....	12-23	16-23	1-8	4-21
4.....	25-58	24-30	9-16	24-39
5.....		34-81	19-26	40-59
6.....			27-36	73-167
7.....			37-47	
8.....		-	50-301	

Region included only those PSU's with a loss or with no gain in population.

Population density groups. -In general, this term refers to the proportion of the population that lives in urban areas. The density groups are defined somewhat differently for each geographic region.⁴ For the very large SMSA's,

except those in the South Region, the criterion for inclusion was population size; these SMSA's were chosen for the sample with certainty. In the South Region, the largest SMSA's were defined in the same way as "other large SMSA's," but were put in a different stratum for sampling purposes.

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APPENDIX II

SAMPLE LOCATIONS OF THE HEALTH AND NUTRITION EXAMINATION SURVEY OF ADULTS, BY REGION, COUNTY, STATE, AND PROBABILITY DESIGN

Region, county, ¹ and State	Probability design		
	1-35	1-65	66400
<u>Northeast</u>			
Essex, Morris, Union, Somerset, Hudson, Middlesex, N.J.	X	X	X
Nassau, Queens, Suffolk, N.Y.	X	X	X
Bronx, N.Y.	X	X	X
Kings, Richmond, N.Y.		X	
Westchester, Rockland, N.Y.: Bergen, Passaic, N.J.		X	
Bucks, Chester, Delaware, Montgomery, Philadelphia, Pa.	X	X	X
Philadelphia, Pa: Camden, Gloucester, Burlington, N.J.		X	
Essex, Middlesex, Norfolk, Plymouth, Suffolk, Mass.	X	X	X
Allegheny, Beaver, Washington, Westmoreland, Pa.	X	X	X
Albany, Schenectady, Rensselaer, Saratoga, N.Y.	X	X	
Lackawanna, Pa.		X	
Holyoke, Chicopee, Springfield, Mass.	X	X	
Bristol, Newport, Providence, Kent, Washington, R.I.		X	
Hartford, Tolland, Conn.	X	X	
Chemung, Tioga, Tompkins, N.Y.		X	
Mercer, Pa.	X	X	
Bedford, Fulton, Pa.		X	
Monroe, N.Y.			X
Blair, Pa.			X
Middlesex, New Haven, Conn.			X
Warren, N.Y.			X
<u>Midwest</u>			
Lake, Porter, Cook, Will, Kane, Ill.	X	X	X
Cook, DuPage, Kane, Lake, McHenry, Ill.		X	
Macomb, Oakland, Wayne, Mich.	X	X	X
Milwaukee, Waukesha, Wis.	X	X	
Hennepin, Ramsey, Anoka, Dakota, Washington, Minn.		X	
Lake, Cuyahoga, Ohio	X	X	
Franklin, Ohio		X	
Buchanan, Mo.	X	X	
Cass, N.Dak.: Clay, Minn.		X	
Jefferson, St. Charles, St. Louis, Mo.: Madison, St. Clair, Ill.		X	
Bay, Mich.	X	X	
DeKalb-Stueben, Ind.: Branch, Mich.	X	X	
Cass, St. Joseph, Mich.		X	
Fayette, Ross, Ohio		X	
LaPorte, Marshall, Starke, Ind.	X	X	
Boone, Greene, Iowa	X	X	

¹County, parish, or borough.

Region, county,¹ and State

Probability design
1-35 1-65 66400

Midwest—Con.

Howard, Iowa; Fillmore, Minn.		X	
Cass, Clay, Jackson, Platte, Mo.			X
Marion, Ind.			X
Montgomery, Greene, Miami, Ohio			X
Jackson, Mich.			X
Jefferson, Leavenworth, Kans.: Platt, Mo.			X
Brown, Clinton, Ohio			X
Rusk, Wis.			X

South

St. Bernard, Jefferson, Orleans, La.		X	X
Washington, D.C.: Fairfax, Arlington, Va.: Prince Georges, Montgomery, Md.	X	X	
Richland, Lexington, S.C.	X	X	
Knox, Anderson, Blount, Tenn.		X	
Roanoke, Va.		X	
Chatham, Ga.	X	X	
Hillsborough, Pinellas, Fla.		X	
Palm Beach, Fla.	X	X	
Natchitoches, La.		X	
Lamar, Marion, Miss.	X	X	
Cabarrus, Stanley, Union, N.C.	X	X	
Hancock, Hamblen, Hawkins, Claiborne, Tenn.		X	X
Barbour, Ala.	X	X	
Bullock, Jenkins, Ga.		X	
Sussex, Del.: Worcester, Md.	X	X	
Fayette, W. Va.		X	
Greenville, S.C.			X
New Castle, Del.			X
Jefferson, Ala.			X
Volusia, Fla.			X
Edgefield, Saluda, S.C.			X
Clay, Calhoun, Roane, W. Va.			X

West

Orange, Los Angeles, Calif.	X	X	X
Los Angeles, Calif.		X	
Alameda, Contra-Costa, San Mateo, San Francisco, Solano, Calif.	X	X	X
Collin, Denton, Dallas, Ellis, Tex.		X	
Bexar, Tex.	X	X	
Pima, Ariz.	X	X	
Douglas, Nebr.: Pottawattamie, Iowa		X	
San Diego, Calif.		X	
Fresno, Calif.	X	X	
Monterey, Calif.		X	
Clallum, San Juan, Wash.	X	X	
Grant, Wash.	X	X	
Gila, Ariz.		X	
Avoyel les, La.	X	X	
Ottertail, Minn.		X	
Adams, Arapahoe, Denver, Jefferson, Boulder, Colo.			X
Sacramento, Calif.			X
Hunt, Rains, Tex.			X
Mason, Thurston, Wash.			X
Greeley, Nance, Nebr.			X
Camadian, Cleveland, Oklahoma, Okla.			X

¹County, parish, or borough.

APPENDIX III

QUESTIONNAIRES AND EXAMINATION FORMS

A. Household Card

FORM HES-5A (CYCLE IV) <small>5-15-74*</small> U.S. DEPARTMENT OF COMMERCE SOCIAL AND ECONOMIC STATISTICS ADMINISTRATION BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR THE U.S. PUBLIC HEALTH SERVICE HOUSEHOLD CARD HEALTH EXAMINATION SURVEY		NOTICE - All information which would permit identification of the individual will be held in strict confidence, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any purposes.																																																									
1. Stand number 2. Identification code		3. Control number PSU Segment Serial		4. Card _____ of _____ C a r d s																																																							
5a. What is your exact address? (Include House No., Apt. No., or other identification and ZIP code) _____ _____ City _____ State _____ ZIP code _____ Listing Sheet No. _____ Sheet No. _____ Line No. _____		14. Noninterview reason TYPE A <input type="checkbox"/> Refusal - Describe in a footnote <input type="checkbox"/> No one at home - repeated calls <input type="checkbox"/> Temporarily absent - Footnote <input type="checkbox"/> Other (Specify) _____ } <i>Fill items 6-8, 11a-c as applicable, 13-15 and 18</i> TYPE B <input type="checkbox"/> Vacant - nonseasonal <input type="checkbox"/> Vacant - seasonal <input type="checkbox"/> Usual residence elsewhere <input type="checkbox"/> Armed Forces <input type="checkbox"/> Other (Specify) _____ } <i>Fill items 6-8, 11a-c as applicable, 13-15</i> TYPE C <input type="checkbox"/> Unused line of listing sheet <input type="checkbox"/> Demolished <input type="checkbox"/> Merged <input type="checkbox"/> Outside segment <input type="checkbox"/> Built after April 1, 1970 <input type="checkbox"/> Other (Specify) _____ } <i>Fill items 8c if marked, and 13-15</i>																																																									
b. Is this your mailing address? <input type="checkbox"/> Same as 5a Mark box or specify if different, include ZIP code. _____ City _____ State _____ ZIP code _____																																																											
c. Special place name _____ Sample unit number _____ Type code _____																																																											
6. YEAR BUILT * Ask <input type="checkbox"/> Do NOT Ask When was this structure originally built? <input type="checkbox"/> Before 4-1-70 <input type="checkbox"/> After 4-1-70 (Go to 6c, complete if required and end interview) (Continue interview)		15. Record of calls <table border="1" style="width: 100%; border-collapse: collapse; font-size: x-small;"> <thead> <tr> <th rowspan="2">Date</th> <th colspan="2">Time</th> <th rowspan="2">Completed</th> </tr> <tr> <th>Beginning</th> <th>Ending</th> </tr> </thead> <tbody> <tr><td>1</td><td>a.m.</td><td>a.m.</td><td></td></tr> <tr><td></td><td>p.m.</td><td>p.m.</td><td></td></tr> <tr><td>2</td><td>a.m.</td><td>a.m.</td><td></td></tr> <tr><td></td><td>p.m.</td><td>p.m.</td><td></td></tr> <tr><td>3</td><td>a.m.</td><td>a.m.</td><td></td></tr> <tr><td></td><td>p.m.</td><td>p.m.</td><td></td></tr> <tr><td>4</td><td>a.m.</td><td>a.m.</td><td></td></tr> <tr><td></td><td>p.m.</td><td>p.m.</td><td></td></tr> <tr><td>5</td><td>a.m.</td><td>a.m.</td><td></td></tr> <tr><td></td><td>p.m.</td><td>p.m.</td><td></td></tr> <tr><td>6</td><td>a.m.</td><td>a.m.</td><td></td></tr> <tr><td></td><td>p.m.</td><td>p.m.</td><td></td></tr> </tbody> </table>				Date	Time		Completed	Beginning	Ending	1	a.m.	a.m.			p.m.	p.m.		2	a.m.	a.m.			p.m.	p.m.		3	a.m.	a.m.			p.m.	p.m.		4	a.m.	a.m.			p.m.	p.m.		5	a.m.	a.m.			p.m.	p.m.		6	a.m.	a.m.			p.m.	p.m.	
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7. Type of living quarters <input type="checkbox"/> Housing unit <input type="checkbox"/> OTHER unit		16. List line numbers of sample persons not interviewed during initial interview. <input type="checkbox"/> None Line number _____																																																									
8. Area segments ONLY * a. Are there any occupied or vacant living quarters besides your own in this building? Y (fill Table X) N * b. Are there any occupied or vacant living quarters besides your own on this floor? Y (fill Table X) N * c. Is there any other building on this property for people to live in - either occupied or vacant? Y (fill Table X) N * d. None																																																											
9. Land use <input type="checkbox"/> RURAL (Go to 10) <input type="checkbox"/> ALL OTHER (19, back) Regular units coded 82 or 84 in item 2. * Special place units coded 82 or 84 in item 2 AND coded 85-89 in item 5c.		17. Record of additional personal calls <table border="1" style="width: 100%; border-collapse: collapse; font-size: x-small;"> <thead> <tr> <th rowspan="2">Date</th> <th colspan="2">Time</th> <th rowspan="2">Line Nos. completed</th> </tr> <tr> <th>Beginning</th> <th>Ending</th> </tr> </thead> <tbody> <tr><td>1</td><td>a.m.</td><td>a.m.</td><td></td></tr> <tr><td></td><td>p.m.</td><td>p.m.</td><td></td></tr> <tr><td>2</td><td>a.m.</td><td>a.m.</td><td></td></tr> <tr><td></td><td>p.m.</td><td>p.m.</td><td></td></tr> <tr><td>3</td><td>a.m.</td><td>a.m.</td><td></td></tr> <tr><td></td><td>p.m.</td><td>p.m.</td><td></td></tr> </tbody> </table>				Date	Time		Line Nos. completed	Beginning	Ending	1	a.m.	a.m.			p.m.	p.m.		2	a.m.	a.m.			p.m.	p.m.		3	a.m.	a.m.			p.m.	p.m.																									
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10. Do you own or rent this place? Own <input type="checkbox"/> Rent <input type="checkbox"/> Rent for free <input type="checkbox"/>		18. For "final" Type A noninterviews enter names, approximate ages, and sex of household members. <table border="1" style="width: 100%; border-collapse: collapse; font-size: x-small;"> <thead> <tr> <th>Line number</th> <th>Name</th> <th>Age</th> <th>Sex</th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td></td><td></td></tr> <tr><td>2</td><td></td><td></td><td></td></tr> <tr><td>3</td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td></tr> </tbody> </table>				Line number	Name	Age	Sex	1				2				3				4				5				6																													
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11a. Does this place (own rent rent for free) have 10 acres or more? 1 Y 2 N (11c) b. During the past 12 months did sales of crops, livestock, and other farm products from this place amount to \$50 or more? 1 Y (19 back) 2 N (19 back) c. During the past 12 months did sales of crops, livestock, and other farm products from this place amount to \$250 or more? 1 Y 2 N		WASHINGTON USE ONLY Total number of persons _____ Total number of sampled persons _____																																																									
GO TO QUESTION 19 ON THE REVERSE SIDE																																																											
12. What is the telephone number here? _____ Area code _____ Number _____ None		NOTE: Footnote reason for noninterviews for sample persons in same detail as in item 14.																																																									
13. Interviewer's name _____ Code _____																																																											
NOTE: BEFORE LEAVING HOUSEHOLD, CHECK THAT 16 HAS AN ENTRY. Determine the best time for callbacks for Supplements and sample persons.		FOOTNOTES																																																									
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NCHS Serial Number	Census Use	Name (Last, first) (20a)	How is -- related to -- (head of household)? (20b)	Household member (20c)	How old was -- on his last birthday? (20d)	What is the month, date, and year of --'s birth? (Use card to check birth date and age for consistency.) (20e)	Enter code (20f)				Enter code (20g)		Is -- now married, widowed, divorced, separated or never married? (20h)	Mark (X) the box for all Persons aged 15-74 (20i)	Refer to HES-28 for all EP's to determine if there are any Sample Persons. Enter SP on the line for each Sample Person, then go to HES-5B (20j)
							W-1 N-2 Ot-3	M-1 F-2	Race	Sex	Marital Status				
	1			Y N	Age	Month	Date	Year							
	2			Y N									<input type="checkbox"/> EP	1	
	3			Y N									<input type="checkbox"/> EP	2	
	4			Y N									<input type="checkbox"/> EP	3	
	5			Y N									<input type="checkbox"/> EP	4	
	6			Y N									<input type="checkbox"/> EP	5	
	7			Y N									<input type="checkbox"/> EP	6	
	8			Y N									<input type="checkbox"/> EP	7	
	9			Y N									<input type="checkbox"/> EP	8	
	10			Y N									<input type="checkbox"/> EP	9	
													<input type="checkbox"/> EP	10	

19a. What is the name of the head of this household? - Enter name in first column.
 b. What are the names of all the persons who live here? - List all persons who live here.
 c. I have listed (Read names) is there anyone else staying here now, such as friends, relatives, or roomers?
 d. Have I missed anyone who USUALLY lives here but is now away from home?
 e. Do any of the people in the household have a home anywhere else?
 If any adult males listed, sk:
 f. Are any of the persons in his household now on full-time active duty with the Armed Forces of the United States? Yes → line(s) _____ (Delete) No

For notes

E If this questionnaire is for an EXTRA unit, enter Control Number of original sample unit → _____

If in AREA SEGMENT, also enter for FIRST unit listed on property → _____

LISTING SHEET
 Sheet number _____ Line number _____

Line No.	LOCATION OF UNIT Where are these quarters located? <i>Enter exact description or location, e.g., basement, 2nd floor, rear.</i>	If listed, enter sheet and line number, STOP Table X, and continue interview for original sample unit. If unlisted, go to 4.	If outside AREA SEGMENT boundary; mark box below, STOP Table X, and go to Household Page, item 8 or 9; or Medical History, question 1 (as applicable).	Are these (specify location) quarters for more than one group of people? If "Yes," fill one line for each group.	USE OR CHARACTERISTICS			CLASSIFICATION
					OCUPIED Do the occupants of these (specify location) quarters live/d eat with any other group of people?	ALL QUARTERS Do these quarters in (specify location) have: Direct access from the outside or through a common hall?	Complete kitchen facilities for this unit only?	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1		S ___ L ___	<input type="checkbox"/> Outside segment boundary	Yes No	Yes: - Go to 9 and circle N No	Yes No	Yes No	N HU OT
2		S ___ L ___	<input type="checkbox"/> Outside segment boundary	Yes No	Yes: - Go to 9 and circle N No	Yes No	Yes No	N HU OT
3		S ___ L ___	<input type="checkbox"/> Outside segment boundary	Yes No	Yes: - Go to 9 and circle N No	Yes No	Yes No	N HU OT

NOTE: Be sure to continue interview for original sample unit.

FORM HES-28 (REV. 10-10-74)

1. In what State were you born? Enter the name of the State or foreign country.	1. State or foreign country (101) <input type="text"/>
2a. What is the highest grade or year of regular school you have ever attended? b. Did you finish the -- grade (year)?	2a. (102) <input type="checkbox"/> None Elementary 1 2 3 4 5 6 7 8 High School 9 10 11 12 (103) College 1 2 3 4 5+ b. (104) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
3. What is your origin or descent?	3. (105) 0 <input type="checkbox"/> German 8 <input type="checkbox"/> Mexican 2 <input type="checkbox"/> Italian 8 <input type="checkbox"/> Mexicano 1 <input type="checkbox"/> Irish 7 <input type="checkbox"/> Puerto Rican 3 <input type="checkbox"/> French 7 <input type="checkbox"/> Cuban 4 <input type="checkbox"/> Polish 7 <input type="checkbox"/> Central or South American 5 <input type="checkbox"/> Russian 7 <input type="checkbox"/> Other Spanish 6 <input type="checkbox"/> English 12 <input type="checkbox"/> Negro 15 <input type="checkbox"/> Scottish 12 <input type="checkbox"/> Black 15 <input type="checkbox"/> Welsh 15 <input type="checkbox"/> Other - Specify 7 8 <input type="checkbox"/> Mexican-American 8 <input type="checkbox"/> Chicano
4a. What were you doing MOST of the past 3 months (For male): working or doing something else? (For females): keeping house, working, or doing something else? b. What were you doing? c. Did you work at a job or business AT ANY TIME during the past 3 months? d. When you were working, did you usually work full time or part time?	4a. (106) 1 <input type="checkbox"/> Working (4d) 2 <input type="checkbox"/> Keeping house (4c) 3 <input type="checkbox"/> Something else b. (107) 0 <input type="checkbox"/> Layoff 1 <input type="checkbox"/> Retired 2 <input type="checkbox"/> Student 3 <input type="checkbox"/> Ill 4 <input type="checkbox"/> Staying home 5 <input type="checkbox"/> Looking for work 6 <input type="checkbox"/> Unable to work 7 <input type="checkbox"/> Other - Specify _____ c. (108) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5b) d. (109) 1 <input type="checkbox"/> Full time 2 <input type="checkbox"/> Part time
5a. Did you work at any time last week or the week before? (For females): not counting work around the house? b. Even though you did not work during that time, do you have a job or business? c. Were you looking for work or on layoff from a job? d. Which - looking for work or on layoff from a job?	5a. (110) 1 <input type="checkbox"/> Yes (6) 2 <input type="checkbox"/> No b. (111) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No c. (112) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Instructions for Q-6) d. (113) 1 <input type="checkbox"/> Looking 2 <input type="checkbox"/> Layoff 3 <input type="checkbox"/> Both
Ask for all persons with a "Yes" in 5a, b, or c. If "Yes" in 5c only, questions 6a through 6d apply to this person's LAST full-time civilian job.	6a. For whom did you work? Name of company, business, organization, or other employer. b. What kind of business or industry is this? For example, TV and radio manufacturing, retail shoe store, State Labor Department, farm. c. What kind of work were you doing? For example, electrical engineer, stock clerk, typist, farmer. d. Class of worker (Fill from entries in 60-c; if not clear, read list.) If self-employed in "OWN" business and not a farm, ask: e. Is the business incorporated?
	6a. Employer b. Industry (114) <input type="text"/> c. Occupation (115) <input type="text"/> d. (116) 1 <input type="checkbox"/> Private paid } (7) 2 <input type="checkbox"/> Gov. Federal } 3 <input type="checkbox"/> Gov. other } 4 <input type="checkbox"/> Own } 5 <input type="checkbox"/> Nonpaid } (7) 6 <input type="checkbox"/> Never worked } (117) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

<p>Now I have some questions about your medical history.</p>	
<p>7. Would you say your health in general is excellent, very good, good, fair, or poor?</p>	<p>7. (118) 1 <input type="checkbox"/> Excellent 2 <input type="checkbox"/> Very good 3 <input type="checkbox"/> Good 4 <input type="checkbox"/> Fair 5 <input type="checkbox"/> Poor</p>
<p>8a. Do you have any health problems now that you would like to talk to a doctor about?</p>	<p>8a. (119) 1 <input type="checkbox"/> Φ Π \dagger 2 <input type="checkbox"/> No (9)</p>
<p>b. What are the problems? _____ _____</p>	<p>b. ▶ DATA PREPARATION USE ONLY ◀</p> <p>(120) 1 <input type="checkbox"/> * 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/></p> <p>(121) 1 <input type="checkbox"/> * 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/></p> <p>(122) 1 <input type="checkbox"/> * 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/></p> <p>(123) 1 <input type="checkbox"/> * 2 <input type="checkbox"/> 3 <input type="checkbox"/></p>
<p>9a. Have you had a cold, flu, or "the virus" during the past month?</p>	<p>9a. (124) 1 <input type="checkbox"/> Φ Π \dagger 2 <input type="checkbox"/> No (10)</p>
<p>b. Do you still have it?</p>	<p>b. (125) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>10. IN THE PAST 5 YEARS have you had a back injury?</p>	<p>10. (126) 1 <input type="checkbox"/> Φ Π \dagger 2 <input type="checkbox"/> No</p>
<p>Now I have some questions about HEARING.</p>	
<p>11a. At any time over the past few years, have you ever noticed ringing in your ears, or have you been bothered by other funny noises in your ears?</p>	<p>11a. (127) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (12)</p>
<p>b. How often — every few days or less often?</p>	<p>b. (128) 1 <input type="checkbox"/> Every few days 2 <input type="checkbox"/> Less often</p>
<p>c. When it does occur, does it bother you quite a bit, just a little, or not at all?</p>	<p>c. (129) 1 <input type="checkbox"/> Quite a bit 2 <input type="checkbox"/> Just a little 3 <input type="checkbox"/> Not at all</p>
<p>12a. Have you EVER had a running ear or any discharge from your ears (not counting wax in the ears)?</p>	<p>12a. (130) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (13) 9 <input type="checkbox"/> DK</p>
<p>b. How often have you had a running ear or any discharge from your ears?</p>	<p>b. (131) 1 <input type="checkbox"/> Once only 2 <input type="checkbox"/> Twice 3 <input type="checkbox"/> 3 or more times 9 <input type="checkbox"/> DK</p>
<p>c. Did you visit a doctor because of this condition?</p>	<p>c. (132) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (13) 9 <input type="checkbox"/> DK</p>
<p>d. Did a doctor give you anything for this condition?</p>	<p>d. (133) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
<p>13a. Have you EVER had deafness or trouble hearing with one or both ears? Do not include any problems which lasted just a short period of time such as colds.</p>	<p>13a. (134) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (14)</p>
<p>b. Did you ever see a doctor about it?</p>	<p>b. (135) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>c. How old were you when you first began having trouble hearing?</p>	<p>c. (136) 1 <input type="checkbox"/> 0-4 years old 2 <input type="checkbox"/> 5-9 years old 3 <input type="checkbox"/> 10-19 years old 4 <input type="checkbox"/> 20-29 years old 5 <input type="checkbox"/> 30-39 years old 6 <input type="checkbox"/> 40-49 years old 7 <input type="checkbox"/> 50 years old or older</p>
<p>d. Since this trouble began, has it gotten worse, better, or stayed about the same?</p>	<p>d. (137) 1 <input type="checkbox"/> Gotten worse 2 <input type="checkbox"/> Gotten better 3 <input type="checkbox"/> Stayed about the same</p>
<p>e. Was the cause of your hearing trouble or deafness — (Read list)</p> <p>Ear infection Born with it Loud noise such as that from machinery, gunfire blasts, or explosions Ear surgery Ear injury Other — Specify _____</p>	<p>e. Yes No DK</p> <p>(429) 1 <input type="checkbox"/> * 2 <input type="checkbox"/> (430) 1 <input type="checkbox"/> * 2 <input type="checkbox"/> (431) 1 <input type="checkbox"/> * 2 <input type="checkbox"/></p> <p>3 <input type="checkbox"/> 3 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 4 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 5 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 6 <input type="checkbox"/> 6 <input type="checkbox"/></p>

HEARING — Continued

13f. How would you rate your hearing in your RIGHT ear = good, a little decreased, a lot decreased, or are you deaf?

g. How would you rate your hearing in your LEFT ear = good, a little decreased, a lot decreased, or are you deaf?

h. Have you ever attended school or class for those with poor hearing or a school for the deaf?

i. Have you ever had any training in lip reading?

j. Have you ever had any training in speech or in speech correction because of poor hearing?

k. Have you ever had any training in how to use your hearing?

l. Have you ever had an operation on your ears?

m. Have you ever had your hearing tested?

n. How old were you when your hearing was first tested?

o. How often do you now have your hearing tested?

p. Have you ever used a hearing aid?

q. Which ear?

r. Do you use a hearing aid now?

s. How well satisfied are you with your present hearing aid? Does it help a lot, a little, very little, or not at all?

● If "Yes" in 13p ask 14a-g using the parenthetical phrase "Without a hearing aid."

14a. (Without a hearing aid) Can you usually HEAR AND UNDERSTAND what a person says without seeing his face if that person WHISPERS to you from across a quiet room?

b. (Without a hearing aid) Can you usually HEAR AND UNDERSTAND what a person says without seeing his face if that person TALKS IN A NORMAL VOICE to you from across a quiet room?

c. (Without a hearing aid) Can you usually HEAR AND UNDERSTAND what a person says without seeing his face if that person SHOUTS to you from across a quiet room?

d. (Without a hearing aid) Can you usually HEAR AND UNDERSTAND a person if that person SPEAKS LOUDLY into your better ear?

e. (Without a hearing aid) Can you usually tell the sound of speech from other sounds and noises?

f. (Without a hearing aid) Can you usually tell one kind of noise from another?

g. (Without a hearing aid) Can you hear loud noises?

13f. (139) 1 Good
2 A little decreased
3 A lot decreased
4 Deaf

g. (140) 1 Good
2 A little decreased
3 A lot decreased
4 Deaf

h. (141) 1 Yes
2 No

i. (142) 1 Yes
2 No

j. (143) 1 Yes
2 No

k. (144) 1 Yes
2 No

l. (145) 1 Yes
2 No

m. (146) 1 Yes
2 No (13p)

n. (147) 1 0-9 years old
2 10-19 years old
3 20-29 years old
4 30 years old or older

o. (148) 1 Twice a year
2 Once a year
3 Once every 2 years
4 Less often than once every 2 years

p. (149) 1 Yes
2 No (14)

q. (150) 1 Right
2 Left
3 Both

r. (151) 1 Yes
2 No (14)

s. (152) 1 Helps a lot
2 Helps a little
3 Helps very little
4 Does not help at all

14a. (153) 1 Yes (15)
2 No

b. (154) 1 Yes (15)
2 No

c. (155) 1 Yes (15)
2 No

d. (156) 1 Yes (15)
2 No

e. (157) 1 Yes (15)
2 No

f. (158) 1 Yes (15)
2 No

g. (159) 1 Yes
2 No

The following series of questions will be about specific medical problems or conditions you might have had in the past or might even have at the present time. Please answer "Yes" or "No" to each question.

Have you EVER had =

15a. Pain or aching in any of your joints on most days for AT LEAST 1 MONTH?	15a. (160) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
b. Pain in your neck or back on most days for AT LEAST 1 MONTH?	b. (161) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
c. Pain in or around either hip joint including the buttock, groin, and side of the upper thigh on most days for AT LEAST 1 MONTH?	c. (162) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
d. Pain in or around the knee including the back of the knee on most days for AT LEAST 1 MONTH?	d. (163) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
e. Swelling at a joint, with pain present in the joint when touched on most days for AT LEAST 1 MONTH?	e. (164) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
f. Stiffness in the joints and muscles when getting out of bed in the morning lasting for AT LEAST 15 MINUTES?	f. (165) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Have you EVER had =	
g. Trouble with recurring persistent cough attacks?	g. (166) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
h. A cough first thing in the morning in the winter? (Count a cough with first smoking or on first going out of doors; exclude clearing of throat or a single cough.)	h. (167) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
i. A cough first thing in the morning in the summer?	i. (168) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
j. Any phlegm from your chest first thing in the morning in the winter? (Count phlegm with the first smoke or on going out of doors; exclude phlegm from the nose. Count swallowed phlegm.)	j. (169) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
k. Any phlegm from your chest the first thing in the morning in the summer?	k. (170) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
l. During the past 3 years have you had a period of increased cough and phlegm lasting for 3 weeks or more?	l. (171) 1 <input type="checkbox"/> Yes = How many times? 2 <input type="checkbox"/> No (1.5m) 7 (172) 1 <input type="checkbox"/> 1 time 2 <input type="checkbox"/> 2 times 3 <input type="checkbox"/> More than 2 times
Have you EVER had =	
m. Trouble with shortness of breath, when hurrying on the level or walking up a slight hill?	m. (173) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
n. Wheezy or whistling sounds in your chest?	n. (174) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
o. Trouble with any pain or discomfort in your chest?	o. (175) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
p. Trouble with any pressure or heavy sensation in your chest?	p. (176) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
q. Severe pain across the front of your chest lasting for half an hour or more?	q. (177) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
r. Pains in either leg when walking?	r. (178) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
s. Heart failure, or "weak heart" of any degree of severity?	s. (179) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
t. Infections of the kidneys or bladder?	t. (180) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
u. Loss of vision or blindness lasting from several minutes to several days?	u. (181) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
v. Difficulty in speaking or very slurred speech lasting from several minutes to several days?	v. (182) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

<p>Have you EVER had =</p> <p>15w. Prolonged weakness or paralysis of one or both sides of the body lasting up to several months?</p>	<p>15w. (183) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>x. Lass of sensation or numbness or tingling sensations lasting several minutes to several days?</p>	<p>x. (184) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>y. A severe head injury leading to unconsciousness lasting for more than 5 minutes?</p>	<p>y. (185) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>DIABETES</p>	
<p>16a. Do you have any reason to think that you may have diabetes, sometimes called sugar diabetes or sugar disease?</p>	<p>16a. (186) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (17)</p>
<p>b. Did a doctor tell you that you had it?</p>	<p>b. (187) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (17)</p>
<p>c. How long ago did you start having it?</p>	<p>c. (188) 1 <input type="checkbox"/> Less than 1 year ago 2 <input type="checkbox"/> 1-4 years ago 3 <input type="checkbox"/> 5 or more years ago</p>
<p>d. Do you take insulin shots?</p>	<p>d. (189) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>e. Do you take any medicine by mouth for diabetes?</p>	<p>e. (190) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (17)</p>
<p>f. What is the name of the medicine? _____</p>	
<p>GOITER/THYROID</p>	
<p>17a. Have you ever had a goiter or any other thyroid trouble?</p>	<p>170. (191) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (18)</p>
<p>b. Who told you that you had goiter or thyroid trouble?</p>	<p>b. (192) 1 <input type="checkbox"/> A doctor 2 <input type="checkbox"/> A nurse 3 <input type="checkbox"/> Other</p>
<p>c. Is, or was, your thyroid: Overactive (hyperactive) or underactive (hypoactive)?</p>	<p>c. (193) 1 <input type="checkbox"/> Overactive 2 <input type="checkbox"/> Underactive 3 <input type="checkbox"/> Neither 9 <input type="checkbox"/> DK</p>
<p>d. How long ago did you first have this trouble?</p>	<p>d. (194) 1 <input type="checkbox"/> Less than 1 year ago 2 <input type="checkbox"/> 1-4 years ago 3 <input type="checkbox"/> 5-9 years ago 4 <input type="checkbox"/> 10 or more years ago</p>
<p>e. Have you been treated by a doctor for goiter or for thyroid trouble?</p>	<p>e. (195) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (18)</p>
<p>f. Were you treated for this condition by a doctor with = (Read list <i>and mark all</i> that apply)</p>	<p>f. (196) 1 <input type="checkbox"/> Medicines 2 <input type="checkbox"/> Surgery 3 <input type="checkbox"/> Radiation 4 <input type="checkbox"/> Anything else = Specify 7</p>
<p>g. Are you currently being treated for this problem?</p>	<p>g. (197) 1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/> No</p>
<p>h. Are you currently taking any pills or medicine to help you lose or gain weight?</p>	<p>h. (198) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>i. When was the last time you saw a doctor about goiter or thyroid trouble?</p>	<p>i. (199) 1 <input type="checkbox"/> Less than 1 month ago 2 <input type="checkbox"/> 1-3 months ago 3 <input type="checkbox"/> 4-6 months ago 4 <input type="checkbox"/> 7-11 months ago 5 <input type="checkbox"/> 1 or more years ago 9 <input type="checkbox"/> DK</p>

<p>Now I would like to ask you some questions about your TEETH.</p>	
<p>18a. Have you lost all your teeth from your upper jaw?</p>	<p>18a. (200) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (19)</p>
<p>b. Do you have a plate for your upper jaw?</p>	<p>b. (201) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (18d)</p>
<p>c. How long have you had your plate?</p>	<p>c. (202) 1 <input type="checkbox"/> Less than 1 year 2 <input type="checkbox"/> 1-4 years 3 <input type="checkbox"/> 5-9 years 4 <input type="checkbox"/> 10-19 years 5 <input type="checkbox"/> 20 or more years } (19)</p>
<p>d. Have you ever had a dental plate for your upper jaw?</p>	<p>d. (203) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>e. How long has it been since you had any natural or false teeth to chew with in your upper jaw?</p>	<p>e. (204) 1 <input type="checkbox"/> Less than 1 year 2 <input type="checkbox"/> 1-4 years 3 <input type="checkbox"/> 5-9 years 4 <input type="checkbox"/> 10-19 years 5 <input type="checkbox"/> 20 or more years</p>
<p>19a. Have you lost all your teeth from your lower jaw?</p>	<p>19a. (205) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (20)</p>
<p>b. Do you have a plate for your lower jaw?</p>	<p>b. (206) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (19d)</p>
<p>c. How long have you had your plate?</p>	<p>c. (207) 1 <input type="checkbox"/> Less than 1 year 2 <input type="checkbox"/> 1-4 years 3 <input type="checkbox"/> 5-9 years 4 <input type="checkbox"/> 10-19 years 5 <input type="checkbox"/> 20 or more years } (20)</p>
<p>d. Have you ever had a dental plate for your lower jaw?</p>	<p>d. (208) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>e. How long has it been since you had any natural or false teeth to chew with in your lower jaw?</p>	<p>e. (209) 1 <input type="checkbox"/> Less than 1 year 2 <input type="checkbox"/> 1-4 years 3 <input type="checkbox"/> 5-9 years 4 <input type="checkbox"/> 10-19 years 5 <input type="checkbox"/> 20 or more years</p>
<p>● If "Yes" in 18b or 19b ask question 20; otherwise skip to instructions above question 21.</p>	
<p>20a. Do you usually wear your plate(s) while eating?</p>	<p>20a. (210) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>b. Do you usually wear your plate(s) when not eating?</p>	<p>b. (211) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>c. Do you usually use denture powder or cream to help keep your plate(s) in place?</p>	<p>c. (212) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>d. Do you think you need a new plate or that the one(s) you have need(s) refitting?</p>	<p>d. (213) 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes, one 3 <input type="checkbox"/> Yes, both 9 <input type="checkbox"/> DK</p>
<p>● If "Yes" to questions 18a and 19a, GO to question 32; otherwise ask:</p>	
<p>21. How would you describe the condition of your TEETH - excellent, good, fair, or poor?</p>	<p>21. (214) 1 <input type="checkbox"/> Excellent 2 <input type="checkbox"/> Good 3 <input type="checkbox"/> Fair 4 <input type="checkbox"/> Poor</p>
<p>22. How would you describe the condition of your GUMS - excellent, good, fair, or poor?</p>	<p>22. (215) 1 <input type="checkbox"/> Excellent 2 <input type="checkbox"/> Good 3 <input type="checkbox"/> Fair 4 <input type="checkbox"/> Poor</p>
<p>23. How many times a day do you usually brush your teeth?</p>	<p>23. (216) _____ Times</p>

TEETH — Continued	
24. Do you think that you ought to go to a dentist now or very soon for a checkup?	24. (217) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK
25. Do you now have an appointment to see a dentist?	25. (218) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
26. Do you think you have any teeth that need filling?	26. (219) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
27a. Do you think you have any teeth that need to be pulled?	27a. (220) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (28)
b. Do you think that all of them need to be pulled?	b. (221) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28a. Have you ever had your teeth cleaned by a dentist or dental hygienist?	28a. (222) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (28c)
b. When was the last time they were cleaned?	b. (223) 1 <input type="checkbox"/> Less than 1 year ago 2 <input type="checkbox"/> 1-2 years ago 3 <input type="checkbox"/> 3-4 years ago 4 <input type="checkbox"/> 5 or more years ago
c. Do you think that your teeth need cleaning now by a dentist or dental hygienist?	c. (224) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
29. Do you have a dentist you usually go to?	29. (225) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
30. How long has it been since you last saw a dentist about yourself?	30. (226) 0 _____ Months R (227) _____ Years (32) 0 <input type="checkbox"/> Less than 1 month 77 <input type="checkbox"/> Never (32)
31. Do you go to a dentist AS OFTEN as once every year?	31. (228) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
32a. Do you have an illness which has recently cut down your appetite? b. What is the name of the illness? _____	32. (229) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (33)
33. Do you have difficulty in swallowing at least 3 days per month? (Don't count the difficulty in swallowing that goes with a cold, sore throat, or flu.)	33. (230) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
34. Have you ever had yellow jaundice (which made your skin or eyes turn yellow)?	34. (231) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
35a. Have you ever had an abdominal operation for — (Read list and mark all that apply)	35. (232) 1 <input type="checkbox"/> Ulcers 2 <input type="checkbox"/> Gallstones 3 <input type="checkbox"/> Hiatus hernia of the diaphragm 4 <input type="checkbox"/> Any other condition — Specify _____ <input type="checkbox"/> None
36a. In the past year have you stayed in a hospital overnight or longer?	36a. (233) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (37)
b. For what condition? (1) First _____ (2) Second _____ (3) Third _____	b. DATA PREPARATION USE ONLY (234) _____ (235) _____ (236) _____
c. How long were you in the hospital? (1) First condition	c. (237) _____ Weeks 0 <input type="checkbox"/> Less than 1 week
(2) Second condition	(238) _____ Weeks 0 <input type="checkbox"/> Less than 1 week
(3) Third condition	(239) _____ Weeks 0 <input type="checkbox"/> Less than 1 week

37a. Has a doctor ever that you had any following condition	a.	37b. Do you still have it?			37c. How many years ago did you first have it?		
		Yes	No	Yes	No	Dk	
Arthritis	(240)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(240) _____
Gout	(242)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(242) _____
Asthma,	(244)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(244) _____
Chronic bronchitis or emphysema	(246)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(246) _____
Tuberculosis	(248)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(248) _____
Rheumatic fever	(250)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(250) _____
Heart murmur	(252)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(252) _____
Heart failure	(254)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(254) _____
Heart attack	(256)	<input type="checkbox"/>	(37c) 2 <input type="checkbox"/>				(256) _____
Stroke	(258)	<input type="checkbox"/>	<input type="checkbox"/>				(258) _____
A peptic, stomach, or duodenal ulcer.	(260)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(260) _____
Recurrent or chronic enteritis.	(262)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(262) _____
Colitis (spastic colon, mucous colitis).	(264)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(264) _____
Gallstones	(266)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(266) _____
Hepatitis	(268)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(268) _____
Chronic cough	(270)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(270) _____
Pleurisy	(272)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(272) _____
Low blood pressure	(274)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(274) _____
Hay fever	(276)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(276) _____
Allergies to food	(278)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(278) _____
Hives	(280)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(280) _____
Other allergies	(282)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(282) _____
Polio or paralysis	(284)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(284) _____
Hiatus hernia of the diaphragm.	(286)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(286) _____
Kidney disease or kidney stones.	(288)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(288) _____
Malignant tumor or growth	(290)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(290) _____
Benign tumor, growth, or cyst (except fat or skin).	(292)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(292) _____
Trouble with blood not clotting properly	(294)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(294) 9 5
Nervous breakdown	(296)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(296) _____
Fracture of hip	(298)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	0 299 _____
Fracture of wrist	(300)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	0 301 _____
Fracture of spine	(302)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	0 303 _____
Fracture of any other bone	(304)	<input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	0 305 _____

ANEMIA	
38a. Have you ever had anemia, sometimes called "low blood?"	38a. (304) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (39) 3 <input type="checkbox"/> DK
b. How long ago did you first have it?	b. (307) _____ Years 00 <input type="checkbox"/> Less than 1 year 99 <input type="checkbox"/> Don't remember
c. Did a doctor ever tell you that you had anemia?	(308) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (39)
d. Was the anemia caused by = (Read list) Poor diet Childbirth Accidental loss of blood Illness Surgery Any other cause = Specify _____	d. (432) 1 <input type="checkbox"/> * 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> (433) 1 <input type="checkbox"/> * 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> (434) DK 1 <input type="checkbox"/> * 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/>
e. Were you bated for this condition by a doctor?	e. (310) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (39)
f. Was the treatment you used a = (Read list and mark all that apply)	f. (311) 1 <input type="checkbox"/> Better diet * 2 <input type="checkbox"/> Iron pills 3 <input type="checkbox"/> Iron shots 4 <input type="checkbox"/> Vitamin pills 5 <input type="checkbox"/> Vitamin shots 6 <input type="checkbox"/> Transfusions 7 <input type="checkbox"/> Any other treatment = Specify _____
g. Are you still being treated for this condition?	g. (312) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Now I have some questions about HYPERTENSION	
39a. Have you EVER been told by a doctor that you had high blood pressure?	39a. (313) 1 <input type="checkbox"/> Yes (39c) 2 <input type="checkbox"/> No
b. Another name for high blood pressure is hypertension. Have you EVER been told by a doctor that you had hypertension?	b. (314) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (47)
c. About how long ago were you FIRST told by a doctor that you had (high blood pressure/hypertension)?	c. (315) _____ Months (316) _____ Years 0 <input type="checkbox"/> Less than 1 month
40. During the post 12 months about how many times have you seen or talked to a doctor about your (high blood pressure/hypertension)?	40. (317) _____ Times 0 <input type="checkbox"/> None
41. Has a doctor EVER advised you to lose weight BECAUSE OF (HIGH BLOOD PRESSURE/HYPERTENSION)?	41. (318) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
42a. Do you now use more salt, less salt, or about the same amount of salt since you learned you had (high blood pressure/hypertension)?	42a. (319) 1 <input type="checkbox"/> More 2 <input type="checkbox"/> Less 3 <input type="checkbox"/> Same
b. Were you EVER advised by a doctor, nurse, or other medical person to use less salt?	b. (320) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
43a. Has a doctor EVER prescribed medicine for your (high blood pressure/hypertension)?	43a. (321) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (44)
b. Are you now taking any medicine prescribed by a doctor for your (high blood pressure/hypertension)?	b. (322) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (44) 3 <input type="checkbox"/> No longer has high blood pressure (44)
c. How often are you supposed to take this medicine = more than once a day, once a day, or less than once a day?	c. (323) 1 <input type="checkbox"/> More than once a day 2 <input type="checkbox"/> Once a day 3 <input type="checkbox"/> Less than once a day
d. How often do you take your medicine when you are supposed to = all the time, often, once in a while, or never?	d. (324) 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 5 <input type="checkbox"/> other = Specify _____

HYPERTENSION — Continued

<p>44. ABOUT how many days during the past 12 months has (high blood pressure/hypertension) kept you in bed all or most of the day?</p>	<p>44. 035 - D a y s <input type="checkbox"/> None</p>
<p>• If "No longer has high blood pressure" in 43b, GO to 45d; otherwise ask:</p> <p>45a. How often does your (high blood pressure/hypertension) bother you — all the time, often, once in a while, or never?</p> <p>b. When it does bother you, are you bothered a great deal, some, or very little?</p> <p>• If "All the time" in 45a, GO to 46; otherwise ask:</p> <p>c. Do you still have (high blood pressure/hypertension)?</p> <p>d. Is this condition completely cured or is it under control?</p>	<p>45a. 326 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 (45c) 5 <input type="checkbox"/> Other — Specify \nearrow</p> <hr/> <p>b. 327 1 <input type="checkbox"/> Great deal 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Very little 4 <input type="checkbox"/> Other — Specify \nearrow</p> <hr/> <p>c. 328 1 <input type="checkbox"/> Yes (46) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <hr/> <p>d. 329 1 <input type="checkbox"/> Cured (47) 2 <input type="checkbox"/> Under control</p>
<p>46. Can you tell when your blood pressure is high — that is, do you have any symptoms?</p>	<p>46. 330 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>47a. Has a doctor EVER talked to you about problems that can be caused by high blood pressure or hypertension?</p> <p>b. Has a nurse or other medical person EVER talked to you about problems that can be caused by high blood pressure or hypertension?</p> <p>c. What type of medical person was this?</p>	<p>47a. 331 1 <input type="checkbox"/> Yes (48) 2 <input type="checkbox"/> No</p> <p>b. 332 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (48)</p> <p>c. 333 1 <input type="checkbox"/> Nurse 2 <input type="checkbox"/> Other — Specify \nearrow</p>
<p>48. ABOUT how long has it been since you LAST had your blood pressure taken?</p>	<p>48. 0 <input type="checkbox"/> Less than 1 month 334 M o n t h s 335 (5 Years) 77 <input type="checkbox"/> Never (51)</p>
<p>49. Were you told that your reading was high, low, normal, or were you not told?</p>	<p>49. 336 1 <input type="checkbox"/> High 2 <input type="checkbox"/> Low 3 <input type="checkbox"/> Normal 4 <input type="checkbox"/> Not told 5 <input type="checkbox"/> Other — Specify \nearrow</p>
<p>50. During the past 12 months, how many times was YOUR blood pressure taken? (Do not count times while a patient in a hospital.)</p>	<p>50. 337 Times</p>
<p>51a. ABOUT how long has it been since you had an electrocardiogram, which involves placing wires on the chest and arms?</p> <p>b. ABOUT how long has it been since you had a chest X-ray?</p>	<p>51a. 0 <input type="checkbox"/> Less than 1 year 338 _____ Years 77 <input type="checkbox"/> Never</p> <p>b. 0 <input type="checkbox"/> Less than 1 year 339 - Y e a r s 77 <input type="checkbox"/> Never</p>

Now, I have some questions about VISION.	
52. Are you blind in one or both eyes?	52. (340) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
53a. Do you now have any of the following conditions: Cataracts, glaucoma, detached retina, or any other condition of the retina?	530. (341) 1 <input type="checkbox"/> Cataracts 2 <input type="checkbox"/> Glaucoma 3 <input type="checkbox"/> Detached retina 4 <input type="checkbox"/> Other condition of retina 5 <input type="checkbox"/> No condition
b. Do you now have any (other) trouble seeing in one or both eyes even when wearing eyeglasses?	b. (342) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
54a. Do you wear eyeglasses?	54a. (343) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
b. Do you wear contact lenses? • If BOTH 54a and 54b are "No," enter B-2 in box in upper right corner and SKIP to Check Item I; otherwise continue with question 55.	b. (344) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
55. How often do you use your (eyeglasses/contact lenses), all of the time, most of the time, some of the time, hardly ever, or never?	55. (345) 1 <input type="checkbox"/> All of the time (Enter A-1 in box in upper right corner and GO to Check Item I.) 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> Hardly ever 5 <input type="checkbox"/> Never (Enter B-2 in box and GO to Check Item I.)
56. Do you use your (eyeglasses/contact lenses) for reading and other close work?	56. (346) 1 <input type="checkbox"/> Yes - A 2 <input type="checkbox"/> No - B
57. Do you use your (eyeglasses/contact lenses) for seeing distant objects better?	57. (347) 1 <input type="checkbox"/> Yes - A 2 <input type="checkbox"/> No - B
• If both 56 and 57 are "No" enter B-2 in the box and ask 58; otherwise record the letter and number from 56 and 57 in the box in upper right corner and GO to Check Item I.	
58. Why do you wear (eyeglasses/contact lenses)? _____	
▶ CHECK ITEM I ◀	
• If A-1, or A-2, or B-1 is entered in upper right box, READ: These first questions are about how well you can see even when wearing eyeglasses or contact lenses. (Read the phrase "When wearing eyeglasses/contact lenses" in each of the following questions.)	
• If B-2 READ: These first questions are about how well you can see.	
59a. (When wearing eyeglasses/contact lenses) How much trouble do you have seeing with your LEFT eye - a lot of trouble, a little trouble, or no trouble at all?	590. (348) 1 <input type="checkbox"/> A lot of trouble 2 <input type="checkbox"/> A little trouble 3 <input type="checkbox"/> No trouble } (60)
b. Are you blind in the left eye?	b. (349) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
60a. (When wearing eyeglasses/contact lenses) How much trouble do you have seeing with your RIGHT eye - a lot of trouble, a little trouble, or no trouble at all?	60a. (350) 1 <input type="checkbox"/> A lot of trouble 2 <input type="checkbox"/> A little trouble 3 <input type="checkbox"/> No trouble } (61)
b. Are you blind in the right eye?	b. (351) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
• If "Yes" in 59b and 60b, GO to question 62; otherwise ask:	
61a. (When wearing eyeglasses/contact lenses) In terms of total vision, how much trouble do you have seeing - a lot of trouble, a little trouble, or no trouble at all?	61a. (352) 1 <input type="checkbox"/> A lot of trouble 2 <input type="checkbox"/> A little trouble (62) 3 <input type="checkbox"/> No trouble (Check Item II)
b. Are you blind?	b. (353) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
620. About how long have you had trouble seeing?	62a. (354) _____ Months (355) _____ Years (356) 1 <input type="checkbox"/> Since birth 9 <input type="checkbox"/> DK } (Check Item II)
b. Has it been less than 3 months, or 3 months or more?	b. (357) 1 <input type="checkbox"/> Less than 3 months 2 <input type="checkbox"/> 3 months or more

► CHECK ITEM II ◀

- If A-1 or 6-1 in upper right box on page 12, READ:
The next questions are about how well you can see in recognizing a friend from different distances. (Read the phrase "When wearing eyeglasses/contact lenses" in each Of the following questions.)
- If A-2 or B-2 in box, READ:
The next questions are about how well you can see in recognizing a friend from different distances.

63. (When wearing eyeglasses/contact lenses) Can you SEE well enough to recognize a friend if you get close to his face? 63. (358) 1 Yes
2 No

64. (When wearing eyeglasses/contact lenses) Can you SEE well enough to recognize a friend who is an arms length away? 64. (359) 1 Yes
2 No (Check Item III)

65. (When wearing eyeglasses/contact lenses) Can you SEE well enough to recognize a friend across a room? 65. (360) 1 Yes
2 No (Check Item III)

66a. (When wearing eyeglasses/contact lenses) Can you SEE well enough to recognize a friend across a street? 66a. (361) 1 Yes
2 No (Check Item III)

b. Do you have any problems seeing distant objects? b. (362) 1 yes
2 No (Check Item III)

c. What types of problems do you have in seeing distant objects?

► CHECK ITEM III ◀

- If A-1 or A-2 in the box, READ:
Now I'm going to ask about how well you can see things that are near to you. Please answer these questions in terms of when you are wearing glasses. (Read the phrase "When wearing eyeglasses/contact lenses" in each Of the following questions where appropriate.)
- If B-1 or B-2 in box, READ:
Now I'm going to ask about how well you can see things that are near to you.

67a. Do you read any newspapers, magazines, or books? 67a. (363) 1 Yes
2 No (67c)

b. (When wearing eyeglasses/contact lenses) Do you have any trouble at all seeing the print? b. (364) 1 Yes (68)
2 No (70)

c. Is this because you have trouble seeing? c. (365) 1 Yes
2 No

68a. (When wearing eyeglasses/contact lenses) Can you SEE well enough to read ordinary newspaper print? 68a. (366) 1 Yes (69)
2 No

b. (When wearing eyeglasses/contact lenses) Can you SEE well enough to recognize letters in ordinary newspaper print? b. (367) 1 Yes
2 No (69b)

69a. In order to (read/recognize) ordinary newspaper print, must you use a hand magnifying glass? 69a. (368) 1 Yes (73)
2 No (70)

b. Can you see well enough to read or recognize ordinary newspaper print if you use a hand magnifying glass? b. (369) 1 Yes (71)
2 No (71)

70a. Do you have any problem seeing ORDINARY NEWS-PAPER print (even when wearing eyeglasses)? 70a. (370) 1 Yes
2 No (73)

b. What types of problems do you have in seeing the print?
_____ (73)

71. (When you are wearing eyeglasses/contact lenses) Can you see large letters in a newspaper, such as the headlines? 71. (371) 1 Yes (73)
2 No

72a. If you are in a room, can you see well enough to tell if a light is on or off? 72a. (372) 1 Yes
2 No (73)

b. Can you see well enough to tell where the light is coming from? b. (373) 1 Yes
2 No

<p>73. During the past 6 months, have you used any medicine, drugs, or pills internally for the following? (Include any over-the-counter medicine or prescription drugs.)</p> <p>Sleep problems or insomnia</p> <p>Headache.</p> <p>Other pains</p> <p>Upset stomach or indigestion,</p> <p>Weakheart</p> <p>Allergies.</p> <p>Nerves</p> <p>Lack of pep (except thyroid pills)</p> <p>Convulsions.</p> <p>Skin conditions.</p> <p>Fluid pills for water loss</p> <p>Weight loss (except fluid pills).</p> <p>Infection (antibiotic or sulfa pills or shots only)</p>	<p>73.</p> <table border="1"> <thead> <tr> <th></th> <th>Regularly</th> <th>Occasionally</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>(374)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> </tr> <tr> <td>(375)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> </tr> <tr> <td>(376)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> </tr> <tr> <td>(377)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> </tr> <tr> <td>(378)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> </tr> <tr> <td>(379)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> </tr> <tr> <td>(380)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> </tr> <tr> <td>(381)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> </tr> <tr> <td>(382)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> </tr> <tr> <td>(383)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> </tr> <tr> <td>(384)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> </tr> <tr> <td>(385)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> </tr> <tr> <td>(386)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> </tr> </tbody> </table>		Regularly	Occasionally	No	(374)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(375)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(376)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(377)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(378)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(379)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(380)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(381)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(382)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(383)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(384)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(385)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(386)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
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<p>74a. Are you on a special diet?</p> <p>b. Is this diet = (Read list and mark all that apply)</p> <p>c. Is this diet = (Read list and mark all that apply)</p> <p>d. Was this diet ordered by a doctor?</p>	<p>74a.</p> <p>(387) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (75)</p> <p>b.</p> <p>(388) 1 <input type="checkbox"/> To lose weight * 2 <input type="checkbox"/> For diabetes 3 <input type="checkbox"/> For kidney failure 4 <input type="checkbox"/> For ulcers 5 <input type="checkbox"/> For allergies 6 <input type="checkbox"/> For heart trouble or high blood pressure</p> <p>(389) 1 <input type="checkbox"/> For pregnancy * 2 <input type="checkbox"/> For any other reason = Specify <u>7</u></p> <p>c.</p> <p>(390) 1 <input type="checkbox"/> Low fat * 2 <input type="checkbox"/> Low protein 3 <input type="checkbox"/> Low salt 4 <input type="checkbox"/> Low carbohydrate 5 <input type="checkbox"/> Low calorie 6 <input type="checkbox"/> Some other type = Specify <u>7</u></p> <p>d.</p> <p>(391) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																																																								
<p>75. In your usual day, aside from recreation, are you physically very active, moderately active, or quite inactive?</p>	<p>75.</p> <p>(392) 1 <input type="checkbox"/> Very active 2 <input type="checkbox"/> Moderately active 3 <input type="checkbox"/> Quite inactive</p>																																																								
<p>76. In things you do for recreation, for example: sports, hiking, dancing, and so forth, do you get much exercise, moderate exercise, or little or no exercise?</p>	<p>76.</p> <p>(393) 1 <input type="checkbox"/> Much exercise 2 <input type="checkbox"/> Moderate exercise 3 <input type="checkbox"/> Little or no exercise</p>																																																								
<p>These next questions are about the use of TOBACCO.</p>																																																									
<p>77a. Have you smoked at least 100 cigarettes during your lifetime?</p>	<p>77a.</p> <p>(394) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (78)</p>																																																								
<p>b. Do you smoke cigarettes now?</p>	<p>b.</p> <p>(395) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (77d)</p>																																																								
<p>c. On the average, about how many a day do you smoke?</p>	<p>c.</p> <p>(396) -Cigarettes per day (77e)</p>																																																								
<p>d. How long has it been since you smoked cigarettes fairly regularly?</p>	<p>d.</p> <p>(397) - Years (77f) 77 <input type="checkbox"/> Under one year 88 <input type="checkbox"/> Never smoked cigarettes regularly (78) 99 <input type="checkbox"/> DK</p>																																																								

<p>77e. On the average, about how many cigarettes a day were you smoking 12 months ago?</p> <p>f. During the period when you were smoking the most, about how many cigarettes a day did you usually smoke?</p> <p>g. About how old were you when you first started smoking cigarettes fairly regularly?</p>	<p>77e.</p> <p>(398) Cigarettes per day 88 <input type="checkbox"/> Did not smoke 99 <input type="checkbox"/> DK</p> <p>f.</p> <p>(399) Cigarettes per day 99 <input type="checkbox"/> DK</p> <p>g.</p> <p>(400) - Years old 88 <input type="checkbox"/> Never smoked regularly 99 <input type="checkbox"/> DK</p>
<p>78a. Have you smoked at least 50 cigars during your entire life?</p> <p>b. Do you smoke cigars now?</p> <p>c. About how many cigars a day do you smoke?</p> <p>d. About how long has it been since you smoked three or more cigars a week?</p> <p>e. Twelve months ago, about how many cigars a day did you usually smoke?</p>	<p>78a.</p> <p>(401) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (79)</p> <p>b.</p> <p>(402) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (79)</p> <p>c.</p> <p>(403) _____ Cigars per day (78e) (IF LESS THAN 1 PER DAY) 88 <input type="checkbox"/> 3 to 6 per week (78e) 99 <input type="checkbox"/> Less than 3 per week</p> <p>d.</p> <p>(404) _____ Years (79) 77 <input type="checkbox"/> Under 1 year 88 <input type="checkbox"/> Never smoked 3 or more cigars a week (79) 99 <input type="checkbox"/> DK</p> <p>e.</p> <p>(405) - Cigars per day (IF LESS THAN 1 PER DAY) 77 <input type="checkbox"/> 3 to 6 per week 88 <input type="checkbox"/> Less than 3 per week 99 <input type="checkbox"/> Did not smoke cigars</p>
<p>79a. Have you smoked at least three packages of pipe tobacco during your entire life?</p> <p>b. Do you smoke a pipe now?</p> <p>c. About how many pipesful of tobacco a day do you usually smoke?</p> <p>d. About how long has it been since you smoked three or more pipesful a week?</p> <p>e. Twelve months ago, about how many pipesful a day did you smoke?</p>	<p>79a.</p> <p>(406) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (80)</p> <p>b.</p> <p>(407) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (79d)</p> <p>c.</p> <p>(408) _____ Pipesful per day (79e) (IF LESS THAN 1 PER DAY) 77 <input type="checkbox"/> 3 to 6 per week (79e) 88 <input type="checkbox"/> Less than 3 per week</p> <p>d.</p> <p>(409) _____ Years (80) 77 <input type="checkbox"/> Under 1 year 88 <input type="checkbox"/> Never smoked 3 or more pipesful a week (80) 99 <input type="checkbox"/> DK</p> <p>e.</p> <p>(410) _____ Pipesful per day (IF LESS THAN 1 PER DAY) 77 <input type="checkbox"/> 3 to 6 per week 88 <input type="checkbox"/> Less than 3 per week 99 <input type="checkbox"/> Did not smoke a pipe</p>
<p>80. Do you presently use _____ (Read list and mark all that apply)</p>	<p>80.</p> <p>(411) 1 <input type="checkbox"/> Snuff 2 <input type="checkbox"/> Chewing tobacco 3 <input type="checkbox"/> Any other form of tobacco -Specify _____ <input type="checkbox"/> None</p>

<p>81. How important do you think it is for people to have a regular physical check-up, very important, fairly important, or hardly important at all?</p>	81.	<p>(412) 1 <input type="checkbox"/> Very important 2 <input type="checkbox"/> Fairly important 3 <input type="checkbox"/> Hardly important 9 <input type="checkbox"/> DK</p>
<p>82. Is there ONE particular doctor or place you usually go to when you are sick or when you need advice about your health?</p>	82.	<p>(413) 1 • J Yes 2 <input type="checkbox"/> No (84)</p>
<p>83. Where do you go for this care or advice, to a clinic, hospital, doctor's office, or some other place? 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?</p>	83.	<p>(414) 1 <input type="checkbox"/> Private doctor's office 2 <input type="checkbox"/> Home 3 <input type="checkbox"/> Doctor's clinic 4 <input type="checkbox"/> Group practice 5 <input type="checkbox"/> Hospital Outpatient Clinic 6 <input type="checkbox"/> Hospital Emergency Room 7 <input type="checkbox"/> Company or industry Clinic 8 <input type="checkbox"/> Other -- Specify</p>
<p>84. How long has it been since you last talked to any doctor about yourself?</p>	84.	<p>(415) - Months OR (416) - Years 0 <input type="checkbox"/> Less than 1 month 77 <input type="checkbox"/> Never (Check Item IV)</p>
<p>85. Do you get check-ups from a doctor AS OFTEN as once every 2 years?</p>	85.	<p>(417) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>↗ CHECK ITEM IV ↖</p>		
<p>Ask questions 86, 87, and 88 only once for each family. If already asked for this household, mark (X) the box and end questions. → <input type="checkbox"/></p>		
<p>86a. Is any language other than English frequently spoken here in this home?</p>	86a.	<p>(418) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (87)</p>
<p>b. What language(s)?</p>	b.	<p>Language(s) spoken (419) <input type="checkbox"/> 1</p>
<p>87. Please look at this card = (Show Flashcard) Which of these income groups represents yours, your --'s etc., total combined family income for the past 12 months; that is, since (date) a year ago? Include income from all sources such as wages, salaries, social security or retirement benefits, help from relatives, rent from property, and so forth.</p>	87.	<p>Group (420) 11 <input type="checkbox"/> A 15 <input type="checkbox"/> E 19 <input type="checkbox"/> I 12 <input type="checkbox"/> B 16 <input type="checkbox"/> F 20 • J J 13 <input type="checkbox"/> C 17 <input type="checkbox"/> G 21 <input type="checkbox"/> K 14 <input type="checkbox"/> D 18 <input type="checkbox"/> H 22 <input type="checkbox"/> L</p>
<p>88. May I see your box of table salt?</p>	88.	<p>(421) 1 <input type="checkbox"/> Iodized 2 <input type="checkbox"/> Not iodized 3 <input type="checkbox"/> No box</p>
<p>Comments</p>	<p>(422)</p>	
	<p>(423)</p>	
	<p>(424)</p>	
	<p>(425)</p>	
	<p>(426)</p>	
	<p>(427)</p>	
	<p>(428)</p>	

C. Water Usage Supplement

FORM HES-SC (10-24-74)	U.S. DEPARTMENT OF COMMERCE SOCIAL AND ECONOMIC STATISTICS ADMINISTRATION <small>BUREAU OF THE CENSUS</small> ACTING AS COLLECTING AGENT FOR THE U.S. PUBLIC HEALTH SERVICE WATER USAGE SUPPLEMENT HEALTH EXAMINATION SURVEY	NOTICE - All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes.		
a. PSU	b. Segment number	c. Serial number	d. Person number	e. NCHS Serial number
READ - Think of water a person drinks may affect his health. Each house has different water depending on such things as the pipes in the house and the service line to the house. I would like to ask you about your use of drinking water.				
<ul style="list-style-type: none"> • These next four questions are about water and drinks that you make from a faucet at this house. Do NOT include drinks made from water at other locations. 		1a.	101 _____ glass(es) <input type="checkbox"/> <input type="checkbox"/> None	
1a. About how many glasses of water do you drink here per day?				
b. About how many glasses of cold drinks made from water such as powdered milk, Kool aide, Tang, frozen juice, iced tea, whiskey with water, etc.,do you drink per-day?		b.	102 _____ glass(es) <input type="checkbox"/> <input type="checkbox"/> None	
c. About how many cups of coffee do you drink per day?		c.	103 _____ cup(s) <input type="checkbox"/> <input type="checkbox"/> None	
d. About how many cups of other hot drinks such as tea, soup, etc.,do you drink per day?		d.	104 _____ cup(s) <input type="checkbox"/> <input type="checkbox"/> None	
e. How long have you lived at this address?		e.	105 _____ month(s) 106 _____ year(s)	
<ul style="list-style-type: none"> • Now we have some questions about drinks made from faucets at other locations such as work, restaurants, and so forth. 		2a.	107 _____ glass(es) <input type="checkbox"/> <input type="checkbox"/> None	
2a. About how many glasses of water do you drink per day at these places?				
b. About how many glasses of cold drinks made from water such as powdered milk, Kool aide, Tang, frozen juice, iced tea, whiskey with water, etc.,do you drink per day?		b.	108 _____ glass(es) <input type="checkbox"/> <input type="checkbox"/> None	
c. About how many cups of coffee do you drink per day?		c.	109 _____ cup(s) <input type="checkbox"/> <input type="checkbox"/> None	
d. About how many cups of other hot drinks such as tea, soup, etc.,do you drink per day?		d.	110 _____ cup(s) <input type="checkbox"/> <input type="checkbox"/> None	
If an entry of glasses or cups in item 2a through d ask questions e and f; otherwise go to item 3.				
e. What is the address of the place that you used most in the last month? (Include number, street, city, State, and ZIP code)		e.	Address	
f. How long have you used water at . . . ?		f.	111 _____ month(s) 1113 _____ year(s)	

<p>• Now we have some questions about drinks made from commercial bottled water. 30.</p> <p>3a. About how many glasses of commercial bottled water do you drink per day?</p>	<p><input type="checkbox"/> 114 _____ glass(es) 0 <input type="checkbox"/> None</p>
<p>b. About how many glasses of cold drinks made from commercial bottled water such as powdered milk, Kool aide, Tang, frozen juice, iced tea, whiskey with water, etc., do you drink per day?</p>	<p><input checked="" type="checkbox"/> 115 _____ glass(es) 0 <input type="checkbox"/> None</p>
<p>c. About how many cups of coffee do you drink per day?</p>	<p><input type="checkbox"/> 116 _____ cup(s) 0 <input type="checkbox"/> None</p>
<p>d. About how many cups of other hot drinks such as tea, soup, etc., do you drink per day?</p>	<p><input checked="" type="checkbox"/> 117 _____ cup(s) 0 <input type="checkbox"/> None</p>
<p>▶ If an entry of glasses or cups in item 3a through d ask questions e, f, and g; otherwise to item 4.</p>	
<p>e. What brand of bottled water do you use?</p>	<p>a. Brand name _____</p>
<p>f. What type of water is this (e.g., mineral, distilled, etc.)?</p>	<p>f. <input checked="" type="checkbox"/> 118 1 <input type="checkbox"/> Mineral 2 <input type="checkbox"/> Distilled 3 <input type="checkbox"/> Other (Specify) 7 _____</p>
<p>g. How long have you used this type of water?</p>	<p>g. <input checked="" type="checkbox"/> 119 _____ month(s) <input checked="" type="checkbox"/> 120 _____ year(s)</p>
<p>• The next questions are about drinks made from other sources such as a well, cistern, spring, etc., on the property but not connected to the house. 40.</p> <p>4a. How many glasses of water do you drink per day?</p>	<p><input checked="" type="checkbox"/> 121 _____ glass(es) 0 <input type="checkbox"/> None</p>
<p>b. About how many glasses of cold drinks made from water such as powdered milk, Kool aide, Tong, frozen juice, iced tea, whiskey with water, etc., do you drink per day?</p>	<p>b. <input checked="" type="checkbox"/> 122 _____ glass(es) 0 <input type="checkbox"/> None</p>
<p>c. About how many cups of coffee do you drink per day?</p>	<p>c. <input checked="" type="checkbox"/> 123 _____ cup(s) 0 <input type="checkbox"/> None</p>
<p>d. About how many cups of other hot drinks such as tea, soup, etc., do you drink per day?</p>	<p>d. <input checked="" type="checkbox"/> 124 _____ cup(s) 0 <input type="checkbox"/> None</p>
<p>▶ If an entry of glasses or cups in item 4a through d ask questions e and f; otherwise go to item 5.</p>	
<p>e. What type of source not connected to a faucet have you used most in the last month (e.g., well, cistern, spring, etc.)</p>	<p>e. <input checked="" type="checkbox"/> 125 1 <input type="checkbox"/> Well 2 <input type="checkbox"/> Cistern 3 <input type="checkbox"/> Spring 4 <input type="checkbox"/> Other (Specify) 7 _____</p>
<p>f. Is this source located at home?</p>	<p>f. <input checked="" type="checkbox"/> 126 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

CHECK ITEM I

Ask questions 5 through 10 once for a household. If already asked for this household, mark (X) the box, end questions and go to Check Item II. → c I

<p>5. Does your faucet water come from a public water system or your own water supply?</p>	<p>5. (12) 1 <input type="checkbox"/> No faucet water in structure (10) 2 <input type="checkbox"/> Public water 3 <input type="checkbox"/> Own supply (7)</p>
<p>5a. What is the name of the water company that supplies your house? _____</p> <p>b. How long have you used water from this company? _____</p>	<p>5a. (12) Name of company _____</p> <p>b. (12) _____ month(s) } (8) (13) _____ year(s) }</p>
<p>7. What type of water line runs from your own water supply to the house? Mark (X) one box after reading list.</p>	<p>7. (13) 1 <input type="checkbox"/> Black iron 7 <input type="checkbox"/> Cement 2 <input type="checkbox"/> Galvanized 8 <input type="checkbox"/> Other (Specify) 7 3 <input type="checkbox"/> Plastic 4 <input type="checkbox"/> Lead 5 <input type="checkbox"/> Brass 9 <input type="checkbox"/> Don't know 6 <input type="checkbox"/> Copper</p>
<p>8a. Do you have a water softener or conditioner connected to the hot or cold water? _____</p> <p>b. Which one? _____</p> <p>c. What brand is it? _____</p>	<p>8a. (13) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (9) 9 <input type="checkbox"/> Don't know (9)</p> <p>b. (13) <input checked="" type="checkbox"/> Hot 2 <input type="checkbox"/> Cold 3 <input type="checkbox"/> Both 9 <input type="checkbox"/> Don't know where connected</p> <p>c. Brand name _____</p>
<p>9a. I would like to check the pipes where they are not painted or chrome-plated. May I check under the kitchen sink? _____</p> <p>b. Mark (X) the type of pipe.</p>	<p>9a. (13) 1 <input type="checkbox"/> Kitchen 2 <input type="checkbox"/> At water heater 3 <input type="checkbox"/> Other location (Specify) 7 _____</p> <p>(13) 4 <input type="checkbox"/> Not checked (Enter reason) 7 _____</p> <p>b. (13) 1 <input type="checkbox"/> Black iron 2 <input type="checkbox"/> Galvanized 3 <input checked="" type="checkbox"/> Plastic 4 <input type="checkbox"/> Lead 5 <input type="checkbox"/> Brass 6 <input type="checkbox"/> Copper 7 <input type="checkbox"/> Other (Specify) 7 _____</p> <p>9 <input type="checkbox"/> Don't know</p>

10. We will be **analyzing** the water available to **people** for drinking or cooking in their homes. May I take a sample of the water from your kitchen faucet (**well**, cistern, spring, etc.)? 10.

SAMPLE OBTAINED
(137) 1 Household faucet
2 Source not **connected** to a faucet

SAMPLE NOT OBTAINED
3 **Use** bottled water only
4 Other (Specify) 7

CHECK ITEM II

READ 77-E FOLLOWING:

Thank you very much for answering the questions about **yourself**. To determine more completely and precisely the health status and needs of the adult U.S. population, the U.S. Public Health Service also needs actual measurements and tests that can only be obtained **by** a health **examination**. For this, a special examination center has been set up and examinations will be conducted on the dates and times indicated on the sheet I will give you. The examination that is given is very thorough and there are no procedures, such as an internal examination, that are in **any** way embarrassing.

We very carefully select a sample of people to be representative of all parts of the population. You have been selected from many thousands of people similar to you with respect to your age, **race, and sex**, and the fact that we cannot substitute any other person for you makes **your participation** in the examination very important.

The examination is entirely free and you will receive a fee of \$10.00 as an expression of appreciation for your help in this important survey and as compensation for your **time and** for any inconvenience. We provide transportation to and from the examination center or we reimburse you if you decide to drive your own car.

None of the results from the examination or answers to the questions I have just asked, will ever be disclosed to anyone for any purpose without the individual's written consent; this is required by law. However, since a valuable examination is being given, most people do request that the examination results be sent to their physician. I would very much like to make an appointment for you at a time that is convenient.

- Appointment made
 Appointment not made (Specify) 3

Notes

D. Health Care Needs Questionnaire

MRA-11-6 (FORMERLY HSM-411-6) 8-75 DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH RESOURCES ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH AND NUTRITION EXAMINATION SURVEY HEALTH CARE NEEDS		Form Approved O.M.B. No. 68-R1184 ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 F R 1687).					
a. Name (Last, first, middle) _____							
b. Deck No. 181	c. Sample No. _____	d. Segment No. _____	e. Serial No. _____	f. Column No. _____			
READ - I need to ask you a number of questions about doctors, dentists, hospitals, and other people who might give you medical care, just how you use them, and what your opinion is on some questions about health care. Your answers will be kept confidential.							
DOCTORS							
1. When was the last time you talked to a doctor about your own health . . .							
	Never	Less than 2 weeks ago	2 Weeks through 5 months ago	6 through 11 months ago	1 but less than 2 years ago	2 through 4 years ago	5 or more years ago
at a private doctor's office?	(001) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
at a hospital outpatient clinic? . . .	(002) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
at a city clinic?	(003) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
at a clinic at work?	(004) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
at another type clinic?	(005) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
at a hospital emergency room?	(006) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
at home?	(007) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
over the telephone?	(008) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
in another way? - Specify _____	(009) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
2. What was the MAIN reason for your last visit with a doctor? (Check only one.)							
	(010)	1 <input type="checkbox"/> A sickness or illness --What was the problem? _____					
		2 <input type="checkbox"/> An injury-- What was the problem? _____					
		3 <input type="checkbox"/> A follow-up visit					
		4 <input type="checkbox"/> A regular checkup					
		5 <input type="checkbox"/> An injection					
		6 <input type="checkbox"/> For a prescription					
		7 <input type="checkbox"/> Some other reason					

<p>3a. For this last visit, how long was it from the time you decided you should see a doctor until you actually saw him:</p> <p>b. Did you have an appointment to see him?</p> <p>c. How long was it from the time you made the appointment until you saw him?</p> <p>d. Was this time longer than you would have liked?</p>	<p>3a. (011) 1 <input type="checkbox"/> Less than one day 2 <input type="checkbox"/> 1-6 days 3 <input type="checkbox"/> 1 but less than 2 weeks 4 <input type="checkbox"/> 2-3 weeks 5 <input type="checkbox"/> 1-2 months 6 <input type="checkbox"/> 3 months or more 9 <input type="checkbox"/> Don't remember</p> <p>b. (012) 1 <input type="checkbox"/> Yes → Ask c 2 <input type="checkbox"/> No → SKIP to 4</p> <p>c. (013) 1 <input type="checkbox"/> Less than one day 2 <input type="checkbox"/> 1-6 days 3 <input type="checkbox"/> 1 but less than 2 weeks 4 <input type="checkbox"/> 2-3 weeks 5 <input type="checkbox"/> 1-2 months 6 <input type="checkbox"/> 3 months or more 9 <input type="checkbox"/> Don't remember</p> <p>d. (014) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't remember</p>
<p>4. From what place did you leave to go to the doctor?</p>	<p>4. (015) 1 <input type="checkbox"/> From home 2 <input type="checkbox"/> From work 3 <input type="checkbox"/> From some other place</p>
<p>5. How did you get from there to the doctor?</p>	<p>5. (016) 1 <input type="checkbox"/> Walked 2 <input type="checkbox"/> Bus 3 <input type="checkbox"/> Own car 4 <input type="checkbox"/> Someone else's car 5 <input type="checkbox"/> Cab 6 <input type="checkbox"/> Ambulance 7 <input type="checkbox"/> Other means</p>
<p>6. How long did it take to get there?</p>	<p>6. (017) 1 <input type="checkbox"/> Less than 15 minutes 2 <input type="checkbox"/> 15-29 minutes 3 <input type="checkbox"/> 30-59 minutes 4 <input type="checkbox"/> 1 hour or more 9 <input type="checkbox"/> Don't remember</p>
<p>7a. At this last visit, about how many minutes did you have to wait before being seen by the doctor?</p>	<p>70. (018) — — — minutes</p>
<p>b. Do you think this wait was too long?</p>	<p>b. (019) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>8. How well satisfied were you with this visit?</p>	<p>8. (020) 1 <input type="checkbox"/> Satisfied 2 <input type="checkbox"/> Not completely satisfied 3 <input type="checkbox"/> Dissatisfied 4 <input type="checkbox"/> No opinion</p>

<p>9a. During the past 12 months, have you had a health problem which you would have liked to see a doctor about but did not for some reason?</p> <p>b. What was the reason you did not see a doctor?</p> <p>Lack of confidence in available doctors</p> <p>Didn't have time</p> <p>Would cost too much.</p> <p>Couldn't get an appointment.</p> <p>Would have to travel too far</p> <p>Didn't have a way to get there</p> <p>Was afraid of finding out what was wrong</p> <p>Didn't have anyone to care for children or other family members</p> <p>Other - Specify _____</p>	<p>9a. (021) 1 <input type="checkbox"/> <i>Handwritten: #11, - 10, & d</i></p> <p>2 <input type="checkbox"/> No -- SKIP to 10</p> <hr/> <p>b.</p> <table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>(022) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(023) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(024) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(025) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(026) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(027) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(028) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(029) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(030) 1 <input type="checkbox"/> <i>Handwritten: c 1</i></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> </tbody> </table>		Yes	No	(022) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(023) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(024) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(025) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(026) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(027) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(028) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(029) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(030) 1 <input type="checkbox"/> <i>Handwritten: c 1</i>	2 <input type="checkbox"/>	
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(030) 1 <input type="checkbox"/> <i>Handwritten: c 1</i>	2 <input type="checkbox"/>																														
<p>10a. When did you last have a general checkup or examination, not counting exams made during a visit for an illness?</p>	<p>10. (031) 1 <input type="checkbox"/> Never -- SKIP to 13</p> <p>2 <input type="checkbox"/> Less than 6 months ago</p> <p>3 <input type="checkbox"/> 6-11 months ago</p> <p>4 <input type="checkbox"/> 1 but less than 2 years ago</p> <p>5 <input type="checkbox"/> 2 years ago or more</p> <p>9 <input type="checkbox"/> Don't remember</p>																														
<p>11. Where did you get this general examination?</p>	<p>11. (032) 1 <input type="checkbox"/> Doctor's office</p> <p>2 <input type="checkbox"/> Hospital clinic</p> <p>3 <input type="checkbox"/> Another clinic</p> <p>4 <input type="checkbox"/> Some other place -Specify _____</p>																														
<p>12. During this last general examination, were you given --</p> <p>a cardiogram?</p> <p>a blood pressure check?</p> <p>a chest x-ray?</p> <p>blood tests?</p> <p>a urinalysis?</p> <p>vision tests?</p> <p>hearing tests?</p> <p>a rectal examination?</p> <p>an internal examination (FEMALES ONLY)?</p>	<p>12.</p> <table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>(033) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(034) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(035) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(036) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(037) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(038) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(039) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(040) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(041) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>8 <input type="checkbox"/> Not applicable</td> </tr> </tbody> </table>		Yes	No	(033) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(034) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(035) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(036) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(037) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(038) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(039) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(040) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(041) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/> Not applicable
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(041) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/> Not applicable																													

13a. When was the last time you received any shots, immunizations or vaccinations to prevent an illness, excluding shots for allergy?

b. Why did you get this shot?

- 13a. (042) 1 Never - SKIP to 14
2 Less than 6 months ago
3 6-11 months ago
4 1-2 years ago
5 3-5 years ago
6 6-9 years ago
7 10 years ago or more
9 Don't remember

- b. (043) 1 Foreign travel
2 During military service
3 Participation in community or work-sponsored immunization campaign (for example, polio or flu)
4 Other - Specify _____

14a. Is there a particular doctor you see regularly or whom you would go to if something were bothering you?

b. If you couldn't see this doctor, is there some other particular doctor you would want to see if something were bothering you?

- 14a. (044) 1 Yes - b
2 No - SKIP to 15

- b. (045) 1 Yes
2 No
9 Don't know

15. Except in an emergency, do you need to have an appointment in order to see a doctor?

15. (046) 1 Yes
2 No

16. When you go to a doctor, do you like the doctor to talk to you about your condition or do you like him just to treat it?

16. (047) 1 Talk
2 Just treat

17. Do the doctors you usually see talk to you about your condition?

17. (048) 1 Yes
2 No


18. Do you try out home remedies or any that you can get without a prescription before going to your doctor about a problem?

18. (049) 1 Yes often
2 Yes, sometimes
3 No

NOTES

1

DENTIST							
19. Do you have a dentist you usually go to?	19	050 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
20. When was the last time you visited or talked with a dentist about yourself.	20.	Never	Less than 6 months ago	6 through 11 months ago	1 but less than 2 years ago	2 through 4 years ago	5 or more years ago
at a dentist's office?	051	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
at a hospital dental clinic? . . .	052	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
at a hospital emergency clinic?	053	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
at another clinic (work, school, etc.)	054	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
over the telephone?	055	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
in another way? - Specify _____	056	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
21. What was the MAIN reason for your last visit or talk with a dentist at either his office or at a clinic?	21.	057 1 <input type="checkbox"/> Adjustment or repair of dental plate 2 <input type="checkbox"/> To have a dental plate made 3 <input type="checkbox"/> Loathache 4 <input type="checkbox"/> Tooth pulled or other surgery 5 <input type="checkbox"/> Trouble with gums 6 <input type="checkbox"/> Regular checkup visit 7 <input type="checkbox"/> For cleaning teeth 8 <input type="checkbox"/> To have teeth filled 9 <input type="checkbox"/> For a prescription 0 <input type="checkbox"/> Some other reason - Specify _____					
22. For this last visit, how long was it from the time you decided you needed or wanted to see a dentist until you actually saw him?	22.	058 1 <input type="checkbox"/> Less than one day 2 <input type="checkbox"/> 1-6 days 3 <input type="checkbox"/> 1 week but less than 2 weeks 4 <input type="checkbox"/> 2-3 weeks 5 <input type="checkbox"/> 1-2 months 6 <input type="checkbox"/> 3 months or more 9 <input type="checkbox"/> Don't remember					

<p>23a. At the time of this last visit or talk with a dentist did you have an appointment?</p> <p>b. How long was it from the time you made the appointment until you saw him?</p> <p>c. Was this wait longer than you would have liked it?</p>	<p>23a. (059) 1 <input type="checkbox"/> Yes – Ask 23b 2 <input type="checkbox"/> No – SKIP to 24</p> <p>b. (060) 1 <input type="checkbox"/> Less than one day 2 <input type="checkbox"/> 1-6 days 3 <input type="checkbox"/> 1 week but less than 2 weeks 4 <input type="checkbox"/> 2-3 weeks 5 <input type="checkbox"/> 1-2 months 6 <input type="checkbox"/> 3 months or more 9 <input type="checkbox"/> Don't remember</p> <p>c. (061) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't remember</p>
<p>24. How did you get to the dentist's office?</p>	<p>24. (062) 1 <input type="checkbox"/> Walked 2 <input type="checkbox"/> Bus or subway 3 <input type="checkbox"/> Car 4 <input type="checkbox"/> Cab 5 <input type="checkbox"/> Other means – Specify _____</p>
<p>25. How long did it take to get there?</p>	<p>25. (063) 1 <input type="checkbox"/> Less than 15 minutes 2 <input type="checkbox"/> 15–29 minutes 3 <input type="checkbox"/> 30–59 minutes 4 <input type="checkbox"/> 1 hour or more 9 <input type="checkbox"/> Don't remember</p>
<p>260. At this last visit with a dentist, about how many minutes did you have to wait before being seen by the dentist?</p> <p>b. Do you think this wait was too long?</p>	<p>(064) - - - minutes</p> <p>b. (065) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>27. How well satisfied were you with this visit?</p>	<p>w. (066) 1 <input type="checkbox"/> Satisfied 2 <input type="checkbox"/> Not completely satisfied 3 <input type="checkbox"/> Dissatisfied 4 <input type="checkbox"/> No opinion</p>
<p>28. Does your dentist or dental clinic call you or send you a note to remind you when your next regular checkup is due?</p>	<p>28. (067) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know</p>
<p>29a. During the past 12 months, have you had a dental problem which you would have liked to see a dentist about but you didn't see the dentist?</p>	<p>29a. (068) 1 <input type="checkbox"/>  – Ask 29b 2 <input type="checkbox"/> No – SKIP to 30</p>

<p>29b. Why didn't you see him?</p> <p>Didn't have time</p> <p>Would cost too much</p> <p>Couldn't get on appointment</p> <p>Would have to travel too far</p> <p>Didn't have a way to get there</p> <p>Didn't have anyone to care for children or other family members</p> <p>Some other reason</p>	<p>29b. Yes No</p> <p>(069) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(070) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(071) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(072) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(073) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(074) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(075) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p>
<p>HOSPITAL</p> <p>30. When was the last time you stayed in a hospital overnight or longer?</p>	<p>30. (076) 1 <input type="checkbox"/> Never – SKIP to 36</p> <p>2 <input type="checkbox"/> Less than 1 month ago</p> <p>3 <input type="checkbox"/> 1-5 months ago</p> <p>4 <input type="checkbox"/> 6-11 months ago</p> <p>5 <input type="checkbox"/> One year ago or more</p> <p>9 <input type="checkbox"/> Don't remember</p>
<p>31. Was this stay in the hospital on account of an emergency or was it planned in advance?</p>	<p>(077) 1 <input type="checkbox"/> Planned</p> <p>2 <input type="checkbox"/> Emergency</p>
<p>32. What was the MAIN reason you went into the hospital that time?</p>	<p>32. (078) 1 <input type="checkbox"/> Sickness or illness</p> <p>2 <input type="checkbox"/> Injury</p> <p>3 <input type="checkbox"/> Surgery</p> <p>4 <input type="checkbox"/> Child birth } SKIP to 34</p> <p>5 <input type="checkbox"/> Checkup }</p> <p>6 <input type="checkbox"/> Some other reason – Specify and SKIP to 34</p>
<p>33a. When you went into the hospital for this _____, just what was the problem?</p> <p>_____</p> <p>_____</p> <p>b. How long was it from the time it was decided you needed to go into the hospital until you went in?</p>	<p>b. (079) 1 <input type="checkbox"/> Less than one day</p> <p>2 <input type="checkbox"/> 1-6 days</p> <p>3 <input type="checkbox"/> 1 but less than 2 weeks</p> <p>4 <input type="checkbox"/> 2-3 weeks</p> <p>5 <input type="checkbox"/> 1-2 months</p> <p>6 <input type="checkbox"/> 3 months or more</p> <p>8 <input type="checkbox"/> Don't remember</p>
<p>34a. What part of the doctor's bill did you or your family have to pay out of your own pocket for the treatment the doctor gave you while you were in the hospital?</p>	<p>34a. (080) 1 <input type="checkbox"/> None – SKIP to 35</p> <p>2 <input type="checkbox"/> Less than half</p> <p>3 <input type="checkbox"/> More than half, but not all</p> <p>4 <input type="checkbox"/> All</p> <p>5 <input type="checkbox"/> Don't know – SK/P to 35</p>
<p>b. Did you get any of this money back from your health insurance?</p>	<p>b. (081) 1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>

35a. What part of this hospital bill did you or your family have to pay out of your own pocket?	35a. (082) 1 <input type="checkbox"/> None – SKIP to 36 2 <input type="checkbox"/> Less than half 3 <input type="checkbox"/> More than half, but not all 4 <input type="checkbox"/> All 5 <input type="checkbox"/> Don't know – 'SKIP to 36																																													
b. Did you get any of this money back from your health insurance?	b. (083) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																													
36a. When you see a doctor at his office or at a clinic, what part of the cost do you or your family usually have to pay out of your own pocket?	36a. (084) 1 <input type="checkbox"/> Never been to a doctor – SKIP to 37 2 <input type="checkbox"/> None – SKIP to 37 3 <input type="checkbox"/> Less than half 4 <input type="checkbox"/> More than half, but not all 5 <input type="checkbox"/> All 9 <input type="checkbox"/> Don't know – SKIP to 37																																													
b. Do you get any of this money back from your health insurance?	b. (085) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																													
37a. Whenever you see a dentist at either his office or at a clinic, what part of the cost do you or your family have to pay out of your own pocket?	37a. (086) 1 <input type="checkbox"/> Never been to a dentist – SKIP to 38 2 <input type="checkbox"/> None – SKIP to 38 3 <input type="checkbox"/> Less than half 4 <input type="checkbox"/> More than half, but not all 5 <input type="checkbox"/> All 9 <input type="checkbox"/> Don't know – SKIP to 38																																													
b. Do you get any of this money back from your health insurance?	b. (087) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																													
38a. What part of the cost of drugs and medicines prescribed by your doctor do you pay out of your own pocket?	38a. (088) 1 <input type="checkbox"/> No drugs or medicines ever prescribed – SKIP to 39 2 <input type="checkbox"/> None – SKIP to 39 3 <input type="checkbox"/> Less than half 4 <input type="checkbox"/> More than half, but not all 5 <input type="checkbox"/> All 9 <input type="checkbox"/> Don't know – SKIP to 39																																													
b. Do you get any of this money back from your health insurance?	b. (089) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																													
39. Do you have insurance or coverage for medical care under	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td> <td style="width: 15%; text-align: center;">Yes</td> <td style="width: 15%; text-align: center;">No</td> <td style="width: 10%;"></td> <td style="width: 50%;"></td> </tr> <tr> <td>Medicare (for elderly) ?</td> <td>(090) 1 <input checked="" type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td style="text-align: center;">→</td> <td></td> </tr> <tr> <td>Private medical insurance?</td> <td>(091) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>Insurance through your place of work?</td> <td>(092) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>Medicaid (for all ages) ?</td> <td>(093) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>Retired military privileges?</td> <td>(094) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>Veterans medical care?</td> <td>(095) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>Some other government assistance program? – Specify _____</td> <td>(096) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>Some other way?</td> <td>(097) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> <td></td> </tr> </table>		Yes	No			Medicare (for elderly) ?	(090) 1 <input checked="" type="checkbox"/>	2 <input type="checkbox"/>	→		Private medical insurance?	(091) 1 <input type="checkbox"/>	2 <input type="checkbox"/>			Insurance through your place of work?	(092) 1 <input type="checkbox"/>	2 <input type="checkbox"/>			Medicaid (for all ages) ?	(093) 1 <input type="checkbox"/>	2 <input type="checkbox"/>			Retired military privileges?	(094) 1 <input type="checkbox"/>	2 <input type="checkbox"/>			Veterans medical care?	(095) 1 <input type="checkbox"/>	2 <input type="checkbox"/>			Some other government assistance program? – Specify _____	(096) 1 <input type="checkbox"/>	2 <input type="checkbox"/>			Some other way?	(097) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		
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39b. What part of your medical bills does it pay?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 15%;">Less than half</th> <th style="width: 15%;">More than half but not all</th> <th style="width: 15%;">All</th> <th style="width: 15%;">Don't know</th> </tr> </thead> <tbody> <tr> <td>(098) 1</td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> </tr> <tr> <td>(099) 1</td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> </tr> <tr> <td>(100) 1</td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> </tr> <tr> <td>(101) 1</td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> </tr> <tr> <td>(102) 1</td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> </tr> <tr> <td>(103) 1</td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> </tr> <tr> <td>(104) 'cl</td> <td></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> </tr> <tr> <td>(105) 1</td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> </tr> </tbody> </table>		Less than half	More than half but not all	All	Don't know	(098) 1	<input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(099) 1	<input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(100) 1	<input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(101) 1	<input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(102) 1	<input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(103) 1	<input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(104) 'cl		2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	(105) 1	<input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
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E. General Well-Being Questionnaire

H RA-1 I-7 (Formerly HSM-411-7) /-74		DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH RESOURCES ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH EXAMINATION SURVEY			Form Approved O.M.B. No. 68-R 1 184
GENERAL WELL-BEING		ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).			
o. Name (Last, first, middle)	b. Deck No. <div style="text-align: center; font-weight: bold;">171</div>	c. Sample No. <div style="text-align: center;">- - - - -</div>	d. Sex 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	e. Age <div style="text-align: center;">-- --</div>	
READ - This section of the examination contains questions about how you feel and how things have been going with you. For each question, mark (X) the answer which best applies to you.					
1. How have you been feeling in general? (DURING THE PAST MONTH)	1. (001)	1 <input type="checkbox"/> In excellent spirits 2 <input type="checkbox"/> In very good spirits 3 <input type="checkbox"/> In good spirits mostly 4 <input type="checkbox"/> I have been up and down in spirits a lot 5 <input type="checkbox"/> In low spirits mostly 6 <input type="checkbox"/> In very low spirits			
2. Have you been bothered by nervousness or your "nerves"? (DURING THE PAST MONTH)	2. (002)	1 <input type="checkbox"/> Extremely so -- to the point where I could not work or take care of things 2 <input type="checkbox"/> Very much so 3 <input type="checkbox"/> Quite a bit 4 <input type="checkbox"/> Some-- enough to bother me 5 <input type="checkbox"/> A little 6 <input type="checkbox"/> Not at all			
3. Have you been in firm control of your behavior, thoughts, emotions OR feelings? (DURING THE PAST MONTH)	3. (003)	1 <input type="checkbox"/> Yes, definitely so 2 <input type="checkbox"/> Yes, for the most part 3 <input type="checkbox"/> Generally so 4 <input type="checkbox"/> Not too well 5 <input type="checkbox"/> No, and I am somewhat disturbed 6 <input type="checkbox"/> No, and I am very disturbed			
4. Have you felt so sad, discouraged, hopeless, or had so many problems that you wondered if anything was worthwhile? (DURING THE PAST MONTH)	4. (004)	1 <input type="checkbox"/> Extremely so -- to the point that I have just about given up 2 <input type="checkbox"/> Very much so 3 <input type="checkbox"/> Quite a bit 4 <input type="checkbox"/> Some -- enough to bother me 5 <input type="checkbox"/> A little bit 6 <input type="checkbox"/> Not at all			
5. Have you been under or felt you were under any strain, stress, or pressure? (DURING THE PAST MONTH)	5. (005)	1 <input type="checkbox"/> Yes -- almost more than I could bear or stand 2 <input type="checkbox"/> Yes -- quite a bit of pressure 3 <input type="checkbox"/> Yes -- some more than usual 4 <input type="checkbox"/> Yes -- some but about usual 5 <input type="checkbox"/> Yes a little 6 <input type="checkbox"/> Not at all			

<p>6. How happy, satisfied, or pleased have you been with your personal life? (DURING THE PAS7 MONTH)</p>	<p>6. 006 1 <input type="checkbox"/> Extremely happy -could not have been more satisfied or pleased</p> <p>2 <input type="checkbox"/> Very happy</p> <p>3 <input type="checkbox"/> Fairly happy</p> <p>4 <input type="checkbox"/> Satisfied -- pleased</p> <p>5 <input type="checkbox"/> Somewhat dissatisfied</p> <p>6 <input type="checkbox"/> Very di ssati sfi ed</p>
<p>7. Have you had any reason to wonder if you were losing your mind, or losing control over the way you act, talk, think, feel, or of your memory? (DURING THE PAS7 MONTH)</p>	<p>7. 007 1 <input type="checkbox"/> Not at all</p> <p>2 <input type="checkbox"/> Only a little</p> <p>3 <input type="checkbox"/> Some-- but not enough to be concerned or worried about</p> <p>4 <input type="checkbox"/> Some and I have been a little concerned</p> <p>5 <input type="checkbox"/> Some and I am quite concerned</p> <p>6 <input type="checkbox"/> Yes, very much so and I am very concerned</p>
<p>8. Have you been anxious, worried, or upset? (DURING THE PAS7 MONTH)</p>	<p>8. 008 1 <input type="checkbox"/> Extremely so -- to the point of being sick or almost sick</p> <p>2 <input type="checkbox"/> Very much so</p> <p>3 <input type="checkbox"/> Quite a bit</p> <p>4 <input type="checkbox"/> Some -- enough to bother me</p> <p>5 <input type="checkbox"/> A little bit</p> <p>6 <input type="checkbox"/> Not at all</p>
<p>9. Have you been woking up fresh ond rested? (DURING THE PAS7 MONTH)</p>	<p>9. 009 1 <input type="checkbox"/> Every day</p> <p>2 <input type="checkbox"/> Most every day</p> <p>3 <input type="checkbox"/> Fairly often</p> <p>4 <input type="checkbox"/> Less than half the time</p> <p>5 <input type="checkbox"/> Rarely</p> <p>6 <input type="checkbox"/> None of the time</p>
<p>10. Have you been bothered by any illness, bodily disorder, poins, or fears about your heolth? (DURING THE PAS7 MONTH)</p>	<p>10. 010 1 <input type="checkbox"/> All the time</p> <p>2 <input type="checkbox"/> Most of the time</p> <p>3 <input type="checkbox"/> A good bit of the time</p> <p>4 <input type="checkbox"/> Some of the time</p> <p>5 <input type="checkbox"/> A little of the time</p> <p>6 <input type="checkbox"/> None of the time</p>
<p>11. Has your doily life been full of things that were interesting to you? (DURING THE PAS7 MONTH)</p>	<p>11. 011 1 <input type="checkbox"/> All the time</p> <p>2 <input type="checkbox"/> Most of the time</p> <p>3 <input type="checkbox"/> A good bit of the time</p> <p>4 <input type="checkbox"/> Some of the time</p> <p>5 <input type="checkbox"/> A little of the time</p> <p>6 <input type="checkbox"/> None of the time</p>
<p>12. Have you felt down-hearted and blue? (DURING THE PAS7 MONTH)</p>	<p>12. 012 1 <input type="checkbox"/> All of the time</p> <p>2 <input type="checkbox"/> Most of the time</p> <p>3 <input type="checkbox"/> A good bit of the time</p> <p>4 <input type="checkbox"/> Some of the time</p> <p>5 <input type="checkbox"/> A little of the time</p> <p>6 <input type="checkbox"/> None of the time</p>

<p>13. Have you been feeling emotionally stable and sure of yourself? (DURING THE PAST MONTH)</p>	<p>13. 013</p> <p>1 <input type="checkbox"/> All of the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> A good bit of the time 4 <input type="checkbox"/> Some of the time 5 <input type="checkbox"/> A little of the time 6 <input type="checkbox"/> None of the time</p>
<p>14. Have you felt tired, worn out, used-up, or exhausted? (DURING THE PAST MONTH)</p>	<p>14. 014</p> <p>1 <input type="checkbox"/> All of the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> A good bit of the time 4 <input type="checkbox"/> Some of the time 5 <input type="checkbox"/> A little of the time 6 <input type="checkbox"/> None of the time</p>
<p>15. How concerned or worried about your HEALTH have you been? (DURING THE PAST MONTH)</p>	<p>15. 015</p> <p>For each of the four scales below, note that the words at each end of the 0 to 10 scale describe opposite feelings. Circle any number along the bar which seems closest to how you have generally felt DURING THE PAST MONTH.</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>Not concerned at all Very concerned</p>
<p>16. How RELAXED or TENSE have you been? (DURING THE PAST MONTH)</p>	<p>16. 016</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>Very relaxed Very tense</p>
<p>17. How much ENERGY, PEP, VITALITY have you felt? (DURING THE PAST MONTH)</p>	<p>17. 017</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>No energy AT ALL, listless Very ENERGETIC, dynamic</p>
<p>18. How DEPRESSED or CHEERFUL have you been? (DURING THE PAST MONTH)</p>	<p>18. 018</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>Very depressed Very cheerful</p>
<p>19. Have you had severe enough personal, emotional, behavior, or mental problems that you felt you needed help DURING THE PAST YEAR?</p>	<p>19. 019</p> <p>1 <input type="checkbox"/> Yes, and I did seek professional help 2 <input type="checkbox"/> Yes, but I did not seek professional help 3 <input type="checkbox"/> I have had (or have now) severe personal problems, but have not felt I needed professional help 4 <input type="checkbox"/> I have had very few personal problems of any serious concern 5 <input type="checkbox"/> I have not been bothered at all by personal problems during the past year</p>

<p>20. Have you ever felt that you were going to have, or were close to having, a nervous breakdown?</p>	<p>20. (020) 1 <input type="checkbox"/> Yes -- during the past year 2 <input type="checkbox"/> Yes -- more than a year ago 3 <input type="checkbox"/> No</p>
<p>21. Have you ever had a nervous breakdown?</p>	<p>21. (021) 1 <input type="checkbox"/> Yes -- during the past year 2 <input type="checkbox"/> Yes -- more than a year ago 3 <input type="checkbox"/> No</p>
<p>22. Have you ever been a patient (or outpatient) at a mental hospital, a mental health ward of a hospital, or a mental health clinic, for any personal, emotional, behavior, or mental problem?</p>	<p>22. (022) 1 <input type="checkbox"/> Yes -- during the past year 2 <input type="checkbox"/> Yes -- more than a year ago 3 <input type="checkbox"/> No</p>
<p>23. Have you ever seen a psychiatrist, psychologist, or psychoanalyst about any personal, emotional, behavior, or mental problem concerning yourself?</p>	<p>23. (023) 1 <input type="checkbox"/> Yes -- during the past year 2 <input type="checkbox"/> Yes -- more than a year ago 3 <input type="checkbox"/> No</p>
<p>24. Have you talked with or had any connection with any of the following about some personal, emotional, behavior, mental problem, worries, or "nerves" CONCERNING YOURSELF DURING THE PAST YEAR?</p> <p>a. Regular medical doctor (except for definite physical conditions or routine check-ups)</p> <p>b. Brain or nerve specialist</p> <p>c. Nurse (except for routine medical conditions)</p> <p>d. Lawyer (except for routine legal services)</p> <p>e. Police (except for simple traffic violations)</p> <p>f. Clergyman, minister, priest, rabbi, etc.</p> <p>g. Marriage Counselor</p> <p>h. Social Worker.</p> <p>i. Other formal assistance:</p>	<p>24a. (024) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>b. (025) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>c. (026) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>d. (027) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>e. (028) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>f. (029) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>g. (030) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>h. (031) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>i. (032) 1 <input type="checkbox"/> Yes -- What kind? _____ 2 <input type="checkbox"/> No</p>
<p>25. Do you discuss your problems with any members of your family or friends?</p>	<p>25. (033) 1 <input type="checkbox"/> Yes - and it helps a lot 2 <input type="checkbox"/> Yes - and it helps some. 3 <input type="checkbox"/> Yes - but it does not help at all 4 <input type="checkbox"/> No - I do not have anyone I can talk with about my problems 5 <input type="checkbox"/> No - no one cares to hear about my problems 6 <input type="checkbox"/> No - I do not care to talk about my problems with anyone 7 <input type="checkbox"/> No - I do not have any problems</p>

EXAMINER OBSERVATION SHEET

(Circle the number for the most appropriate observation for each alphabet set)

47. A. Test qualifications
1. Refused at least one item
 2. Couldn't comprehend at least one item
 3. Simple error - missed item, skipped page, etc.
 4. Time called, page missing, other non-examinee factor
 5. Feel this is a poor quality record of questionable value (other than above)
 6. Other (describe) _____
 - *7. None - record complete, no qualifications

NAME: Last, First, Middle

SAMPLE NO. _____

SEX: M F

AGE: _____

B. Reasons for not obtaining full, acceptable GWB (assessment limitations)

1. Lack of interviewers
2. Lack of time
3. Examinee failed to return to complete exam
4. Examinee too ill, drunk, etc.
5. Foreign language barrier
6. Seemed to be mentally retarded
7. Mental functioning or verbal comprehension too limited (o/t 5, 6)
8. Confused mental state, senile, etc.
9. Too emotionally disturbed or upset
10. Refused, non-cooperative, "difficult"
11. Other (describe) _____
- * 12. None: obtained full, acceptable GWB

48. GWB examiner number _____
(If no examiner number, leave blank)

Comments:

C. Indications of current problems from examinee

1. Direct reference to a current psychologic problems, i.e., under treatment for "nerves", taking tranquilizers, sedatives, sleeping pills, memory loss, delusions, senile, brain damage, retarded
2. Death of someone mentioned as negative affect or distressing
3. Distressing or limiting medical problem or condition mentioned
4. Medical or psychologic problem of someone else mentioned
5. Reference to problems of living, i.e., money, drug use or reaction, alcohol, limited physical movement, lonely, unhappy, job loss, unhappy love/sex condition, problems with children or spouse, etc.
6. Reference to problems of other family members, close friends, close associates
7. More than 2 year history mentioned for questions 20-23
8. Other (describe) _____
- *9. No apparent problems

49. Technician Observation
C.

D. Interviewer impression of subjective distress or state (Any personal, situation, or condition mentioned or behavior, appearance, suggesting well being - distress)

0. Mentally or emotionally disturbed
1. Severely distressed
2. Moderately distressed
3. Mild distress
4. Some problems but apparently coping well or not distressed
5. Overly euphoric, hyperactive, or "pushing"
6. Highly restrained, tense, apprehensive, uncertain
7. Other (describe) _____
- *8. Mild positive affect (feeling tone or state)
9. Strong positive affect

Comments:

E. Interviewer impression of comprehension of task (filling-out GWB)

0. Could not do task (do not consider negative refusal)
1. Comprehension low
2. Comprehension questionable
3. Translator used or foreign language noted
4. Literacy level seemed low
5. Dialect or non-mainstream American-English
6. Mental process slow, uncertain
7. Speech slurred or hardly audible-difficult to understand
8. Some other problem (describe) _____
- *9. No apparent limitations

0. _____
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
- *9. _____

50. Technician's Examiner No. _____

F. Supplement A—Arthritis

HRA-1 I-2 (FORMERLY HSM-41 I-2) 6-75 DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH RESOURCES ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH AND NUTRITION EXAMINATION SURVEY SUPPLEMENT A - ARTHRITIS	Form Approved O.M.B. No. 68-R1184 ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 CFR 1687).	
Name (Last, first, middle)	Deck No. 121	Sample No.
READ — Earlier you mentioned having had either pain in a joint or in the back or neck, swelling of a joint, or morning stiffness in the joints or muscles. Here are some additional questions about it.		
1a. Have you had pain in either the back or neck on most days for at least one month?	1a. (001) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 2a	
b. Has this pain in the back or neck been present on any one occasion for at least six weeks?	b. (002) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
c. Where is the pain usually located? Neck Upper back Mid-back Lower back.....	c. Yes No (003) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (004) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (005) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (006) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
d. When you have this pain, where is it most intense? Neck Upper back Mid-back Lower back.....	d. Yes No (007) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (008) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (009) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (010) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
e. Is the pain present when you are resting at night?	e. (011) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
f. When you have the pain, does it awaken you from sleep at night?	f. (012) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
g. Does the pain in the back ever seem to spread?	g. (013) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Not applicable, no pain in back	
h. Where does it spread to? To the back of the right leg To the back of the left leg To the back of both legs To the top of the head To the sides of the body	h. Yes No (014) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (015) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (016) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (017) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (018) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	

Item I (Continued)

i. Has pain in the neck ever seemed to spread?

- i. (019) 1 Yes
 2 No
 3 Not applicable, no pain in neck

j. Where does it spread to?

To the top and back of the head.

- j. Yes No
 (020) 1 2

To either shoulder area

- (021) 1 2

To the arms or hands

- (022) 1 2

Other - Specify _____

- (023) 1 2

k. Is your back or neck pain made worse -
 by coughing, sneezing, or deep breathing? . . .

- k. Yes No
 (024) 1 2

with bending or twisting motion?

- (025) 1 2

after prolonged activity?

- (026) 1 2

after prolonged sitting?

- (027) 1 2

after prolonged standing?

- (028) 1 2

l. How old were you when you first experienced
 this recurring back or neck pain?

- l. (029) 1 Less than 20 years old
 2 20 - 29 years old
 3 30 - 39 years old
 4 40 - 49 years old
 5 50 - 59 years old
 6 60 years old or older

m. When was the last time you had this pain?

- m. (030) 1 ☠ ♦
 2 Less than 1 year ago but not now
 3 1 - 2 years ago
 4 3 - 5 years ago
 5 6 years ago or more

n. What is the longest episode of back or
 neck pain you have ever had?

- n. (031) 1 Less than one month
 2 One but less than two months
 3 2 - 3 months
 4 4 - 5 months
 5 6 months or more
 9 Don't remember

o. Does this back or neck pain occur more
 frequently now than it used to occur?

- o. (032) 1 Yes
 2 No

p. Have you ever had a sprained back due to
 some type of physical activity?


- p. (033) 1 Yes
 2 ☠ ♦

q. Have you ever had a "whiplash" injury
 of the neck?

- q. (034) 1 Yes
 2 No

<p>1r. Have you ever had a ruptured disc in either your back or neck?</p> <p>s. At what age?</p> <p>t. Were you in traction?</p> <p>u. Was surgery necessary?</p> <p>v. Have you ever stayed overnight in a hospital for back or neck pain?</p>	<p>1r. (035) 1 <input type="checkbox"/> Yes <i>035</i> 2 <input type="checkbox"/> No - SKIP to v</p> <p>s. (036) - - years</p> <p>t. (037) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>u. (038) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>v. (039) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																																	
<p>2a. Have you had pain in or around either hip joint (including the buttock, groin, and side of the upper thigh) on most days for at least one month?</p> <p>b. Has this pain in the hip area been present on any one occasion for at least six weeks?</p> <p>c. Where did you first notice it?</p> <p>d. In the hip area, where is the pain usually most intense?</p> <p>Right buttock</p> <p>Left buttock</p> <p>Both buttocks.</p> <p>Right groin</p> <p>Left groin</p> <p>Both groins</p> <p>Side of right thigh</p> <p>Side of left thigh.</p> <p>Sides of both upper thighs.</p> <p>Other - Specify _____</p>	<p>2a. (040) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 3a</p> <p>b. (041) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>c. (042) 1 <input type="checkbox"/> Left hip 2 <input type="checkbox"/> Right hip 3 <input type="checkbox"/> Both hips</p> <table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>(043) 1 <input type="checkbox"/> cl</td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(044) 1 <input type="checkbox"/> cl</td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(045) 1 <input type="checkbox"/> cl</td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(046) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(047) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(048) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(049) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(050) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(051) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(052) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> </tbody> </table>		Yes	No	(043) 1 <input type="checkbox"/> cl	2 <input type="checkbox"/>		(044) 1 <input type="checkbox"/> cl	2 <input type="checkbox"/>		(045) 1 <input type="checkbox"/> cl	2 <input type="checkbox"/>		(046) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(047) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(048) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(049) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(050) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(051) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(052) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	
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<p>e. From the hip, has the pain tended to spread to -</p> <p>the inside of your leg?</p> <p>the front of your leg?</p> <p>the outside of your leg?</p> <p>the back of your leg?</p> <p>f. Have you had pain in or around the hip when either coughing or sneezing?</p> <p>g. When this hip pain is present, does it hurt at rest as well as when moving?</p>	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>(053) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(054) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(055) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(056) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> </tbody> </table> <p>f. (057) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>g. (058) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>		Yes	No	(053) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(054) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(055) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		(056) 1 <input type="checkbox"/>	2 <input type="checkbox"/>																			
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<p>2h. How old were you when you first experienced this recurring pain in the hip?</p>	<p>2h. (059) 1 <input type="checkbox"/> Less than 20 years old 2 <input type="checkbox"/> 20 – 29 years old 3 <input type="checkbox"/> 30 – 39 years old 4 <input type="checkbox"/> 40 – 49 years old 5 <input type="checkbox"/> 50 – 59 years old 6 <input type="checkbox"/> 60 years old or older</p>
<p>i. When was the last time you had the pain?</p>	<p>i. (060) 1 <input type="checkbox"/> Now 2 <input type="checkbox"/> Less than 1 year ago but not now 3 <input type="checkbox"/> 1 – 2 years ago 4 <input type="checkbox"/> 3 – 5 years ago 5 <input type="checkbox"/> 6 years ago or more</p>
<p>j. What is the longest episode of hip pain you have ever had?</p>	<p>j. (061) 1 <input type="checkbox"/> Less than one month 2 <input type="checkbox"/> 1 month but less than 2 months 3 <input type="checkbox"/> 2 – 3 months 4 <input type="checkbox"/> 4 – 5 months 5 <input type="checkbox"/> 6 months or more 9 <input type="checkbox"/> Don't remember</p>
<p>k. Have you ever had a fractured hip?</p>	<p>k. (062) 1 <input type="checkbox"/> Yes – Ask l 2 <input type="checkbox"/> No – SKIP to p</p>
<p>l. Which hip was broken?</p>	<p>l. (063) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both</p>
<p>m. How old were you when it happened?</p>	<p>m. (064) — — Years</p>
<p>n. Was the hip in traction?</p>	<p>n. (065) 1 <input type="checkbox"/> 2 <input type="checkbox"/> </p>
<p>o. Was there surgery?</p>	<p>o. (066) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>p. Have you ever had a dislocated hip?</p>	<p>p. (067) 1 <input type="checkbox"/> — q 2 <input type="checkbox"/> No – SKIP to 3a</p>
<p>q. Which hip was dislocated?</p>	<p>q. (068) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both</p>
<p>r. How old were you when it happened?</p>	<p>r. (069) — — Years</p>
<p>s. Was the hip in traction?</p>	<p>s. (070) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>t. Was there surgery?</p>	<p>t. (071) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>3a. Have you had pain in or around the knee (including the back of the knee) on most days for at least one month?</p>	<p>3a. (072) 1 <input type="checkbox"/> Yes – Ask b 2 <input type="checkbox"/> No – SKIP to 4a</p>
<p>b. Has this pain in the knee area been present on any one occasion for at least six weeks?</p>	<p>b. (073) 1 <input type="checkbox"/> 2 <input type="checkbox"/> No</p>

<p>3c. In which knee did you first have it?</p>	<p>3c.</p>	<p>(074) 1 <input type="checkbox"/> Left knee 2 <input type="checkbox"/> Right knee 3 <input type="checkbox"/> Both knees 9 <input type="checkbox"/> Don't remember</p>																					
<p>d. How old were you when you first experienced recurring pain in the knee?</p>	<p>d.</p>	<p>(075) 1 <input type="checkbox"/> Less than 20 years old 2 <input type="checkbox"/> 20-29 years old 3 <input type="checkbox"/> 30-39 years old 4 <input type="checkbox"/> 40-49 years old 5 <input type="checkbox"/> 50-59 years old 6 <input type="checkbox"/> 60 years old or older</p>																					
<p>e. When this knee pain is present, where is it most intense?</p> <p>Right knee.....  Both knees Behind the right knee Behind the left knee Behind both knees</p>	<p>e.</p>	<table border="1"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>(076) 1 <input type="checkbox"/></td> <td></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(077) 1 <input type="checkbox"/></td> <td></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(078) 1 <input type="checkbox"/></td> <td></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(079) 1 <input type="checkbox"/></td> <td></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(080) 1 <input type="checkbox"/></td> <td></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(081) 1 <input type="checkbox"/></td> <td></td> <td>2 <input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	(076) 1 <input type="checkbox"/>		2 <input type="checkbox"/>	(077) 1 <input type="checkbox"/>		2 <input type="checkbox"/>	(078) 1 <input type="checkbox"/>		2 <input type="checkbox"/>	(079) 1 <input type="checkbox"/>		2 <input type="checkbox"/>	(080) 1 <input type="checkbox"/>		2 <input type="checkbox"/>	(081) 1 <input type="checkbox"/>		2 <input type="checkbox"/>
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<p>f. When this knee pain is present, does it hurt at rest as well as when moving?</p>	<p>f.</p>	<p>(082) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																					
<p>g. When this knee pain is present, is there also swelling of the knee joint?</p>	<p>g.</p>	<p>(083) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																					
<p>h. When this pain is present, have you every had "locking" of the knee?</p>	<p>h.</p>	<p>(084) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																					
<p>i. Has either knee ever "given way" under you?</p>	<p>i.</p>	<p>(085) 1 <input type="checkbox"/> Yes -- Ask j 2 <input type="checkbox"/> No -- SKIP to k</p>																					
<p>j. Which knee?</p>	<p>j.</p>	<p>(086) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both</p>																					
<p>k. When was the last time you had this knee pain?</p>	<p>k.</p>	<p>(087) 1 <input type="checkbox"/> Now 2 <input type="checkbox"/> Less than 1 year ago but not now 3 <input type="checkbox"/> 1-2 years ago 4 <input type="checkbox"/> 3-5 years ago 5 <input type="checkbox"/> 6 years ago or more</p>																					
<p>l. What was the longest episode of knee pain you have ever had?</p>	<p>l.</p>	<p>(088) 1 <input type="checkbox"/> Less than one month 2 <input type="checkbox"/> One but less than 2 months 3 <input type="checkbox"/> 2-3 months 4 <input type="checkbox"/> 4-5 months 5 <input type="checkbox"/> 6 months or more 9 <input type="checkbox"/> Don't remember</p>																					
<p>m. Have you ever had a fractured knee?</p>	<p>m.</p>	<p>(089) 1 <input type="checkbox"/> Yes -- Ask n 2 <input type="checkbox"/> No -- SKIP to o</p>																					
<p>n. Which knee?</p>	<p>n.</p>	<p>(090) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both</p>																					

<p>3o. Have you ever had a severe twisting of either knee with resultant sprain or swelling lasting more than two weeks?</p> <p>p. Which knee?</p> <p>q. Have you ever had any other knee injury?</p> <p>r. Which knee?</p>	<p>30. (091) 1 <input type="checkbox"/> Yes — Ask p 2 <input type="checkbox"/> No — SKIP to q</p> <p>p. (092) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both</p> <p>q. (093) 1 <input type="checkbox"/> Yes — Ask r 2 <input type="checkbox"/> No — SKIP to 4a</p> <p>r. (094) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both</p>																																													
<p>4a. Have you ever had hip, knee, or back disease treated by an operation?</p> <p>b. Which joint?</p> <p>IF HIP: (1) Which hip?</p> <p>IF KNEE: (2) Which knee?</p> <p>c. What was the operation or procedure? <i>Specify</i></p> <hr/>	<p>40. (095) 1 <input type="checkbox"/> Yes — Ask b 2 <input type="checkbox"/> No — SKIP to 5a</p> <p>b. (096) 1 <input type="checkbox"/> Hip 4 <input type="checkbox"/> Hip and knee 2 <input type="checkbox"/> Knee 5 <input type="checkbox"/> Back and knee 3 <input type="checkbox"/> Back 6 <input type="checkbox"/> Hip and back 7 <input type="checkbox"/> ALL</p> <p>(1) (097) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both</p> <p>(2) (098) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both</p>																																													
<p>5o. Have you had pain or aching in any joint other than the hip, back, or knee on most days for at least six weeks?</p> <p>b. Which joints were painful?</p> <p>Fingers</p> <p>Wrist</p> <p>Elbow.</p> <p>Shoulder.</p> <p>Ankle.</p> <p>F o o t</p>	<p>5a. (099) 1 <input type="checkbox"/> Yes — Ask b and c 2 <input type="checkbox"/> No — SKIP to 6a</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2"></th> <th colspan="3" style="text-align: center;">5c. If "Yes," — Which?</th> </tr> <tr> <th colspan="2"></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> <th></th> </tr> <tr> <th></th> <th style="text-align: center;">b. & c.</th> <th></th> <th></th> <th style="text-align: center;">Right Left Both</th> </tr> </thead> <tbody> <tr> <td>(100)</td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/></td> <td>(101)</td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(102)</td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/></td> <td>(103)</td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(104)</td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/></td> <td>(105)</td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(106)</td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/></td> <td>(107)</td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(108)</td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/></td> <td>(109)</td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>(110)</td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/></td> <td>(111)</td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></td> <td></td> </tr> </tbody> </table>			5c. If "Yes," — Which?					Yes	No			b. & c.			Right Left Both	(100)	1 <input type="checkbox"/> 2 <input type="checkbox"/>	(101)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		(102)	1 <input type="checkbox"/> 2 <input type="checkbox"/>	(103)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		(104)	1 <input type="checkbox"/> 2 <input type="checkbox"/>	(105)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		(106)	1 <input type="checkbox"/> 2 <input type="checkbox"/>	(107)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		(108)	1 <input type="checkbox"/> 2 <input type="checkbox"/>	(109)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		(110)	1 <input type="checkbox"/> 2 <input type="checkbox"/>	(111)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	
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(110)	1 <input type="checkbox"/> 2 <input type="checkbox"/>	(111)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>																																											
<p>6a. Have you ever had any swelling of joints with pain present when the joint was touched on most days for at least one month?</p> <p>b. Has this swelling been present on any one occasion for at least six weeks?</p>	<p>6a. (112) 1 <input type="checkbox"/> Yes — Ask b 2 <input type="checkbox"/> No — SKIP to 7a</p> <p>b. (113) 1 <input type="checkbox"/> ☆ M † 2 <input type="checkbox"/> †</p>																																													

<p>6c. Which joints are usually involved whenever you have this swelling and tenderness on touching?</p> <p>Fingers.....</p> <p>Wrists.....</p> <p>Elbows.....*</p> <p>Shoulders.....</p> <p>Hips.....</p> <p>Knees.....</p> <p>Ankles.....</p> <p>Feet.....</p> <p>6e. How old were you when you first experienced this swelling of the joints?</p> <p>f. When was the last time you had this?</p>	<p>6c. & d.</p> <p>Yes No</p> <p>(114) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(116) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(118) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(120) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(122) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(124) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(126) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(128) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>e. (130) 1 <input type="checkbox"/> Less than 20 years old 2 <input type="checkbox"/> 20 - 29 years old 3 <input type="checkbox"/> 30 - 39 years old 4 <input type="checkbox"/> 40 - 49 years old 5 <input type="checkbox"/> 50 - 59 years old 6 <input type="checkbox"/> 60 years old or older</p> <p>f. (131) 1 <input type="checkbox"/> Now 2 <input type="checkbox"/> Less than 1 year ago but not now 3 <input type="checkbox"/> 1 - 2 years ago 4 <input type="checkbox"/> 3 - 5 years ago 5 <input type="checkbox"/> 6 years ago or more</p>	<p>6d. If "Yes," - Which?</p> <p>Right Left Both</p> <p>(115) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(117) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(119) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(121) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(123) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(125) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(127) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(129) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p>
<p>7a. Have you had stiffness in your joints and muscles when first getting out of bed in the morning on most mornings for at least one month?</p> <p>b. Has this morning stiffness been present on any one occasion for at least six weeks?</p>	<p>7a. (132) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 8a</p> <p>b. (133) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	
<p>c. Which joints are usually involved whenever you have this morning stiffness)</p> <p>Fingers.....</p> <p>Wrists.....</p> <p>Elbows.....</p> <p>Shoulders.....</p> <p>Hips.....</p> <p>Knees.....</p> <p>Ankles.....</p> <p>Feet.....</p> <p>Back.....</p>	<p>c. & d.</p> <p>Yes No</p> <p>(134) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(136) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(138) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(140) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(142) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(144) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(146) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(148) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(150) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p>	<p>7d. If "Yes," - Which?</p> <p>Right Left Both</p> <p>(135) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(137) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(139) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(141) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(143) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(145) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(147) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(149) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p>

<p>7e. How long after getting up and moving around does the morning stiffness last?</p>	<p>7e. (152) 1 <input type="checkbox"/> Less than 15 minutes 2 <input type="checkbox"/> 15 minutes to one half hour 3 <input checked="" type="checkbox"/> More than one half hour but less than all day 4 <input type="checkbox"/> All day</p>																																				
<p>f. How old were you when you first experienced this morning stiffness of joints?</p>	<p>f. (153) 1 <input type="checkbox"/> Less than 20 years old 2 <input type="checkbox"/> 20 -- 29 years old 3 <input type="checkbox"/> 30 -- 39 years old 4 <input type="checkbox"/> 40 -- 49 years old 5 <input type="checkbox"/> 50 -- 59 years old 6 <input type="checkbox"/> 60 years old or older</p>																																				
<p>g. When was the last time you had this?</p>	<p>g. (154) 1 <input type="checkbox"/> Now 2 <input type="checkbox"/> Less than 1 year ago but not now 3 <input type="checkbox"/> 1 -- 3 years ago 4 <input type="checkbox"/> 4 -- 9 years ago 5 <input checked="" type="checkbox"/> 10 years ago or more</p>																																				
<p>8a. Have you ever had pain, swelling, or stiffness in a joint as the result of an accident or injury?</p>	<p>8a. (155) 1 <input type="checkbox"/> Yes -- Ask b 2 <input checked="" type="checkbox"/> No -- SKIP to 9</p>																																				
<p>b. Was this the cause of the pain, swelling, or stiffness mentioned previously, do you think?</p>	<p>b. (156) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know</p>																																				
<p>c. Is this the cause of any pain, swelling, or stiffness which might still be present, do you think?</p>	<p>c. (157) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know</p>																																				
<p>9. Have you ever been treated by any of the following people for your joint troubles?</p> <p>General practitioner</p> <p>Internist</p> <p>Rheumatologist</p> <p>Orthopedist</p> <p>Chiropractor</p> <p>Osteopath</p> <p>Foot doctor (chiroprapist or podiatrist)</p> <p>Physical therapist</p> <p>Occupational therapist</p> <p>Other -- Specify _____</p> <p>Never been treated</p>	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>(158)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(159)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(160)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(161)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(162)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(163)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(164)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(165)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(166)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(167)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(168)</td> <td>9 <input type="checkbox"/> SKIP to 11a</td> <td></td> </tr> </tbody> </table>		Yes	NO	(158)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(159)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(160)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(161)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(162)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(163)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(164)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(165)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(166)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(167)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(168)	9 <input type="checkbox"/> SKIP to 11a	
	Yes	NO																																			
(158)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																																			
(159)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																																			
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(167)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																																			
(168)	9 <input type="checkbox"/> SKIP to 11a																																				

10a. Are you currently being treated by a doctor for the troubles you have just described?

b. What type of doctor is he?

c. What did he say the problem was?

d. When was the last time you saw him?

e. Who originally referred you to this doctor?

f. Where do you usually see him?

g. How long will it be until your next visit to him?

10a. (169) 1 Yes - Ask b
2 No - SKIP to 10

b. (170) 1 General practitioner
2 Internist
3 Rheumatologist
4 Orthopedist
5 Chiropractor
6 Osteopath
7 Other specialist
8 Other - Specify _____

c. DATA PREPARATION USE ONLY

(171) 1 (174) 1
(172) 1 (175) 1
(173) 1 (176) 1

d. (177) 1 Less than 1 month ago
2 1 - 3 months ago
3 4 - 6 months ago
4 7 - 11 months ago
5 1 year ago or more
9 Don't know

e. (178) 1 No one
2 He's the regular doctor
3 Another doctor
4 Family
5 Clinic
6 Health nurse
7 Friend
8 Other - Specify -----

f. (179) 1 His office
2 At clinic
3 At home
4 Other

g. (180) 1 Less than 1 month
2 1 - 2 months
3 3 - 6 months
4 7 - 11 months
5 1 year or more
9 Don't know

11a. Have you ever used any of the following kinds of treatment for your joint troubles?	11a.	11b. Did it do you any good?
	Yes No	Yes No
Splints or casts	(181) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	(182) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Braces	(183) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	(184) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Diathermy or paraffin.	(185) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	(186) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Hot packs or heating pads.	(187) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	(188) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Cold packs or ice.	(189) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	(190) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Rest	(191) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	(192) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Traction	(193) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	(194) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Exercises or physical therapy	(195) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	(196) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Aspirin.	(197) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	(198) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Cane	(199) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	(200) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Crutch	(201) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	(202) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Stiff mattress.	(203) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	(204) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Bed board.	(205) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	(206) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
c. If "Yes" to 11a or 11b - Do you use it regularly?	c.	
	Yes No	
Splints or casts	(207) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Braces	(208) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Diathermy or paraffin.	(209) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Hot packs or heating pads.	(210) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Cold packs or ice	(211) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Rest	(212) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Traction.	(213) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Exercises or physical therapy	(214) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Aspirin.	(215) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Cane	(216) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Crutch	(217) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Stiff mattress.	(218) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Bed board.	(219) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
12a. Have you ever had injections into any of your joints?	12a.	(220) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 13a
b. Did they do you any good?	b.	(221) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

13a. Have you ever taken any of the following medications for your joints?	130.	Yes	No	Don't know
Any cortisone-like medicine by mouth	(222)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Butazolidin	(223)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Darvon or Tylenol.	(224)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Indocin.	(225)	<input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
b. If "Yes" → Did it do any good?	b.	Yes	NO	
Any cortisone-like medicine by mouth	(226)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Butazolidin	(227)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Darvon or Tylenol.	(228)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Indocin.	(229)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
14. Can you do the following things without the help of someone else or the help of some special device?	14.	Yes	No	
Go up or down stairs	(230)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Get into or out of a car	(231)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Use washing facilities.	(232)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Dress yourself	(233)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Feed yourself ,	(234)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Get into or out of bed.	(235)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
15. At the present time, does your joint condition restrict your physical activity very little, quite a bit, or a whole lot?	15.	(236) 1 <input type="checkbox"/> Very little 2 <input type="checkbox"/> Quite a bit 3 <input type="checkbox"/> A whole lot		
16. Have you ever had to stoy in bed at home for long periods of time because of your joints?	16.	(237) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
17. Have you ever stayed overnight in a hospital because of joint problems?	17.	(238) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
18. With respect to your joint trouble, would you say your condition is mild, moderate, or severe?	18.	(239) 1 <input type="checkbox"/> Mild 2 <input type="checkbox"/> Moderate 3 <input type="checkbox"/> Severe		
19. What was your lob status one month before you first developed your joint condition?	19.	(240) 1 <input type="checkbox"/> Retired because of age 2 <input type="checkbox"/> Retired because of disability 3 <input type="checkbox"/> Unemployed 4 <input type="checkbox"/> Working full-time 5 <input type="checkbox"/> Working part-time 6 <input type="checkbox"/> Housewife with full duties 7 <input type="checkbox"/> Housewife with partial or no duties 8 <input type="checkbox"/> Other — Specify _____ _____		

20a. As a result of your joint condition, has there been a change in your job status?

b. What is it now?

20a. (241) 1 Yes - Ask b
2 No - SKIP to 21

b. (242) 1 Retired because of disability
2 Unemployed
3 Changed to easier job
4 Working
5 Housewife with partial duties
6 Housewife with no duties
7 Other - Specify

21. How many work days do you estimate that you lost during the past 12 months as a result of your joint condition?

21. (243) 1 None
2 1 - 4 days
3 5 - 9 days
4 10 - 14 days
5 15 - 19 days
6 20 - 29 days
7 30 days or more

(244)

(245)

NOTES

G. Supplement B—Respiratory

HRA-11-3 (Formerly HSM-411-3) 4/75 DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH RESOURCES ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH AND NUTRITION EXAMINATION SURVEY SUPPLEMENT B – RESPIRATORY	Form Approved O.M.B. No. 68-RI 184 ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).																			
a. Name (Last, first, middle)	b. Deck No. <div style="text-align: center; font-weight: bold; font-size: 1.2em;">131</div>	c. Sample No. <div style="text-align: center;">-----</div>																		
READ – Earlier you mentioned having had either persistent cough, phlegm, wheezing, shortness of breath, asthma, or hay fever. Here are some additional questions about this trouble.																				
▶ PERSISTENT COUGHING																				
1a. Was your problem that of persistent coughing?	1a.	(001) 1 <input type="checkbox"/> Yes – Ask b 2 <input type="checkbox"/> No – SKIP to 2a																		
b. How long have you had this condition?	b.	(002) 1 <input type="checkbox"/> Less than 1 year 2 <input type="checkbox"/> 1-3 years 3 <input type="checkbox"/> 4-9 years 4 <input type="checkbox"/> 10 years or more																		
c. Have you been bothered by this within the past year?	c.	(003) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
d. When you have this trouble, do you also have chest pains?	d.	(004) 1 <input type="checkbox"/> Yes – Ask e 2 <input type="checkbox"/> No – SKIP to f																		
e. Where?	e.	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> <th style="width: 40%; text-align: center;">Yes</th> <th style="width: 40%; text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Upper back</td> <td>(005) 1 <input type="checkbox"/> Y</td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Lower back.</td> <td>(006) 1 <input type="checkbox"/> cl</td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Upperchest.</td> <td>(007) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Along the rib edge</td> <td>(008) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>On the sides</td> <td>(009) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	Upper back	(005) 1 <input type="checkbox"/> Y	2 <input type="checkbox"/>	Lower back.	(006) 1 <input type="checkbox"/> cl	2 <input type="checkbox"/>	Upperchest.	(007) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Along the rib edge	(008) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	On the sides	(009) 1 <input type="checkbox"/>	2 <input type="checkbox"/>
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Along the rib edge	(008) 1 <input type="checkbox"/>	2 <input type="checkbox"/>																		
On the sides	(009) 1 <input type="checkbox"/>	2 <input type="checkbox"/>																		
f. Do you bring up phlegm with the cough?	f.	(010) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
g. Do you cough persistently like this on most days for as much as THREE months each year?	g.	(011) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
h. Do any medicines you take help relieve the cough?	h.	(012) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
i. What time of year do these coughing attacks seem at their worst?	i.	(013) 1 <input type="checkbox"/> Winter 2 <input type="checkbox"/> Summer 3 <input type="checkbox"/> No difference																		

2a. Have you had trouble with coughing spells when you first get up in the early morning? (Count a cough with first smoke or on first going out of doors; exclude clearing of throat or a single cough.)

2a. (014) 1 ☞ - ☞
 2 No - SKIP to 3a

b. How long have you had this particular condition?

b. (015) 1 Less than 1 year
 2 1-3 years
 3 4-9 years
 4 10 years or more
 9 Don't know

c. Do you have chest pains when you have morning coughing spells?

c. (016) 1 ☞ - ☞ **d**
 2 No - SKIP to e

d. Where?

	Yes	No
Upper back	(017) 1 <input type="checkbox"/>	2 <input type="checkbox"/>
Lower back.. ..	(018) 1 <input type="checkbox"/>	2 <input type="checkbox"/>
Upper chest.	(019) 1 <input type="checkbox"/>	2 <input type="checkbox"/>
Along the rib edge.	(020) 1 <input type="checkbox"/>	2 <input type="checkbox"/>
On the sides	(021) 1 <input type="checkbox"/>	2 <input type="checkbox"/>

e. What time of year are these morning coughing spells at their worst?

e. (022) 1 Winter
 2 Summer
 3 No difference

f. Do you have a morning cough like this on most days for as much as THREE months each year?

f. (023) 1 Yes
 2 ☞

g. Do you usually have a persistent cough at other times during the day or at night in the winter? (IGNORE AN OCCASIONAL COUGH.)

g. (024) 1 Yes
 2 ☞

h. Do you usually have a persistent cough at other times during the day or at night in the summer? (IGNORE AN OCCASIONAL COUGH.)

h. (025) 1 Yes
 2 No

PHLEGM

3a. Do you usually bring up any phlegm from your chest first thing in the morning? (Count phlegm with the first smoke or on going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.)

30. (026) 1 Yes - Ask b
 2 No - SKIP to 4a

b. How long have you had this condition?

b. (027) 1 Less than 1 year
 2 1-3 years
 3 4-9 years
 4 10 years or more
 9 Don't know

<p>c. What color is the phlegm?</p> <p>Green.</p> <p>Yellow.</p> <p>Clear</p> <p>Blood-streaked.</p>	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>028</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>029</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>030</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>031</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	028	1 <input type="checkbox"/>	2 <input type="checkbox"/>	029	1 <input type="checkbox"/>	2 <input type="checkbox"/>	030	1 <input type="checkbox"/>	2 <input type="checkbox"/>	031	1 <input type="checkbox"/>	2 <input type="checkbox"/>			
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030	1 <input type="checkbox"/>	2 <input type="checkbox"/>																	
031	1 <input type="checkbox"/>	2 <input type="checkbox"/>																	
<p>d. Do you also bring up any phlegm from your chest at other times during the day or at night, in the winter? (At least two times or more)</p>	<p>d. 032 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																		
<p>e. Do you also bring up any phlegm from your chest during the day, or at night, in the summer? (At least two times or more)</p>	<p>e. 033 1 (Y e s 2 <input type="checkbox"/> No</p>																		
<p>f. What time of year do you seem to bring up the most phlegm from your chest?</p>	<p>f. 034 1 <input type="checkbox"/> Winter 2 <input type="checkbox"/> Summer 3 <input type="checkbox"/> No difference</p>																		
<p>g. If you have brought up phlegm, do you bring it up on most days for as much as THREE months each year?</p>	<p>g. 035 1 <input type="checkbox"/> Y e s 2 <input type="checkbox"/> No</p>																		
<p>▶ SHORTNESS OF BREATH</p>																			
<p>4a. Have you had shortness of breath either when hurrying on the level or walking up a slight hill?</p>	<p>4a. 036 1 <input type="checkbox"/> ☆ † ‡ † - Ask b 2 <input type="checkbox"/> No - SKIP to 5c</p>																		
<p>b. Have you had this problem most days for as much as THREE months each year?</p>	<p>b. 037 <input type="checkbox"/> ☆ † ‡ † 2 <input type="checkbox"/> No</p>																		
<p>c. Do you get short of breath when walking with other people at an ordinary pace on the level?</p>	<p>c. 038 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																		
<p>d. Do you have to stop for breath when walking at your own pace on the level?</p>	<p>d. 039 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																		
<p>e. Do you have to stop for breath after walking about 100 yards or after a few minutes on the level?</p>	<p>e. 040 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> † ‡</p>																		
<p>f. How long ago did you first have this trouble with shortness of breath?</p>	<p>f. 041 1 <input type="checkbox"/> Less than 1 year ago 2 <input type="checkbox"/> 1-3 years ago 3 <input type="checkbox"/> 4-9 years ago 4 <input type="checkbox"/> 10 years ago or more 9 <input type="checkbox"/> Don't know</p>																		
<p>g. Have you gotten chest pains along with the shortness of breath?</p>	<p>g. 042 1 <input type="checkbox"/> Y e s - Ask h 2 <input type="checkbox"/> No - SKIP to i</p>																		
<p>h. Where?</p> <p>Upper chest.</p> <p>Upper back</p> <p>Lower back.</p> <p>Along the lower ribs</p> <p>On the sides</p>	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>043</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>044</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>045</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>046</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>047</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	043	1 <input type="checkbox"/>	2 <input type="checkbox"/>	044	1 <input type="checkbox"/>	2 <input type="checkbox"/>	045	1 <input type="checkbox"/>	2 <input type="checkbox"/>	046	1 <input type="checkbox"/>	2 <input type="checkbox"/>	047	1 <input type="checkbox"/>	2 <input type="checkbox"/>
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046	1 <input type="checkbox"/>	2 <input type="checkbox"/>																	
047	1 <input type="checkbox"/>	2 <input type="checkbox"/>																	

4i. Do you develop wheezing as well as shortness of breath?	4i.	(048) 1 <input type="checkbox"/> ☆ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/> <input type="checkbox"/>																											
j. Have you ever felt like you were going to pass out from the shortness of breath?	j.	(049) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																											
WHEEZING																													
5a. Has your chest ever sounded wheezy or whistling?	5a.	(050) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 6a																											
b. How long have you had this condition?	b.	(051) 1 <input type="checkbox"/> Less than 1 year 2 <input type="checkbox"/> 1-3 years 3 <input type="checkbox"/> 4-9 years 4 <input type="checkbox"/> 10 years or more																											
c. Do you get this wheezing or whistling with colds?	c.	(052) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																											
d. Do you get this occasionally apart from colds?	d.	(053) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																											
e. Does this usually occur daily?	e.	(054) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																											
f. What time of year does it seem worst?	f.	(055) 1 <input type="checkbox"/> Winter 2 <input type="checkbox"/> Summer 3 <input type="checkbox"/> No difference																											
g. Is this wheeziness present on most days for as much as THREE months each year?	g.	(056) 1 <input type="checkbox"/> ☆ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/> <input type="checkbox"/>																											
h. Do you take any medicines for wheezing?	h.	(057) 1 <input type="checkbox"/> Yes - Ask i 2 <input type="checkbox"/> No - SKIP to 6a																											
i. Do they help relieve the wheezing?	i.	(058) 1 <input type="checkbox"/> Not at all 2 <input type="checkbox"/> A small amount 3 <input type="checkbox"/> A great deal																											
ASTHMA																													
5a. Have you had, or do you now have asthma?	5a.	(059) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 7a																											
b. What is it related to or due to?	b.	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>D u s t</td> <td>(060) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Foods</td> <td>(061) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Animal contacts</td> <td>(062) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Drugs</td> <td>(063) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Pollens.</td> <td>(064) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Molds</td> <td>(065) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Other - Specify _____</td> <td>(066) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Don't know</td> <td>(067) 9 <input type="checkbox"/></td> <td></td> </tr> </tbody> </table>		Yes	No	D u s t	(060) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Foods	(061) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Animal contacts	(062) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Drugs	(063) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Pollens.	(064) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Molds	(065) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Other - Specify _____	(066) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Don't know	(067) 9 <input type="checkbox"/>	
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Other - Specify _____	(066) 1 <input type="checkbox"/>	2 <input type="checkbox"/>																											
Don't know	(067) 9 <input type="checkbox"/>																												

<p>6c. How long have you had this condition?</p> <p>d. Since you were a child?</p> <p>e. Do you have asthma symptoms on most days for as much as THREE months each year?</p> <p>f. What time of year is it worst?</p> <p>Spring</p> <p>Summer</p> <p>Fall</p> <p>Winter</p> <p>g. Do you take any medicines for it?</p>	<p>6c. (068) 1 <input type="checkbox"/> Less than 1 year - SKIP to e 2 <input type="checkbox"/> 1-3 years - SKIP to e 3 <input type="checkbox"/> 4-9 years ago - SKIP to e 4 <input type="checkbox"/> 10 years or more - Go to d</p> <p>d. (069) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>e. (070) 1 (Yes 2 <input type="checkbox"/> No</p> <p>f.: Yes No</p> <p>(071) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(072) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(073) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(074) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>g. (075) 1 (Yes 2 <input type="checkbox"/> No</p>
<p>HAYFEVER</p> <p>7a. Have you had, or do you now have, hayfever?</p> <p>b. What is it related to or due to?</p> <p>Dust</p> <p>Foods</p> <p>Animal contacts</p> <p>Drugs</p> <p>Pollens..</p> <p>Molds</p> <p>Air conditioners</p> <p>Other - Specify _____</p> <p>Don't know</p> <p>c* How long have you had this condition?</p> <p>d. Since you were a child?</p>	<p>7a. (076) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 8a</p> <p>b. Yes No</p> <p>(077) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(078) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(079) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(080) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(081) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(082) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(083) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(084) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(085) 9 <input type="checkbox"/></p> <p>c. (086) 1 <input type="checkbox"/> Less than 1 year - SKIP to e 2 <input type="checkbox"/> 1-3 years - SKIP to e 3 <input type="checkbox"/> 4-9 years - SKIP to e 4 <input type="checkbox"/> 10 years or more - Ask d</p> <p>d. (087) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

7e. Do you have hayfever symptoms on most days for as much as THREE months each year?	7e. (088) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
f. What time of the year is it worst? Spring..... Summer..... Fall..... Winter.....	f. Yes No (089) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (090) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (091) c I 2 <input type="checkbox"/> (092) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
g. Do you take any medicines for it?	g. (093) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
MEDICAL CARE	
8a. Have you ever been tested for TB (tuberculosis)?	(094) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 9a
b. How were you tested? A skin test..... Chest x-ray..... Sputum examination..... Don't know.....	b. Yes No (095) c I 2 <input type="checkbox"/> (096) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (097) E I 2 <input type="checkbox"/> (098) 9 C I
c. How often are you tested?	c. (099) 1 <input type="checkbox"/> Once every year 2 <input type="checkbox"/> Once every two years 3 <input type="checkbox"/> Once every 3-5 years 4 <input type="checkbox"/> Less often than once every 5 years
d. How long ago were you last tested?	d. (100) 1 <input type="checkbox"/> Less than 1 year ago 2 <input type="checkbox"/> 1-2 years ago 3 <input checked="" type="checkbox"/> 3-5 years ago 4 <input type="checkbox"/> 6-9 years ago 5 <input checked="" type="checkbox"/> 10 years ago or more 9 <input type="checkbox"/> Don't know
9a. Have you seen a doctor or anyone else about the chest or lung conditions you mentioned previously?	9a. (101) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 10
b. What is the name of the doctor you see? _____	
c. What type of doctor is he?	c. (102) 1 <input type="checkbox"/> General Practitioner 2 <input type="checkbox"/> Internist 3 <input type="checkbox"/> Osteopath 4 <input type="checkbox"/> Surgeon 5 <input type="checkbox"/> Lung specialist 6 <input checked="" type="checkbox"/> Allergist 7 <input type="checkbox"/> Other - Specify.....
d. Who initially referred you to this doctor?	d. (103) 1 <input type="checkbox"/> No one 2 <input type="checkbox"/> He's the regular doctor 3 <input type="checkbox"/> Another physician 4 <input type="checkbox"/> Health nurse 5 <input type="checkbox"/> Clinic 6 <input type="checkbox"/> Family 7 <input type="checkbox"/> Other - Specify.....

9e. How long after you first developed the problem did you see him? 9e.

- 104 1 1-6 days
 2 1-7 weeks
 3 2-6 months
 4 7-11 months
 5 One year or more
 9 Don't know

f. What did he say the condition or conditions affecting your chest were? f.

DATA PREPARATION USE ONLY

- 105 1 110 1 115 1
 106 1 111 'cl
 107 c l 112 1
 108 c l 113 1
 109 1 cl 114 1

g. When you see the doctor about your chest condition, how often do you receive a chest x-ray? g.

- 116 1 At every visit
 2 At every other visit
 3 Less often than every other visit

h. Does he prescribe the medicine for the condition? ho

- 117 1 Yes - *Y&I*
 2 No - SKIP to j

i. How is the medicine taken? i.

- Swallowed
- Breathed
- Injected
- Other - Specify _____

- | | Yes | No |
|--------------------------------|----------------------------|----|
| 118 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| 119 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| 120 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| 121 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |

j. Has he told you to do any of these other things for it? j.

- Breathing exercises
- Use a breathing machine
- Stop smoking
- Decrease smoking
- Regular checkup
- Lots of rest
- Decrease activity
- Other - Specify _____

- | | Yes | No |
|---|----------------------------|----|
| 122 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| 123 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| 124 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| 125 1 <input checked="" type="checkbox"/> | 2 <input type="checkbox"/> | |
| 126 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| 127 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |
| 128 c l | 2 <input type="checkbox"/> | |
| 129 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | |

k. When was the last time you saw him? k.

- 130 1 Less than 1 month ago
 2 1-3 months ago
 3 4-6 months ago
 4 7-11 months ago
 5 1 year ago or more
 9 Don't know

<p>9l. Where do you usually see him?</p>	<p>9l. (131)</p> <p>1 <input type="checkbox"/> At his office</p> <p>2 <input type="checkbox"/> At a clinic</p> <p>3 <input type="checkbox"/> At home</p> <p>4 <input type="checkbox"/> Other - Specify _____</p>
<p>m. How long will it be until your next appointment?</p>	<p>m. (132)</p> <p>1 <input type="checkbox"/> Less than 1 month</p> <p>2 <input type="checkbox"/> 1-3 months</p> <p>3 <input type="checkbox"/> 4-6 months</p> <p>4 <input type="checkbox"/> 7-11 months</p> <p>5 <input checked="" type="checkbox"/> 1 year or more</p> <p>9 <input type="checkbox"/> Don't know</p>
<p>10. Within the past 12 months, has your chest condition gotten worse, gotten better, or stayed about the same?</p>	<p>10. (133)</p> <p>1 <input type="checkbox"/> Gotten worse</p> <p>2 <input checked="" type="checkbox"/> Gotten better</p> <p>3 <input type="checkbox"/> Stayed about the same</p>
<p>11. Have you ever been disabled because of any chest condition?</p>	<p>11. (134)</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>
<p>12. Have you ever stayed overnight in a hospital because of a chest condition?</p>	<p>12. (135)</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>
<p>13. What was your job status one month before you first had a problem with a chest or lung condition?</p>	<p>13. (136)</p> <p>1 <input type="checkbox"/> Retired because of age</p> <p>2 <input type="checkbox"/> Retired because of disability</p> <p>3 <input type="checkbox"/> Unemployed</p> <p>4 <input type="checkbox"/> Working full-time</p> <p>5 <input type="checkbox"/> Working part-time</p> <p>6 <input type="checkbox"/> Housewife with full duties</p> <p>7 <input checked="" type="checkbox"/> Housewife with partial or no duties</p> <p>8 <input type="checkbox"/> Other - Specify _____</p>
<p>14a. As a result of your chest or lung condition, has there been a change in your job status?</p> <p>b. What is it now?</p>	<p>14a. (137)</p> <p>1 <input type="checkbox"/> Yes - Ask b</p> <p>2 <input type="checkbox"/> No - SKIP to 15</p> <p>b. (138)</p> <p>1 <input type="checkbox"/> Retired because of disability</p> <p>2 <input type="checkbox"/> Unemployed</p> <p>3 <input type="checkbox"/> Working only part-time</p> <p>4 <input type="checkbox"/> Changed to easier job</p> <p>5 <input type="checkbox"/> Housewife with partial duties</p> <p>6 <input type="checkbox"/> Housewife with no duties</p> <p>7 <input type="checkbox"/> Other - Specify _____</p>
<p>15. How many work days would you estimate you have lost during the past 12 months because of your chest or lung condition, excluding colds or flu?</p>	<p>15. (139)</p> <p>1 <input type="checkbox"/> None</p> <p>2 <input checked="" type="checkbox"/> 1-4 days</p> <p>3 <input type="checkbox"/> 5-9 days</p> <p>4 <input checked="" type="checkbox"/> 10-14 days</p> <p>5 <input type="checkbox"/> 15-19 days</p> <p>6 <input checked="" type="checkbox"/> 20-29 days</p> <p>7 <input type="checkbox"/> 30 days or more</p>

H. Supplement C—Cardiovascular

<p>HSM-411-4 (PAGE 1) REV. 5/71</p> <p style="text-align: center;">DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH AND NUTRITION EXAMINATION SURVEY</p> <p style="text-align: center;">SUPPLEMENT C – CARDIOVASCULAR</p>	<p>Form Approved O.M. B. No. 68-R 1 184</p> <p>ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).</p>																								
<p>a. Name (Last, first, middle)</p>	<p>b. Deck No. c. Sample No.</p> <p style="text-align: center;">141 — ———</p>																								
<p>READ – Earlier you mentioned having a history of either chest pains, chest discomfort or heaviness, leg pains while walking, or heart failure. Here are some additional questions about it.</p>																									
<p>la. Was the problem that of chest pains, chest discomfort, pressure, or heaviness?</p>	<p>la. (001) 1 <input type="checkbox"/> Yes – Ask b 2 <input type="checkbox"/> No – SKIP to 2a</p>																								
<p>b. How would you best describe this pain or discomfort?</p> <p>Heaviness.....</p> <p>Burning sensation.....</p> <p>Tightness.....</p> <p>Stabbing pain.....</p> <p>Pressure.....</p> <p>Sharp pain.....</p> <p>Shooting pains.....</p>	<p>b.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> <th style="width: 40%; text-align: center;">Yes</th> <th style="width: 40%; text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>(002) 1 <input type="checkbox"/></td> <td style="text-align: center;">1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> </tr> <tr> <td>(003) 1 <input type="checkbox"/></td> <td style="text-align: center;">1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> </tr> <tr> <td>(004) 1 <input type="checkbox"/></td> <td style="text-align: center;">1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> </tr> <tr> <td>(005) 1 <input type="checkbox"/></td> <td style="text-align: center;">1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> </tr> <tr> <td>(006) 1 <input type="checkbox"/></td> <td style="text-align: center;">1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> </tr> <tr> <td>(007) 1 <input type="checkbox"/></td> <td style="text-align: center;">1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> </tr> <tr> <td>(008) 1 <input type="checkbox"/></td> <td style="text-align: center;">1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	(002) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(003) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(004) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(005) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(006) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(007) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(008) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
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(008) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>																							
<p>c. Have you had it more than THREE times?</p>	<p>c. (009) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																								
<p>d. Have you been bothered by this within the past 12 months?</p>	<p>d. (010) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																								
<p>e. How old were you when you first had it?</p>	<p>e. (011) 1 <input type="checkbox"/> 10 – 19 years old 2 <input type="checkbox"/> 20 – 29 years old 3 <input type="checkbox"/> 30 – 39 years old 4 <input type="checkbox"/> 40 – 49 years old 5 <input type="checkbox"/> 50 – 59 years old 6 <input type="checkbox"/> 60 years old or older</p>																								
<p>f. Do you get it if you walk at an ordinary pace on level ground?</p>	<p>f. (012) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																								
<p>g. Do you get it if you walk uphill or hurry?</p>	<p>g. (013) 1 <input type="checkbox"/> Yes – Ask h 2 <input type="checkbox"/> No – SKIP <input type="checkbox"/> k</p>																								

<p>1h. What do you do if you get it while walking?</p> <p>stop.</p> <p>Slow down,</p> <p>Continue at same pace.</p> <p>Take medicine.</p>	<p>1h.</p> <table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>(014)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(015)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(016)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(017)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	(014)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(015)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(016)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(017)	1 <input type="checkbox"/>	2 <input type="checkbox"/>						
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(017)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																				
<p>i. If you do stop or slow down, is it relieved or not?</p>	<p>i.</p> <table border="0"> <tbody> <tr> <td>(018)</td> <td>1 <input type="checkbox"/></td> <td>Relieved – Ask j</td> </tr> <tr> <td></td> <td>2 <input type="checkbox"/></td> <td>Not relieved – SKIP to k</td> </tr> </tbody> </table>	(018)	1 <input type="checkbox"/>	Relieved – Ask j		2 <input type="checkbox"/>	Not relieved – SKIP to k															
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	2 <input type="checkbox"/>	Not relieved – SKIP to k																				
<p>j. How soon?</p>	<p>j.</p> <table border="0"> <tbody> <tr> <td>(019)</td> <td>1 <input type="checkbox"/></td> <td>Less than 10 minutes</td> </tr> <tr> <td></td> <td>2 <input type="checkbox"/></td> <td>10 minutes or more</td> </tr> </tbody> </table>	(019)	1 <input type="checkbox"/>	Less than 10 minutes		2 <input type="checkbox"/>	10 minutes or more															
(019)	1 <input type="checkbox"/>	Less than 10 minutes																				
	2 <input type="checkbox"/>	10 minutes or more																				
<p>k. When you get pain or discomfort, where is it located?</p> <p>Upper middle chest,</p> <p>Lower middle chest.</p> <p>Left side of chest.</p> <p>Left arm</p> <p>Right side of chest</p> <p>Other – Specify _____</p>	<p>k.</p> <table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>(020)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(021)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(022)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(023)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(024)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(025)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	(020)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(021)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(022)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(023)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(024)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(025)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
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<p>l. Do any of these things tend to bring it on?</p> <p>Excitement or emotion</p> <p>Stooping over</p> <p>Eating a heavy meal</p> <p>Coughing spells</p> <p>Cold wind</p> <p>Exertion</p>	<p>l.</p> <table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>(026)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(027)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(028)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(029)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(030)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(031)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	(026)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(027)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(028)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(029)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(030)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(031)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
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(031)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																				
<p>2a. Have you ever had severe pain across the front of your chest lasting for half an hour or more?</p>	<p>2a.j</p> <table border="0"> <tbody> <tr> <td>(032)</td> <td>1 <input type="checkbox"/></td> <td>Yes – Ask b</td> </tr> <tr> <td></td> <td>2 <input type="checkbox"/></td> <td>No – SKIP to 3a</td> </tr> </tbody> </table>	(032)	1 <input type="checkbox"/>	Yes – Ask b		2 <input type="checkbox"/>	No – SKIP to 3a															
(032)	1 <input type="checkbox"/>	Yes – Ask b																				
	2 <input type="checkbox"/>	No – SKIP to 3a																				
<p>b. How many of these attacks have you had?</p>	<p>b.</p> <table border="0"> <tbody> <tr> <td>(033)</td> <td>1 <input type="checkbox"/></td> <td>One</td> </tr> <tr> <td></td> <td>2 <input type="checkbox"/></td> <td>2 – 3</td> </tr> <tr> <td></td> <td>3 <input type="checkbox"/></td> <td>4 or more</td> </tr> </tbody> </table>	(033)	1 <input type="checkbox"/>	One		2 <input type="checkbox"/>	2 – 3		3 <input type="checkbox"/>	4 or more												
(033)	1 <input type="checkbox"/>	One																				
	2 <input type="checkbox"/>	2 – 3																				
	3 <input type="checkbox"/>	4 or more																				
<p>c. What was the date of your last attack?</p>	<p>c.</p> <table border="0"> <tbody> <tr> <td>(034)</td> <td>Month</td> <td>Year</td> </tr> <tr> <td></td> <td>__ __</td> <td>__ __</td> </tr> </tbody> </table>	(034)	Month	Year		__ __	__ __															
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<p>d. What was the duration of the pain during your last attack?</p>	<p>d.</p> <table border="0"> <tbody> <tr> <td>(035)</td> <td>1 <input type="checkbox"/></td> <td>30 – 59 minutes</td> </tr> <tr> <td></td> <td>2 <input type="checkbox"/></td> <td>– 2 hours</td> </tr> <tr> <td></td> <td>3 <input type="checkbox"/></td> <td>3 – 5 hours</td> </tr> <tr> <td></td> <td>4 <input type="checkbox"/></td> <td>6 – 11 hours</td> </tr> <tr> <td></td> <td>5 <input type="checkbox"/></td> <td>12 – 23 hours</td> </tr> <tr> <td></td> <td>6 <input checked="" type="checkbox"/></td> <td>24 – 47 hours</td> </tr> <tr> <td></td> <td>7 <input type="checkbox"/></td> <td>2 days or more</td> </tr> </tbody> </table>	(035)	1 <input type="checkbox"/>	30 – 59 minutes		2 <input type="checkbox"/>	– 2 hours		3 <input type="checkbox"/>	3 – 5 hours		4 <input type="checkbox"/>	6 – 11 hours		5 <input type="checkbox"/>	12 – 23 hours		6 <input checked="" type="checkbox"/>	24 – 47 hours		7 <input type="checkbox"/>	2 days or more
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	6 <input checked="" type="checkbox"/>	24 – 47 hours																				
	7 <input type="checkbox"/>	2 days or more																				

<p>2e. Did you see a doctor about this lost attack?</p> <p>f. What did he say it was?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>2e. (036) 1 <input type="checkbox"/> Yes - Ask f 2 <input type="checkbox"/> No - SKIP to 3a</p> <p>f. DATA PREPARATION USE ONLY</p> <p>(037) 1 <input type="checkbox"/> 001 1 <input type="checkbox"/></p> <p>(038) 1 <input type="checkbox"/> 002 1 <input type="checkbox"/></p> <p>(039) 1 <input type="checkbox"/> 043 1 <input type="checkbox"/></p> <p>(040) 1 <input type="checkbox"/> 004 1 <input type="checkbox"/></p>
<p>3a. Do you get pain or discomfort in either leg while walking?</p> <p>b. Do you also get this pain in your legs while standing still?</p> <p>c. In what parts of your leg do you feel this pain?</p> <p>d. Do you get the pain in your legs while quiet or while sitting?</p> <p>e. Do you get it when you walk up a hill in a hurry?</p> <p>f. Do you get it when you walk at an ordinary pace on level ground?</p> <p>g. Does the pain in your legs come on after you have taken a few steps?</p> <p>h. Does the pain disappear while you are still walking?</p> <p>i. What do you do when you get it while you are walking?</p> <p>stop.</p> <p>Slow down</p> <p>Continue at same pace.</p> <p>Take medicine.</p> <p>j. If you stop, is it relieved or not?</p> <p>k. How soon after stopping?</p> <p>l. Is the pain more likely to occur when you are hurrying than when you are walking at a slower, more even pace?</p>	<p>3a. (045) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 4a</p> <p>b. (046) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>c. (047) 1 <input type="checkbox"/> Lower part (calf) 2 <input type="checkbox"/> Upper part (thigh) 3 <input type="checkbox"/> Both lower and upper parts</p> <p>d. (048) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>e. (049) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>f. (050) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>g. (051) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>h. (052) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>i. Yes No</p> <p>(053) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(054) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(055) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(056) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>j. (057) 1 <input type="checkbox"/> [I] Relieved - Ask k 2 <input type="checkbox"/> Not relieved - SKIP to l</p> <p>k. (058) 1 <input type="checkbox"/> Less than 10 minutes 2 <input type="checkbox"/> 10 minutes or more</p> <p>l. (059) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

<p>4a. Have you ever seen a doctor about chest pains, chest discomfort, pains in the legs while walking, or heart failure?</p> <p>b. What is the name of the doctor?</p> <p>_____</p>	<p>4a. (060) 1 <input type="checkbox"/> Yes — Ask b <input type="checkbox"/> No — SKIP <input type="checkbox"/> 5</p>																																
<p>c. What type of doctor is he?</p>	<p>c. (061) 1 <input type="checkbox"/> General practitioner 2 <input type="checkbox"/> Osteopath 3 <input type="checkbox"/> Heart specialist 4 <input type="checkbox"/> Other specialist 5 <input type="checkbox"/> Other — Specify _____ 9 <input type="checkbox"/> Don't know</p>																																
<p>d. Who initially referred you to this doctor?</p> <p>No one.</p> <p>He's the regular doctor</p> <p>Another doctor</p> <p>Family.</p> <p>Clinic.</p> <p>Health nurse</p> <p>Other — Specify _____</p>	<table border="0"> <tr> <td></td> <td>d.</td> <td>Yes</td> <td>No</td> </tr> <tr> <td>(062)</td> <td>1</td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(063)</td> <td>1</td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(064)</td> <td>1</td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(065)</td> <td>1</td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(066)</td> <td>1</td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(067)</td> <td>1</td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(068)</td> <td>1</td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> </table>		d.	Yes	No	(062)	1	<input type="checkbox"/>	2 <input type="checkbox"/>	(063)	1	<input type="checkbox"/>	2 <input type="checkbox"/>	(064)	1	<input type="checkbox"/>	2 <input type="checkbox"/>	(065)	1	<input type="checkbox"/>	2 <input type="checkbox"/>	(066)	1	<input type="checkbox"/>	2 <input type="checkbox"/>	(067)	1	<input type="checkbox"/>	2 <input type="checkbox"/>	(068)	1	<input type="checkbox"/>	2 <input type="checkbox"/>
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(068)	1	<input type="checkbox"/>	2 <input type="checkbox"/>																														
<p>e. How long after this trouble first started did you first visit your doctor about it?</p>	<p>e. (069) 1 <input type="checkbox"/> Less than 1 day 2 <input type="checkbox"/> 1 — 2 days 3 <input type="checkbox"/> 3 — 6 days 4 <input type="checkbox"/> 1 — 3 weeks 5 <input type="checkbox"/> 1 — 5 months 6 <input type="checkbox"/> 6 — 11 months 7 <input type="checkbox"/> 1 year or more 9 <input type="checkbox"/> Don't remember</p>																																
<p>f. At that time, what did he say the problem was?</p> <p>_____</p> <p>_____</p>																																	
<p>g. Did you have a cardiogram at the first visit?</p>	<p>g. (070) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																																
<p>h. Did you have one at a later visit?</p>	<p>h. (071) 1 <input type="checkbox"/> Yes — Ask i 2 <input type="checkbox"/> No — SKIP to 4j</p>																																
<p>i. How long was it from the time of the first visit?</p>	<p>i. (072) 1 <input type="checkbox"/> 1 — 2 days 2 <input type="checkbox"/> 3 — 6 days 3 <input type="checkbox"/> 1 — 3 weeks 4 <input type="checkbox"/> 1 — 5 months 5 <input type="checkbox"/> 6 — 11 months 6 <input type="checkbox"/> 1 year or more 9 <input type="checkbox"/> Don't know</p>																																

<p>4j. Did you have a chest X-ray at the first visit?</p>	<p>4j. (073) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																											
<p>k. Did you have one at a later visit?</p>	<p>k. (074) 1 <input type="checkbox"/> Yes - Ask l 2 <input type="checkbox"/> No - SKIP to m</p>																											
<p>l. How long was it from the time of the first visit?</p>	<p>l. (075) 1 <input type="checkbox"/> 1 - 2 days 2 <input type="checkbox"/> 3 - 6 days 3 <input type="checkbox"/> 1 - 3 weeks 4 <input type="checkbox"/> 1 - 5 months 5 <input type="checkbox"/> 6 - 11 months 6 <input type="checkbox"/> 1 year or more 9 <input type="checkbox"/> Don't know</p>																											
<p>m. Have you had any other tests for this condition? (such as blood or urine)</p>	<p>m. (076) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																											
<p>n. Did the doctor prescribe medicines to take for your condition?</p>	<p>n. (077) 1 <input type="checkbox"/> Yes - Ask o 2 <input type="checkbox"/> No - SKIP to p</p>																											
<p>o. How do you take the medicine?</p> <p>Swallowed.</p> <p>Under the tongue</p> <p>Injected</p> <p>Other - Specify _____</p>	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>(078) 1 <input type="checkbox"/></td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(079) 1 <input type="checkbox"/></td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(080) 1 <input type="checkbox"/></td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(081) 1 <input type="checkbox"/></td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	(078) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(079) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(080) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(081) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>												
	Yes	No																										
(078) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>																										
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(080) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>																										
(081) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>																										
<p>p. Has he told you to do any of these other things?</p> <p>Make regular visits</p> <p>Have regular cardiograms</p> <p>Decrease activity</p> <p>Increase activity</p> <p>Rest</p> <p>Do exercises</p> <p>Stop smoking,</p> <p>Other - Specify _____</p>	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>(082) 1 <input type="checkbox"/></td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(083) 1 <input type="checkbox"/></td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(084) 1 <input type="checkbox"/></td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(085) 1 <input type="checkbox"/></td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(086) 1 <input type="checkbox"/></td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(087) 1 <input type="checkbox"/></td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(088) 1 <input type="checkbox"/></td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(089) 1 <input type="checkbox"/></td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	(082) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(083) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(084) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(085) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(086) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(087) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(088) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(089) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	Yes	No																										
(082) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>																										
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(086) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>																										
(087) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>																										
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(089) 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>																										
<p>q. When was the last time you saw him?</p>	<p>q. (090) 1 <input type="checkbox"/> Less than 1 month ago 2 <input type="checkbox"/> 1 - 3 months ago 3 <input type="checkbox"/> 4 - 6 months ago 4 <input type="checkbox"/> 7 - 11 months ago 5 <input type="checkbox"/> 1 year ago or more 9 <input type="checkbox"/> Don't remember</p>																											
<p>r. Where do you usually see him?</p>	<p>r. (091) 1 <input type="checkbox"/> At his office 2 <input type="checkbox"/> At a clinic 3 <input type="checkbox"/> At home 4 <input type="checkbox"/> Other - Specify _____</p>																											

<p>4s. How long will it be until your next visit?</p>	<p>4s. (092) 1 <input type="checkbox"/> Less than 1 month 2 <input type="checkbox"/> 1 - 3 months 3 <input type="checkbox"/> 4 - 6 months 4 <input type="checkbox"/> 7 - 11 months 5 <input type="checkbox"/> 1 year or more 9 <input type="checkbox"/> Don't know</p>
<p>t. Would you say that the treatments you have had have done you any good?</p>	<p>t. (093) 1 <input type="checkbox"/> No, not at all 2 <input type="checkbox"/> Yes, partly 3 <input type="checkbox"/> Yes, quite a bit</p>
<p>5. Within the past 12 months, would you say that your condition has gotten worse, gotten better, or stayed about the same?</p>	<p>5. (094) 1 <input type="checkbox"/> Gotten worse 2 <input type="checkbox"/> Gotten better 3 <input type="checkbox"/> Stayed about the same</p>
<p>5. Have you ever been disabled because of chest pain, leg pain, or heart failure?</p>	<p>6. (095) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>7. Have you ever stayed overnight in a hospital because of chest pain, leg pain, or heart failure?</p>	<p>7. (096) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>3. What was your job status one month before you first developed chest pain, leg pain, or heart failure?</p>	<p>8. (097) 1 <input type="checkbox"/> Retired because of age 2 <input type="checkbox"/> Retired because of disability 3 <input type="checkbox"/> Unemployed 4 <input checked="" type="checkbox"/> Working full-time 5 <input type="checkbox"/> Working part-time 6 <input type="checkbox"/> Housewife with full duties 7 <input checked="" type="checkbox"/> Housewife with partial or no duties 8 <input type="checkbox"/> Other - Specify _____</p>
<p>9a. As a result of your condition, has there been a change in your job status?</p>	<p>9a. (098) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 10</p>
<p>b. What is it now?</p>	<p>b. (099) 1 <input type="checkbox"/> Retired because of disability 2 <input type="checkbox"/> Unemployed 3 <input type="checkbox"/> Working only part-time 4 <input type="checkbox"/> Changed to easier job 5 <input checked="" type="checkbox"/> Housewife with partial duties 6 <input type="checkbox"/> Housewife with no duties 7 <input checked="" type="checkbox"/> Other - Specify _____</p>
<p>10. How many work days would you estimate you have lost during the past 12 months because of your heart condition?</p>	<p>10. (100) 1 <input type="checkbox"/> None 2 <input type="checkbox"/> 1 - 4 days 3 <input checked="" type="checkbox"/> 5 - 9 days 4 <input type="checkbox"/> 10 - 14 days 5 <input type="checkbox"/> 15 - 19 days 6 <input checked="" type="checkbox"/> 20 - 29 days 7 <input type="checkbox"/> 30 days or more</p>

J. Body Measurements

HRA 127A (Formerly HSM-425-7A) 74 DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH RESOURCES ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH EXAMINATION SURVEY BODY MEASUREMENTS		Form Approved O.M.B. No. 68-R1184 ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 F R 1687).		
a. Deck No. <div style="text-align: center; font-size: 1.2em;">111</div>	b. Examiner No. <div style="text-align: center;">_ _ _</div>	c. Recorder No.		
NOTE } Measurement in cm. unless otherwise specified. Measure left side also if the last digit of examinee's sample number is 3 or 6.				
1. Bitrochanteric breadth	1.	(009) _ _ . _ _		
2. Elbow breadth	2.	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">(001) RIGHT SIDE _ _ . _ _</td> <td style="width: 50%; text-align: center;">(002) LEFT SIDE _ _ . _ _</td> </tr> </table>	(001) RIGHT SIDE _ _ . _ _	(002) LEFT SIDE _ _ . _ _
(001) RIGHT SIDE _ _ . _ _	(002) LEFT SIDE _ _ . _ _			
3. Upper arm girth	3.	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">(003) RIGHT SIDE _ _ . _ _</td> <td style="width: 50%; text-align: center;">(004) LEFT SIDE _ _ . _ _</td> </tr> </table>	(003) RIGHT SIDE _ _ . _ _	(004) LEFT SIDE _ _ . _ _
(003) RIGHT SIDE _ _ . _ _	(004) LEFT SIDE _ _ . _ _			
Chest circumference				
4a. Full expiration	4a.	(018) _ _ _ . _ _		
b. Full inspiration	b.	(017) _ _ _ . _ _		
5. Triceps skinfold (mm.)	5.	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">(005) RIGHT SIDE _ _ . _ _</td> <td style="width: 50%; text-align: center;">(006) LEFT SIDE _ _ . _ _</td> </tr> </table>	(005) RIGHT SIDE _ _ . _ _	(006) LEFT SIDE _ _ . _ _
(005) RIGHT SIDE _ _ . _ _	(006) LEFT SIDE _ _ . _ _			
6. Subscapular skinfold (mm.)	6.	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">(007) RIGHT SIDE _ _ . _ _</td> <td style="width: 50%; text-align: center;">(008) LEFT SIDE _ _ . _ _</td> </tr> </table>	(007) RIGHT SIDE _ _ . _ _	(008) LEFT SIDE _ _ . _ _
(007) RIGHT SIDE _ _ . _ _	(008) LEFT SIDE _ _ . _ _			
7. Sitting height	7.	(010) _ _ . _ _		
When both sides are measured				
8. Is examinee right or left handed?	8.	(016) <input type="checkbox"/> Right handed 2 <input type="checkbox"/> Left handed 3 <input type="checkbox"/> Uses both hands about the same 4 <input type="checkbox"/> Not sure 5 <input type="checkbox"/> Not applicable		
9. Weight (lbs.)	9.	(013) _ _ _ . _ _		
10a. Standing height (cm.)	10a.	(014) _ _ _ . _ _		
b. Standing height (inches)	b.	_ _ _ /		
NOTES				
		Sample Number <div style="text-align: center; font-size: 1.5em; font-weight: bold;">N^o 98743</div>		

K. General Medical Examination

HRA-12-3 FORMERLY HSM-425-3 (7/74) DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH RESOURCES ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS GENERAL MEDICAL EXAMINATION - AGES 25-74 HEALTH EXAMINATION SURVEY		Form Approved O.M.B. No. 68-R1184 ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).						
a. Name (Last, first, middle)		b. Deck No. <div style="text-align: center; font-size: 1.2em; font-weight: bold;">231</div>	c. Pulse <div style="text-align: center;">(001) - - -</div>	d. Blood pressure <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Systolic</td> <td style="width: 50%; text-align: center;">Diastolic</td> </tr> <tr> <td style="text-align: center;">(002) - - -</td> <td style="text-align: center;">(003) - - -</td> </tr> </table>	Systolic	Diastolic	(002) - - -	(003) - - -
Systolic	Diastolic							
(002) - - -	(003) - - -							
1. HEAD, EYES, EARS, NOSE, AND THROAT: <i>If findings, mark applicable box and continue with a. If no findings, SKIP to 2a.</i>		(004) 1 <input type="checkbox"/> Findings 2 <input type="checkbox"/> No findings Yes	4. ABDOMINAL EVALUATION: <i>If findings, mark applicable box and continue with a. If no findings, SKIP to 5.</i>		(048) 1 <input type="checkbox"/> Findings 2 <input type="checkbox"/> No findings Yes			
a. Conjunctival injection		(010) 1 <input type="checkbox"/>	a. Hepatomegaly.		(049) 1 <input type="checkbox"/>			
b. Filiform papillary atrophy of tongue		(019) 1 <input type="checkbox"/>	b. Splenomegaly		(050) 1 <input type="checkbox"/>			
c. Fungiform papillary hypertrophy of tongue		(020) 1 <input type="checkbox"/>	c. Uterine enlargement		(051) 1 <input type="checkbox"/>			
d. Fissures of tongue		(022) 1 <input type="checkbox"/>	d. Umbilical hernia.		(052) 1 <input type="checkbox"/>			
e. Serrations or swelling of tongue		(023) 1 <input type="checkbox"/>	M <input checked="" type="checkbox"/> Mass(es)		(054) 1 <input type="checkbox"/>			
f. Scarlet beefy tongue		(024) 1 <input type="checkbox"/>	(1) Area(s) - Enter number(s)		(055) - - - - -			
g. Other - Specify _____		(029) 1 <input type="checkbox"/>	(2) Other findings - Describe \nearrow _____		(056) 1 <input type="checkbox"/>			
2a. THYROID EVALUATION: (WHO Classification)		(030) 1 <input type="checkbox"/> Group 0 2 <input type="checkbox"/> Group 1 3 <input type="checkbox"/> Group 2 4 <input type="checkbox"/> Group 3	f. Surgical scars		(057) 1 <input type="checkbox"/>			
b. OTHER THYROID FINDINGS:		(031) 1 <input type="checkbox"/> Findings 2 <input type="checkbox"/> No findings (GO to 3) R L Both	(1) Area(s) - Enter number(s)		(058) - - - - -			
(1) Tenderness.		(032) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	(2) Other findings - Describe \nearrow _____		(059) 1 <input type="checkbox"/>			
(2) Nodule.		(033) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>						
(3) Isthmus		(034) 1 <input type="checkbox"/>						
(4) Other - Describe _____		(035) 1 <input type="checkbox"/>						
3. CARDIOVASCULAR EVALUATIONS: <i>If findings, mark applicable box and continue with a. If no findings, SKIP to 4.</i>		(043) 1 <input type="checkbox"/> Findings 2 <input type="checkbox"/> No findings Yes						
a. Cyanosis		(044) 1 <input type="checkbox"/>	S A M P L E <div style="font-size: 1.5em; font-weight: bold;">N 98743</div>					
b. Irregular pulse.		(045) 1 <input type="checkbox"/>						

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE















PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION
NATIONAL CENTER FOR HEALTH STATISTICS
HEALTH EXAMINATION SURVEY

ASSURANCE OF CONFIDENTIALITY
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GENERAL MEDICAL EXAMINATION

Deck No. **232**

A. EXTERNAL EAR (Except canal)

	Right	Left
1. No findings - SKIP to B              	1. <input type="checkbox"/> (001)	1. <input type="checkbox"/> (002)
2. Findings - Continue with 3 . . . 2.	2. <input type="checkbox"/>	2. <input type="checkbox"/>
3. Operative scar . . . 3.	3. <input type="checkbox"/> (003)	3. <input type="checkbox"/> (004)
4. Other - Describe . . . 4.	4. <input type="checkbox"/> (005)	4. <input type="checkbox"/> (006)
5. Pierced ears . . . 5.	5. <input type="checkbox"/> (007) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	

B. AUDITORY CANAL

	Right	Left
1. No findings - SKIP to C 1.	1. <input type="checkbox"/> (008)	1. <input type="checkbox"/> (009)
2. Findings - Continue with 3 . . . 2.	2. <input type="checkbox"/>	2. <input type="checkbox"/>
3. Occluded: a. Partially 3a.	3a. <input type="checkbox"/> (010)	3a. <input type="checkbox"/> (011)
b. Completely b.	b. <input type="checkbox"/>	b. <input type="checkbox"/>
4. Occluded by: a. Cerumen 4a.	4a. <input type="checkbox"/> (012)	4a. <input type="checkbox"/> (013)
b. Other - Describe b.	b. <input type="checkbox"/>	b. <input type="checkbox"/>

C. DRUM

	Right	Left
1. No findings - SKIP to D 1.	1. <input type="checkbox"/> (014)	1. <input type="checkbox"/> (015)
2. Findings - Continue with 4 . . . 2.	2. <input type="checkbox"/>	2. <input type="checkbox"/>
3. Not visible 3.	3. <input type="checkbox"/>	3. <input type="checkbox"/>
4. Dull (Opaque) 4.	4. <input type="checkbox"/> (016)	4. <input type="checkbox"/> (017)
5. Transparent 5.	5. <input type="checkbox"/>	5. <input type="checkbox"/>
6. Bulging 6.	6. <input type="checkbox"/> (018)	6. <input type="checkbox"/> (019)
7. Retracted 7.	7. <input type="checkbox"/>	7. <input type="checkbox"/>
8. Calcium plaques . . . 8.	8. <input type="checkbox"/> (020)	8. <input type="checkbox"/> (021)
9. Other findings - Describe 9.	9. <input type="checkbox"/> (022)	9. <input type="checkbox"/> (023)

C. DRUM - Continued

	Right	Left
10. Red 10.	10. <input type="checkbox"/> (024)	10. <input type="checkbox"/> (025)
11. Other discolorations . . . 11.	11. <input type="checkbox"/>	11. <input type="checkbox"/>
12. Fluid 12.	12. <input type="checkbox"/> (026)	12. <input type="checkbox"/> (027)
13. Scars 13.	13. <input type="checkbox"/> (028)	13. <input type="checkbox"/> (029)
14. Perforated 14.	14. <input type="checkbox"/> (030)	14. <input type="checkbox"/> (031)
a. With discharge 14a.	14a. <input type="checkbox"/> (030)	14a. <input type="checkbox"/> (031)
b. Without discharge b.	b. <input type="checkbox"/>	b. <input type="checkbox"/>

D. NARES

	Right	Left
1. No findings - SKIP to E 1.	1. <input type="checkbox"/> (032)	1. <input type="checkbox"/> (033)
2. Findings - Continue with 3 . . . 2.	2. <input type="checkbox"/>	2. <input type="checkbox"/>
3. Obstruction a. Acute 3a.	3a. <input type="checkbox"/> (034)	3a. <input type="checkbox"/> (035)
b. Chronic b.	b. <input type="checkbox"/>	b. <input type="checkbox"/>
4. Other significant findings - a. Deviated septum . . . 4a.	4a. <input type="checkbox"/> (036)	4a. <input type="checkbox"/> (037)
b. Swollen turbinates b.	b. <input type="checkbox"/> (038)	b. <input type="checkbox"/> (039)
c. Chronic inflammation c.	c. <input type="checkbox"/> (040)	c. <input type="checkbox"/> (041)
d. Other -Describe . . . d .	d. <input type="checkbox"/> (042)	d. <input type="checkbox"/> (043)

E. NECK

1. No findings - SKIP to F 1.	1. <input type="checkbox"/> (044)
2. Findings - Continue with 3 . . . 2.	2. <input type="checkbox"/>
3. Adenopathy 3.	3. <input type="checkbox"/> (045)
4. Tracheal deviation. 4.	4. <input type="checkbox"/> (046)
5. Other - Describe . . . 5.	5. <input type="checkbox"/> (047)

Sample Number
Nº 98743

F. CHEST		Dimin. brth. sounds	Absent b.s.	Bronchial b.s.	Rales	Rhonchi	Wheeze
1. Auscultation <input checked="" type="radio"/> 1 <input type="checkbox"/> No findings - SKIP to G <input type="checkbox"/> 2 Findings	Right chest						
	Upper lobe	<input checked="" type="radio"/> 049 1 <input type="checkbox"/>	2 <input type="checkbox"/>	<input checked="" type="radio"/> 050 1 <input type="checkbox"/>	<input checked="" type="radio"/> 051 1 <input type="checkbox"/>	<input checked="" type="radio"/> 052 1 <input type="checkbox"/>	<input checked="" type="radio"/> 053 1 <input type="checkbox"/>
	Middle lobe	<input checked="" type="radio"/> 054 1 <input type="checkbox"/>	2 <input type="checkbox"/>	<input checked="" type="radio"/> 055 1 <input type="checkbox"/>	<input checked="" type="radio"/> 056 1 <input type="checkbox"/>	<input checked="" type="radio"/> 057 1 <input type="checkbox"/>	<input checked="" type="radio"/> 058 1 <input type="checkbox"/>
	Lower lobe	<input checked="" type="radio"/> 059 1 <input type="checkbox"/>	2 <input type="checkbox"/>	<input checked="" type="radio"/> 060 1 <input type="checkbox"/>	<input checked="" type="radio"/> 061 1 <input type="checkbox"/>	<input checked="" type="radio"/> 062 1 <input type="checkbox"/>	<input checked="" type="radio"/> 063 1 <input type="checkbox"/>
	Left chest						
	Upper lobe	<input checked="" type="radio"/> 064 1 <input type="checkbox"/>	2 <input type="checkbox"/>	<input checked="" type="radio"/> 065 1 <input type="checkbox"/>	<input checked="" type="radio"/> 066 1 <input type="checkbox"/>	<input checked="" type="radio"/> 067 1 <input type="checkbox"/>	<input checked="" type="radio"/> 068 1 <input type="checkbox"/>
Lower lobe	<input checked="" type="radio"/> 069 1 <input type="checkbox"/>	2 <input type="checkbox"/>	<input checked="" type="radio"/> 070 1 <input type="checkbox"/>	<input checked="" type="radio"/> 071 1 <input type="checkbox"/>	<input checked="" type="radio"/> 072 1 <input type="checkbox"/>	<input checked="" type="radio"/> 073 1 <input type="checkbox"/>	

2. Other chest findings

074 1 None 2 Findings _____

G. HEART

1. P.M.I. 1.	<input checked="" type="radio"/> 075 1 <input type="checkbox"/> Felt	2 <input type="checkbox"/> Not felt												
2. Interspace 2.	<input checked="" type="radio"/> 076 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/>													
3. Midclavicular line 3.	<input checked="" type="radio"/> 077 1 <input type="checkbox"/> At	2 <input type="checkbox"/> Inside 3 <input type="checkbox"/> Outside												
4. Thrills 4.	<input checked="" type="radio"/> 078 1 <input type="checkbox"/> Absent	2 <input type="checkbox"/> Present												
a. Systolic a.	<input checked="" type="radio"/> 079 1 <input type="checkbox"/> Base	2 <input type="checkbox"/> Apex												
b. Diastolic b.	<input checked="" type="radio"/> 080 1 <input type="checkbox"/> Base	2 <input type="checkbox"/> Apex												
5. Heart sounds														
a. 1st heart sound 5a.	<input checked="" type="radio"/> 081 1 <input type="checkbox"/> Normal	2 <input type="checkbox"/> Accentuated 3 <input type="checkbox"/> Diminished												
b. 2nd heart sound b.	<input checked="" type="radio"/> 082 1 <input type="checkbox"/> Normal	2 <input type="checkbox"/> Accentuated 3 <input type="checkbox"/> Diminished												
6. Murmurs 6.	<input checked="" type="radio"/> 083 <input type="checkbox"/> None - Skip to 7													
a. Type a.	<table border="0"> <tr> <td colspan="3"> SYSTOLIC MURMUR(S) <input checked="" type="radio"/> 084 1 <input type="checkbox"/> Functional 2 <input type="checkbox"/> Organic 9 <input type="checkbox"/> Don't know </td> <td colspan="3"> DIASTOLIC MURMUR(S) <input checked="" type="radio"/> 085 1 <input type="checkbox"/> Functional 2 <input type="checkbox"/> Organic 9 <input type="checkbox"/> Don't know </td> </tr> </table>		SYSTOLIC MURMUR(S) <input checked="" type="radio"/> 084 1 <input type="checkbox"/> Functional 2 <input type="checkbox"/> Organic 9 <input type="checkbox"/> Don't know			DIASTOLIC MURMUR(S) <input checked="" type="radio"/> 085 1 <input type="checkbox"/> Functional 2 <input type="checkbox"/> Organic 9 <input type="checkbox"/> Don't know								
SYSTOLIC MURMUR(S) <input checked="" type="radio"/> 084 1 <input type="checkbox"/> Functional 2 <input type="checkbox"/> Organic 9 <input type="checkbox"/> Don't know			DIASTOLIC MURMUR(S) <input checked="" type="radio"/> 085 1 <input type="checkbox"/> Functional 2 <input type="checkbox"/> Organic 9 <input type="checkbox"/> Don't know											
b. Location	<table border="0"> <tr> <td colspan="6">GRADE</td> <td colspan="6">GRADE</td> </tr> </table>		GRADE						GRADE					
GRADE						GRADE								
(1) Apex b(1)	<input checked="" type="radio"/> 086 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/>	<input checked="" type="radio"/> 087 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/>												
(2) Midprecordium (2)	<input checked="" type="radio"/> 088 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/>	<input checked="" type="radio"/> 089 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/>												
(3) Left base (3)	<input checked="" type="radio"/> 090 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/>	<input checked="" type="radio"/> 091 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/>												
(4) Right base (4)	<input checked="" type="radio"/> 092 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/>	<input checked="" type="radio"/> 093 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/>												

Continue with 6c, "Origin" on Page 3

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G. HEART - Continued

6. Murmurs - Continued

c. Origin

		Systolic	Diastolic	Both
(1) Mitral	6c.(1)	094 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(2) Aortic.	(2)	095 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(3) Tricuspid.	(3)	096 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(4) Pulmonic	(4)	097 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(5) ASD	(5)	098 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(6) VSD	(6)	099 9 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(7) Other	(7)	100 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(8) Don't know	(8)	100 9 EI		

7. Other cardiac or cardiovascular findings

- a. Edema 7a.
- b. Other - Describe b.

- c. Neck vein distension c.

102 1 <input type="checkbox"/>	No - Skip to H	2 <input type="checkbox"/>	Yes - Continue with 7a
103 1 <input type="checkbox"/>			
104 1 <input type="checkbox"/>			
105 1 <input type="checkbox"/>			

H. PULSE - ARTERIAL EVALUATION

1. Palpation

- a. Right radial 1a.
- b. Right femoral b.
- c. Right **dorsalis** pedis c.
- d. Left radial d.
- e. Left femoral e.
- f. Left **dorsalis** pedis f.

	Normal	Sclerotic	Tortuous	Sclerotic and Tortuous
106 1 <input type="checkbox"/>		2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
107 1 <input type="checkbox"/>		2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
108 1 <input type="checkbox"/>		2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
109 1 <input type="checkbox"/>		2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
110 1 <input type="checkbox"/>		2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
111 1 <input type="checkbox"/>		2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

2. Pulsations

- a. Right radial 2a.
- b. Right femoral b.
- c. Right **dorsalis** pedis c.
- d. Other - Describe d.

- e. Left radial e.
- f. Left femoral f.
- g. Left **dorsalis** pedis g.
- h. Other - Describe h.

	Normal	Diminished	Bounding	Absent
112 1 <input type="checkbox"/>		2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
113 1 <input type="checkbox"/>		2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
114 1 <input type="checkbox"/>		2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
115 1 cI		2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
116 1 <input type="checkbox"/>		2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
117 1 <input type="checkbox"/>		2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
118 1 <input type="checkbox"/>		2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
119 1 <input type="checkbox"/>		2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

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I. KNEES

(120) 1 Findings — Continue with I
 2 No findings — Skip to J

1. Bony irregularity

		R	L	Both
a. Genu varum	lo.	(121) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Genu valgum	b.	(122) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Genu recurvatum	c.	(123) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. Fixed flexion	d.	(124) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e. Other — Describe.	e.	(125) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

2. Pain on motion

		Act.	Pas.	Both	Tenderness
a. Right medial	2a.	(126) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(127) 1 <input type="checkbox"/>
b. Right lateral	b.	(128) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(129) 1 <input type="checkbox"/>
c. Right diffuse	c.	(130) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(131) 1 <input type="checkbox"/>
d. Left medial	d.	(132) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(133) 1 <input type="checkbox"/>
e. Left lateral	e.	(134) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(135) 1 <input type="checkbox"/>
f. Left diffuse	f.	(136) 1 cl	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(137) 1 <input type="checkbox"/>
g. Right suprapatellar	g.			(138) 1 <input type="checkbox"/>
h. Left suprapatellar	h.			139 1 <input type="checkbox"/>
i. Right infrapatellar	i.			(140) 1 <input type="checkbox"/>
j. Left infrapatellar	j.			(141) 1 cl

3. Other findings

		R	L	Both
a. Swelling	3a.	(142) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Fluid	b.	(143) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Soft tissue proliferation	c.	(144) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. Subpatellar crepitus.	d.	(145) 1 C I	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e. Muscular wasting thigh	e.	(146) 1 Cl	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f. Other — Describe	f.	(147) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

J. HIPS

(148) 1 Findings — Continue with I
 2 No findings — Skip to K

1. Pain on motion

		ACTIVE			PASSIVE		
		R	L	Both	R	L	Both
a. Extension	lo.	(149) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(150) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Flexion	b.	(151) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(152) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Abduction	c.	(153) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(154) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. Adduction	d.	(155) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(156) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e. Ext. rot.	e.	(157) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(158) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f. Int. rot	f.	(159) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(160) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

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J. HIPS – Continued

1. Other findings

- | | | | | | |
|----------------------------------|-----|-------|----------------------------|----------------------------|----------------------------|
| a. Muscle wasting (glutea) | Ta. | (161) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| b. Trochanter tenderness | b. | (162) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| c. Groin tenderness | c. | (163) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| d. Other – Describe _____ | | (164) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |

R L Both

K. JOINTS

- (165) 1 No findings – Skip to L
 2 Findings – Describe and continue with 1 _____

Other joints	MANIFESTATIONS													
	Tender		Swelling		Deformity		Limitation		Heberden's nodes		Pain on motion		Other	
1. Shoulder	(166)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(167)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(168)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(169)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L		(170)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(171)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	
2. Elbow	(172)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(173)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(174)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(175)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L		(176)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(177)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	
3. Wrist	(178)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(179)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(180)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(181)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L		(182)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(183)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	
4. Metacarpophalangeal (No. involved)	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT		RIGHT	LEFT	RIGHT	LEFT	
	(184)	(185)	(186)	(187)	(188)	(189)	(190)	(191)		(192)	(193)	(194)	(195)	
	1 <input type="checkbox"/>	<input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>		1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	
	2 <input type="checkbox"/>	<input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>		2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	
	3 <input type="checkbox"/>	<input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>		3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	
5. Proximal-interphalangeal (No. involved)	(196)	(197)	(198)	(199)	(200)	(201)	(202)	(203)		(204)	(205)	(206)	(207)	
	1 <input type="checkbox"/>	<input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>		1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	
	2 <input type="checkbox"/>	<input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>		2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	
	3 <input type="checkbox"/>	<input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>		3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	
	4 <input type="checkbox"/>	<input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>		4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	
6. Distalinterphalangeal (No. involved)	(208)	(209)	(210)	(211)	(212)	(213)	(214)	(215)	RIGHT	LEFT	(218)	(219)	(220)	(221)
	1 <input type="checkbox"/>	<input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	(216)	(217)	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
	2 <input type="checkbox"/>	<input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
	3 <input type="checkbox"/>	<input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
	4 <input type="checkbox"/>	<input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>
7. Ankle	(222)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(223)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(224)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(225)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L		(226)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(227)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	
8. Feet	(228)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(229)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(230)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(231)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L		(232)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(233)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	

L BACK

1 No findings - Skip to M
 2 Findings - Continue with 1

- 1. Scoliosis 1.
- 2. Kyphosis 2.
- 3. Lordosis 3.
- 4. Tenderness
 - a. Sciatic notch 4a.
 - b. Sacroiliac b.
 - c. Other - Describe

(234) 1
 (235) 1
 (236) 1
 (237) 1
 (238) 1 R 2 L 3 Both
 (239) 1 R 2 L 3 Both
 240 1

- 5. Limitation of motion
 - a. Cervical spine Sa.
 - b. Thoracic spine b.
 - c. Lumbar spine flexion c.
 - d. Lumbar spine, right lateral flexion d.
 - e. Lumbar spine, left lateral flexion e.
 - f. Full extension f.

(241) 1
 (242) 1
 (243) 1
 (244) 1
 (245) 1
 (246) 1
 (247) 1

- 6. Pain on motion 6.
- 7. Flexion 7.
- 8. Extension 8.
- 9. Right lateral bending 9.
- 10. Left lateral bending 10.
- 11. Right rotation 11.
- 12. Left rotation 12.

1 Negative 2 Positive

	Cervical	Thoracic	Low back	Diffuse	8 certain
(248) 1 <input type="checkbox"/>	(249) 1 <input type="checkbox"/>	0 250 1 <input type="checkbox"/>	(251) 1 <input type="checkbox"/>	8 2 1 <input type="checkbox"/>	
(253) 1 <input type="checkbox"/>	(254) 1 <input type="checkbox"/>	255 1 <input type="checkbox"/>	(256) 1 <input type="checkbox"/>	25 1 <input type="checkbox"/>	
(258) 1 <input type="checkbox"/>	(259) 1 <input type="checkbox"/>	(260) 1 <input type="checkbox"/>	(261) 1 <input type="checkbox"/>	(262) 1 <input type="checkbox"/>	
(263) 1 <input type="checkbox"/>	(264) 1 <input type="checkbox"/>	(265) 1 <input type="checkbox"/>	(266) 1 <input type="checkbox"/>	(267) 1 <input type="checkbox"/>	
(268) 1 <input type="checkbox"/>	(269) 1 <input type="checkbox"/>	(270) 1 <input type="checkbox"/>	(271) 1 <input type="checkbox"/>	(272) 1 <input type="checkbox"/>	
(273) 1 <input type="checkbox"/>	(274) 1 <input type="checkbox"/>	0 275 1 <input type="checkbox"/>	(276) 1 <input type="checkbox"/>	(277) 1 <input type="checkbox"/>	

M. STRAIGHT-LEG-RAISING TEST

- 1. Right leg 1.
- 2. Left leg 2.
- 3. Increase -
 - a. On ankle (right leg) 3a.
 - b. Dorsiflexion (Left leg)

(278) 1 Neg. 2 Pos.
 (280) 1 Neg. 2 Pos.
 (279) 1 Yes 2 No
 (281) 1 * + 2 No

N. OTHER SYSTEMS

(Reticulo endothelial, G.I., etc.)

(282) 1 No findings - Skip to 0
 2 Findings - Describe →

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0. BLOOD PRESSURE

1. Recumbent 1. 1:28³ 1 A.M. 0 204 --- 0 285 ---
 2. Sitting 2. 2:07 2 P.M. 0 207 --- 0 288 ---

P. SUMMARY OF DIAGNOSTIC IMPRESSIONS

Normal; no abnormal findings noted
 Abnormal significant finding noted **below**

		Severity			Certainty (0-9)	ICD code	
		Min.	Mod.	Sev.			
1. Cardiovascular							
a. _____	1a.	<input checked="" type="checkbox"/> 290	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	0 291 --- <input checked="" type="checkbox"/> 292 ---	
b. _____	b.	<input checked="" type="checkbox"/> 293	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	0 294 --- 0 295 ---	
c. _____	c.	<input checked="" type="checkbox"/> 296	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 297 --- <input checked="" type="checkbox"/> 298 ---	
2. Musculo-skeletal							
a. _____	2a.	<input checked="" type="checkbox"/> 299	1	Cl	<input type="checkbox"/> 2	<input type="checkbox"/> 3	0 300 --- 0 301 ---
b. _____	b.	<input checked="" type="checkbox"/> 302	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	0 303 --- <input checked="" type="checkbox"/> 304 ---	
c. _____	c.	<input checked="" type="checkbox"/> 305	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 306 --- <input checked="" type="checkbox"/> 307 ---	
3. Respiratory							
a. _____	3a.	<input checked="" type="checkbox"/> 308	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 309 --- <input checked="" type="checkbox"/> 310 ---	
b. _____	b.	<input checked="" type="checkbox"/> 311	311	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 312 --- <input checked="" type="checkbox"/> 313 ---
c. _____	c.	<input checked="" type="checkbox"/> 314	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 315 --- <input checked="" type="checkbox"/> 316 ---	
4. Other systems - Specify							
a. _____	4a.	<input checked="" type="checkbox"/> 317	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 318 --- <input checked="" type="checkbox"/> 319 ---	
b. _____	b.	<input checked="" type="checkbox"/> 320	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 321 --- <input checked="" type="checkbox"/> 322 ---	
c. _____	c.	<input checked="" type="checkbox"/> 323	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 324 --- 0 325 ---	
5.							
a. _____	5a.	<input checked="" type="checkbox"/> 326	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 327 --- <input checked="" type="checkbox"/> 328 ---	
b. _____	b.	<input checked="" type="checkbox"/> 329	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 330 --- <input checked="" type="checkbox"/> 331 ---	
c. _____	c.	<input checked="" type="checkbox"/> 332	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 333 --- <input checked="" type="checkbox"/> 334 ---	

Name of physician

Sample Number
N? 98743

L. Audiometry (Air)

HRA-12-10 <small>FORMERLY HSM-425-10 (7-74)</small> DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE <small>PUBLIC HEALTH SERVICE HEALTH RESOURCES ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS</small>			Form Approved O.M.B. No. 68-RI 184		
AUDIOMETRY (AIR) HEALTH EXAMINATION SURVEY					
a. Deck No. 241		b. Audio No. 001 - - - - -		c. Examiner No. 02 - -	
b START <i>HERE IF SAMPLE NUMBER EVEN</i> 1. AIR CONDUCTION - RIGHT EAR			START <i>HERE IF SAMPLE NUMBER ODD</i> 2. AIR CONDUCTION - LEFT EAR		
Retest R with masking on L* (a)	Frequency (Hz) (b)	Hearing level (c)	Retest L with masking on R* (a)	Frequency (Hz) (b)	Hearing level (c)
003	1000	004	031	1000	032
009	2000	010	037	2000	038
035	4000	016	043	4000	044
021	500	022	049	500	050
027	1000	028	055	1000	056
3. CONDITION AFFECTING TEST RESULTS Mark (X) only one 059 1 <input type="checkbox"/> None 2 <input type="checkbox"/> Cold or sinusitis now 3 <input type="checkbox"/> Ear discharge 4 <input type="checkbox"/> Ringing or other noises in ears 5 <input type="checkbox"/> Equipment defect** 6 <input type="checkbox"/> Cold or sinusitis within one week 7 <input type="checkbox"/> Earache within week 8 <input type="checkbox"/> Other - Describe ** <i>↗</i>			*Retest poorer ear with A/C masking on better ear only if differences in A/C-HL between the two ears is 40 dB or more ** Specify frequencies affected and describe ₃ _____ _____ _____ _____ _____ _____		
Comments					
					SAMPLE NUMBER N? 98743

M. Respiratory Function Tests

1RA-12-9 (Formerly HSM-425-9) <small>4-74</small> DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH RESOURCES ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH EXAMINATION SURVEY RESPIRATORY FUNCTION TESTS	Form Approved O.M.B. No. 68-R1 184 -ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).																		
Deck No. 251	Room temperature <div style="text-align: center;"> 000 <u>1</u> — — °C </div>																		
A. SPIROMETER 1. Was test satisfactory? 1.	<div style="display: flex; justify-content: space-between;"> 002 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No — Explain 7 </div> <hr/> <hr/>																		
B. SINGLE BREATH DIFFUSING CAPACITY 1. inspired Co. 1.	<div style="text-align: center;"> <u>1</u> <u>0</u> <u>0</u> % </div>																		
2. Small spirometer temperature 2.	<div style="text-align: center;"> 003 — — °C </div>																		
3a. Uncorrected barometric pressure 3a.	<div style="text-align: center;"> 004 — — — — mm. Hg. </div>																		
b. Barometer temperature b.	<div style="text-align: center;"> 001 — — °C </div>																		
4. inspired helium. 4.	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%; text-align: center;">TRIAL #1</th> <th style="width: 33%; text-align: center;">TRIAL #2</th> <th style="width: 33%; text-align: center;">TRIAL #3</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">005 — — — —</td> <td style="text-align: center;">010 — — — —</td> <td style="text-align: center;">015 — — — —</td> </tr> <tr> <td style="text-align: center;">006 — — — —</td> <td style="text-align: center;">011 — — — —</td> <td style="text-align: center;">016 — — — —</td> </tr> <tr> <td style="text-align: center;">007 — — — —</td> <td style="text-align: center;">012 — — — —</td> <td style="text-align: center;">017 — — — —</td> </tr> <tr> <td style="text-align: center;">008 — — — —</td> <td style="text-align: center;">013 — — — —</td> <td style="text-align: center;">018 — — — —</td> </tr> <tr> <td style="text-align: center;">009 — — — —</td> <td style="text-align: center;">014 — — — —</td> <td style="text-align: center;">019 — — — —</td> </tr> </tbody> </table>	TRIAL #1	TRIAL #2	TRIAL #3	005 — — — —	010 — — — —	015 — — — —	006 — — — —	011 — — — —	016 — — — —	007 — — — —	012 — — — —	017 — — — —	008 — — — —	013 — — — —	018 — — — —	009 — — — —	014 — — — —	019 — — — —
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008 — — — —	013 — — — —	018 — — — —																	
009 — — — —	014 — — — —	019 — — — —																	
5. Expired helium percent. 5.																			
6. Expired Co meter reading 6.																			
7. Breath holding time *cm 7.																			
8. Volume inspired V.C. (ATPS) ml 8.																			
9. Was test satisfactory? 9.	<div style="display: flex; justify-content: space-between;"> 020 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No — Explain 7 </div> <hr/>																		
• From tracing — ½ inspiration point measured to onset of expiration																			
NOT ES																			
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: auto;"> Sample Number N ^o 98743 </div>																			

N. Physician's Supplement

<p>HRA-12-24 774)</p> <p style="text-align: center;">DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH RESOURCES ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS</p> <p style="text-align: center;">PHYSICIAN'S SUPPLEMENT HEALTH EXAMINATION SURVEY</p>	<p style="text-align: right;">Form Approved O.M.B. No. 68-W 184</p> <p>ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).</p> <p>Deck No. 082</p>																																																																																																
<p>1. Ocular fundi</p> <p>a. Normal</p> <p>b. Fundus not visualized</p> <p>c. Globe absent</p> <p>d. Increased light reflex</p> <p>e. N&row arterioles</p> <p>f. Tortuous arterioles</p> <p>g. AV compression</p> <p>h. Hemorrhage</p> <p>i. Exudate</p> <p>j. Venous engorgement</p> <p>k. Popilledema</p> <p>l. Disc abnormal</p> <p>m. Lens opacities</p> <p>n. Iritis</p> <p>o. Othei - Specify ?</p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 5%;"></th> <th style="width: 15%;">Right</th> <th style="width: 15%;">Left</th> <th style="width: 15%;">Both</th> <th style="width: 40%;"></th> </tr> </thead> <tbody> <tr> <td style="text-align: right;">1a.</td> <td style="text-align: center;">(101)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>→ If box 3 marked, SKIP to 2a</td> </tr> <tr> <td style="text-align: right;">b.</td> <td style="text-align: center;">(102)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>→ If box(es) 1, 2, or 3 marked, SKIP to 1m</td> </tr> <tr> <td style="text-align: right;">c.</td> <td style="text-align: center;">(103)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>→ If box 3 marked, SKIP to 2a</td> </tr> <tr> <td style="text-align: right;">d.</td> <td style="text-align: center;">(104)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td style="text-align: right;">e.</td> <td style="text-align: center;">(105)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td style="text-align: right;">f.</td> <td style="text-align: center;">(106)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td style="text-align: right;">g.</td> <td style="text-align: center;">(107)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td style="text-align: right;">h.</td> <td style="text-align: center;">(108)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td style="text-align: right;">i.</td> <td style="text-align: center;">(109)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td style="text-align: right;">j.</td> <td style="text-align: center;">(110)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td style="text-align: right;">k.</td> <td style="text-align: center;">(111)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td style="text-align: right;">l.</td> <td style="text-align: center;">(112)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td style="text-align: right;">m.</td> <td style="text-align: center;">(113)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td style="text-align: right;">n.</td> <td style="text-align: center;">(114)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td style="text-align: right;">o.</td> <td style="text-align: center;">(115)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td></td> </tr> </tbody> </table>			Right	Left	Both		1a.	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<p>2a. Did a doctor ever tell you that you had protein, albumin, blood or sugar in your urine?</p> <p>b. Which?</p> <p>Protein</p> <p>Albumin</p> <p>Blood</p> <p>Sugar</p>	<p>2a. (116) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 3</p> <p>b.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 5%;"></th> <th style="width: 15%;">Yes</th> <th style="width: 15%;">No</th> </tr> </thead> <tbody> <tr> <td style="text-align: right;">Protein</td> <td style="text-align: center;">(117)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Albumin</td> <td style="text-align: center;">(118)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Blood</td> <td style="text-align: center;">(119)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Sugar</td> <td style="text-align: center;">(120)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> </tbody> </table>			Yes	No	Protein	(117)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Albumin	(118)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Blood	(119)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Sugar	(120)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																																																																												
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<p>3. During the past 6 months have you had parasites or worms in your stools?</p>	<p>3. (121) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know</p>																																																																																																
<p>SAMPLE NUMBER</p> <p style="font-size: 24pt;">Nº 98743</p>																																																																																																	

<p>4a. Do you have trouble with your bowels which makes you constipated or gives you diarrhea?</p>	<p>4a. (122) 1 <input type="checkbox"/> Constipated - constipated 2 <input type="checkbox"/> Yes - diarrhea 3 <input type="checkbox"/> No</p>															
<p>b. How often do you usually have a bowel movement?</p>	<p>b. (123) 1 <input type="checkbox"/> Once a week or less often 2 <input type="checkbox"/> 2-3 times a week 3 <input type="checkbox"/> 4-6 times a week 4 <input type="checkbox"/> Once a day 5 <input type="checkbox"/> 2-3 times a day 6 <input type="checkbox"/> 4 or more times a day</p>															
<p>c. Have your movements ever been white, gray, dark black, or streaked with blood?</p>	<p>c. (124) 1 <input type="checkbox"/> White, gray, dark black, or streaked with blood <i>d</i> 2 <input type="checkbox"/> No - SKIP to 5a</p>															
<p>d. Which?</p> <p>White</p> <p>Gray</p> <p>Dark black</p> <p>Streaked with blood</p>	<p>d.</p> <table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>(125) 1 <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(126) 1 <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(127) 1 <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(128) 1 <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	(125) 1 <input type="checkbox"/>	<input type="checkbox"/>	2 <input type="checkbox"/>	(126) 1 <input type="checkbox"/>	<input type="checkbox"/>	2 <input type="checkbox"/>	(127) 1 <input type="checkbox"/>	<input type="checkbox"/>	2 <input type="checkbox"/>	(128) 1 <input type="checkbox"/>	<input type="checkbox"/>	2 <input type="checkbox"/>
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(128) 1 <input type="checkbox"/>	<input type="checkbox"/>	2 <input type="checkbox"/>														
<p>5a. Has a doctor ever told you that you had loss of blood from the stomach or bowels?</p>	<p>5a. (129) 1 <input type="checkbox"/> Loss of blood from the stomach or bowels <i>b</i> 2 <input type="checkbox"/> No - SKIP to 6a</p>															
<p>b. Do you still have it?</p>	<p>b. (130) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know</p>															
<p>c. How many years ago did you first have it?</p>	<p>c. (131) — — Years ago</p>															
<p>6a. Have you ever had an abdominal operation?</p>	<p>6a. (132) 1 <input type="checkbox"/> Yes - Ask <i>b</i> 2 <input type="checkbox"/> No - SKIP to 7</p>															
<p>b. Was it for . . .</p> <p>Tumor of the stomach, bowel, or colon?</p> <p>Tumor or cyst of the womb or ovaries?</p>	<p>b.</p> <table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>(133) 1 <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(134) 1 <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	(133) 1 <input type="checkbox"/>	<input type="checkbox"/>	2 <input type="checkbox"/>	(134) 1 <input type="checkbox"/>	<input type="checkbox"/>	2 <input type="checkbox"/>						
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(133) 1 <input type="checkbox"/>	<input type="checkbox"/>	2 <input type="checkbox"/>														
(134) 1 <input type="checkbox"/>	<input type="checkbox"/>	2 <input type="checkbox"/>														
<p>7. Do you have episodes (or "spells") of pain or discomfort in your abdomen or stomach of at least 3 days per month? (Don't count ones that go with a cold, sore throat, flu, or (for women) menstrual periods.)</p>	<p>7. (135) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>															
<p>8. Do you have episodes (or "spells") of vomiting of at least 3 days per month? (Don't count ones that go with colds, sore throats, flu, or (for women) menstrual periods.)</p>	<p>8. (136) 1 <input type="checkbox"/> Vomiting of at least 3 days per month 2 <input type="checkbox"/> No</p> <p>SAMPLE NUMBER</p> <p>N_? 98743</p>															

<p>9a. During the past year, have you had at least one drink of beer, wine, or liquor?</p> <p>b. How often do you drink?</p> <p>c. Which do you most frequently drink -- beer, wine, or liquor?</p> <p>d. When you drink (beer/wine/liquor), how much do you usually drink over 24 hours? (Enter an amount only for the one marked in 9c.)</p>	<p>9a.</p> <p>b.</p> <p>c.</p> <p>d.</p>	<p>(137) 1 <input type="checkbox"/> Yes -- Ask b 2 <input type="checkbox"/> No -- SKIP to Check Item</p> <p>(138) 1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Just about every day 3 <input type="checkbox"/> About 2 or 3 times a week 4 <input type="checkbox"/> About 1-4 times a month 5 <input type="checkbox"/> More than 3 but less than 12 times a year 6 <input type="checkbox"/> No more than 2 or 3 times a year -- SKIP to Check Item</p> <p>(139) 1 <input type="checkbox"/> Beer 2 <input type="checkbox"/> Wine 3 <input type="checkbox"/> Liquor</p> <p>(140) ___ Glasses of beer ___ Glasses of wine ___ Drinks of liquor</p>
CHECK ITEM		<p>(141) 1 <input type="checkbox"/> Female -- Ask 10a 2 <input type="checkbox"/> Male -- END OF QUESTIONNAIRE</p>
<p>10a. How old were you when your periods or menstrual cycles started?</p> <p>b. Have they entirely stopped?</p> <p>c. At what age?</p>	<p>10a.</p> <p>b.</p> <p>c.</p>	<p>(142) <u>Years</u> - Ask b 02 <input type="checkbox"/> Haven't started yet -- END OF QUESTIONNAIRE</p> <p>(143) 1 <input type="checkbox"/> Yes - Ask c 2 <input type="checkbox"/> No -- SKIP to 10c</p> <p>(144) ___ - Years</p>
<p>11a. Have you taken birth control pills during the past 6 months?</p> <p>b. Are you taking them now?</p>	<p>11a.</p> <p>b.</p>	<p>(145) 1 <input type="checkbox"/> Yes -- Ask b 2 <input type="checkbox"/> No - SKIP to 12a</p> <p>(146) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>12a. Are you or have you ever been pregnant?</p> <p>b. What is the total number of pregnancies you have had?</p> <p>c. What is the total number of miscarriages you have had?</p> <p>d. What is the total number of live births you have had?</p> <p>e. Are you pregnant now?</p>	<p>12a.</p> <p>b.</p> <p>c.</p> <p>d.</p> <p>e.</p>	<p>(147) 1 <input type="checkbox"/> Yes -- Ask b 2 <input type="checkbox"/> No -- END OF QUESTIONNAIRE</p> <p>(148) ___ - Number</p> <p>(149) ___ - Number</p> <p>(150) ___ - Number</p> <p>(151) 1 <input type="checkbox"/> Yes - Ask f 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know</p>
<p>f. Which month of pregnancy are you in?</p>	<p>f.</p>	<p>(152) ___ - Month</p>
		<p>SAMPLE NUMBER N! 98743</p>

O. Report of Physical Findings

Confidentiality has been assured examinees as set forth in 22 F.R. 1687
 DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
 PUBLIC HEALTH SERVICE
 NATIONAL CENTER FOR HEALTH STATISTICS
 ROCKVILLE, MD. 20882
 HEALTH EXAMINATION SURVEY

REPORT OF PHYSICAL FINDINGS

Dear Doctor:

Recently the person named below **was a sample person who voluntarily participated as an examinee in the Health Examination Survey** conducted at special facilities of the U.S. Public Health Service. The objectives of the Survey are to obtain information on the health status of the U.S. population. The examination is not, and was not intended to be, a substitute for a visit to the examinee's physician, **nor** was it intended to be a complete examination. At the request of the examinee, however, we do send a report of certain selected procedures to his/her physician.

Reported below are physical findings which our physicians thought were significant and should be brought to your attention (i.e., for which no treatment had been sought and/or no history given). Also reported are some test reports and/or laboratory data. Although we are not engaged in follow-up or treatment of our findings, we appreciate the cooperation of our examinees and hope that we can contribute to their medical care by making this information available to you.

In addition to items listed below a separate letter will be sent reporting any significant conditions found on knee and hip X-rays if any are present.

Sincerely,

Arnold Engel

Arnold Engel, M.D.
 Medical Advisor

Examinee's name and address	Date of examination		Age	Height	Chest X-ray	EKG	
			Sex	Weight	<input type="checkbox"/> Encl. <input type="checkbox"/> Not done	<input type="checkbox"/> Encl. <input type="checkbox"/> Not done	
MEDICAL <input type="checkbox"/> No new significant findings	VISUAL ACUITY R Eye L Eye 20 / ____ 20 / ____ <input type="checkbox"/> Without glasses <input type="checkbox"/> With glasses <input type="checkbox"/> With contacts <input type="checkbox"/> Not tested		BLOOD PRESSURE Systolic Diastolic		AUDIOGRAM - Decibels		
			CPS	500	1000	2000	4000
			Right				
		Left					
Hematocrit _____ vol % Hemoglobin _____ gm % RBC count _____ mill/cc WBC count _____ thou/cc	URINE Albumin _____ Sugar _____	Neg Ph <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 Blood <input type="checkbox"/> Pos c l Neg	TR 1 2 3 4	SAMPLE NUMBER Nº 98743			

c 1 SEE REVERSE SIDE FOR NOTES ON TESTS AND PROCEDURES

NOTES ON TESTS AND PROCEDURES

Medical Examination - The physician's examination included the head and neck, chest (cardiopulmonary), abdomen, and extremities (musculoskeletal and neurological) - however, rectal, pelvic, and breast examinations were excluded.

X-Rays and EKG - A 12 lead EKG and A-P plus Lateral Chest X-rays were taken unless contraindicated. Knee and hip plus low back A-P X-rays were taken except on females age 49 or less. Copies enclosed are without interpretation - HES interpretations will be made later and used only as survey data.

Hematology - Screening limits *

Determination	Micro-hematocrit Vol. %	Cyanmet-hemoglobin Hgb Gm%	Coulter counter RBC/cc	Coulter counter WBC/cc
Adult Males	41 - 52	14.0 - 16.5	4.6 - 6.2 mill.	4.3 - 10 thou.
Adult Females	36 - 48	12.0 - 14.5	4.2 - 5.4 mill.	4.3 - 10 thou.
Pregnant Females	33 - 42	10.5 - 14.0	3.7 - 4.9 mill.	5.0 - 12 thou.

Urinalysis - Dip and read method using Ames Multistix.

Audiometry - Air conduction readings are reported in decibels with respect to audiometric zero (ISO - 1964), which is considered normal.

ROUGH GUIDELINES FOR dB REPORT AT 500 - 2000 cps.

- 25 dB or less - Hearing normal or more acute
- 30 - 40 dB - Near normal (difficulty with faint speech)
- 45 - 55 dB - Mild (difficulty with normal speech)
- 60 - 70 dB - Moderate (difficulty with loud speech)
- 75 - 100 dB - Severe (hears only amplified speech)
- 105 or more - Profound (usually cannot understand amplified speech)

Clinical Chemistry - Laboratory tests on blood are performed by a central laboratory. Results shown below, if any, are those received from the laboratory prior to the time this report was mailed. Additional results, if any, will be forwarded to you promptly when received.

BLOOD

Test	Result	Screening limits *	Test	Result	Screening limits *
Folate (S)	_____ mug%	5 - 30 mug%	T ₄	_____	3.0 - 7.5 mcg%
Vitamin C (P)	_____ mg%	0.2 - 4.0 mg%	Murph - Pattee Test (if in&at ed)	_____	5.0 - 14.5 mcg%
Cholesterol	_____ mg%	260 or less	Total bilirubin (S)	_____ mg%	0.2 - 1.0 mg%
BUN	_____ mg%	30 mg% or less	SGOT (S)	_____ units	10 - 40 units
Creatinine	_____ mg%	1.50 mg% or less	Alk. phos. (S)	_____ I.U.	30 - 80 I.U. (SMA)
Sodium	_____ mEq/l	135 - 155	Uric acid (S)	_____ mg%	2.5 - 7.0 mg%
Potassium	_____ mEq/l	3.5 - 5.0	Calcium (S)	_____ mg%	9.0 - 11.0 mg%
T ₃ Euthy.	_____	0.88 - 1.10	Phosphorous (SorP)	_____ mg%	2.5 - 4.8 mg%
Hypo.	_____	Over - 1.10			
Hyper.	_____	Less - 0.88			
			(P) = Plasma (S) = Serum		

* Results outside the screening limits are considered to warrant further investigation of the examinee.

HRA-12-22
(8-23-74)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION
NATIONAL CENTER FOR HEALTH STATISTICS

VISION TEST
HEALTH EXAMINATION SURVEY

ASSURANCE OF CONFIDENTIALITY - All information which would permit identification of the individual will be held strictly confidential, will only be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).

a. Deck No. 163	b. Name (Last, first, middle)	
c. Age _____	d. Sex 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	e. Sample No. _____
f. Examiner No. (Distance)	g. Name of Examiner (Distance)	
h. Examiner No. (Near)	i. Name of Examiner (Near)	

A. DISTANCE VISION

1. With or without correction **(099)** 1 Wears glasses for test 3 Forgot (glasses, contact lenses)
Mark (X) one → 2 Wears contact lenses for test 4 Does not wear either glasses or contact lenses

2. INSTRUCTION - Draw a diagonal line through each letter missed. Draw a horizontal line through sections of line not attempted and through top full line not attempted.

a. With correction				b. Without correction				c. With usual correction							
Both eyes				Both eyes				(1) Left eye - (Odd numbers first)				(2) Right eye - (Even numbers first)			
Chart	Line	Number of errors allowed	Score Mark (X) only one box	Chart	Line	Number of errors allowed	Score Mark (X) only one box	Chart	Line	Number of errors allowed	Score Mark (X) only one box	Chart	Line	Number of errors allowed	Score Mark (X) only one box
(a)	(b)	(c)	(d)	(a)	(b)	(c)	(d)	(a)	(b)	(c)	(d)	(a)	(b)	(c)	(d)
Big L			(100)	Big L			(101)	Big L			(102)	Big L			(103)
K	400	0	00 <input type="checkbox"/>	K	400	0	00 <input type="checkbox"/>	K	400	0	00 <input type="checkbox"/>	K	400	0	00 <input type="checkbox"/>
K	200	0	01 <input type="checkbox"/>	K	200	0	01 <input type="checkbox"/>	K	200	0	01 <input type="checkbox"/>	K	200	0	01 <input type="checkbox"/>
DV	160	0	02 <input type="checkbox"/>	DV	160	0	02 <input type="checkbox"/>	DV	160	0	02 <input type="checkbox"/>	DV	160	0	02 <input type="checkbox"/>
ZS	125	0	03 <input type="checkbox"/>	ZS	125	0	03 <input type="checkbox"/>	ZS	125	0	03 <input type="checkbox"/>	ZS	125	0	03 <input type="checkbox"/>
ORN -KH	100	2	04 <input type="checkbox"/>	ORN -KH	100	2	04 <input type="checkbox"/>	ORN -KH	100	2	04 <input type="checkbox"/>	ORN -KH	100	2	04 <input type="checkbox"/>
DV	80	0	05 <input type="checkbox"/>	DV	80	0	05 <input type="checkbox"/>	DV	80	0	05 <input type="checkbox"/>	DV	80	0	05 <input type="checkbox"/>
HVC	60	1	06 <input type="checkbox"/>	HVC	60	1	06 <input type="checkbox"/>	HVC	60	1	06 <input type="checkbox"/>	HVC	60	1	06 <input type="checkbox"/>
ZHVD	50	1	07 <input type="checkbox"/>	ZHVD	50	1	07 <input type="checkbox"/>	ZHVD	50	1	07 <input type="checkbox"/>	ZHVD	50	1	07 <input type="checkbox"/>
OCVR	40	1	08 <input type="checkbox"/>	OCVR	40	1	08 <input type="checkbox"/>	OCVR	40	1	08 <input type="checkbox"/>	OCVR	40	1	08 <input type="checkbox"/>
HOCRDS	30	2	09 <input type="checkbox"/>	HOCRDS	30	2	09 <input type="checkbox"/>	HOCRDS	30	2	09 <input type="checkbox"/>	HOCRDS	30	2	09 <input type="checkbox"/>
KDVRZCOS	25	2	10 <input type="checkbox"/>	KDVRZCOS	25	2	10 <input type="checkbox"/>	KDVRZCOS	25	2	10 <input type="checkbox"/>	KDVRZCOS	25	2	10 <input type="checkbox"/>
VRNHZDCSKO	20	3	11 <input type="checkbox"/>	VRNHZDCSKO	20	3	11 <input type="checkbox"/>	VRNHZDCSKO	20	3	11 <input type="checkbox"/>	VRNHZDCSKO	20	3	11 <input type="checkbox"/>
ZSVDKHNORC	16	3	12 <input type="checkbox"/>	ZSVDKHNORC	16	3	12 <input type="checkbox"/>	ZSVDKHNORC	16	3	12 <input type="checkbox"/>	ZSVDKHNORC	16	3	12 <input type="checkbox"/>

3. Test results: **(104)** 1 Test not done - Specify _____
Mark (X) one → 2 Test unsatisfactory - Specify _____

P. Vision Test

B. NEAR VISION

1. With or without correction:

- 1 Wears glasses for test 3 Forgot (glasses, contact lenses)
 2 Wears contact lenses for test 4 Does not wear either glasses or contact lenses

2. Test using Sloan reading cards (both eyes) - Put horizontal line through words read correctly.

Selection (a)	Attempted (b)	Distance (cm) (c)	Smallest selection read satisfactorily Mark (X) one (d)	Number wrong (e)
500	O ₁₀₆ 1 <input type="checkbox"/>	O ₁₀₇ _ _ _ _	O ₁₀₈ 1 <input type="checkbox"/>	O ₁₀₉ _ _ _ _
350	(110) 1 <input type="checkbox"/>	O ₁₁₁ _ _ _ _	O ₁₁₂ 1 <input type="checkbox"/>	O ₁₁₃ _ _ _ _
250	O ₁₁₄ 1 <input type="checkbox"/>	O ₁₁₅ _ _ _ _	O ₁₁₆ 1 <input type="checkbox"/>	O ₁₁₇ _ _ _ _
200	O ₁₁₈ 1 <input type="checkbox"/>	O ₁₁₉ _ _ _ _	O ₁₂₀ 1 <input type="checkbox"/>	O ₁₂₁ _ _ _ _
150	O ₁₂₂ 1 <input type="checkbox"/>	O ₁₂₃ _ _ _ _	O ₁₂₄ 1 r-1	O ₁₂₅ - - - -
125	O ₁₂₆ 1 <input type="checkbox"/>	O ₁₂₇ - - - -	O ₁₂₈ 1 <input type="checkbox"/>	O ₁₂₉ _ _ _ _
100	O ₁₃₀ 1 <input type="checkbox"/>	O ₁₃₁ _ _ _ _	O ₁₃₂ 1 <input type="checkbox"/>	O ₁₃₃ - - - -
75	(134) 1 <input type="checkbox"/>	O ₁₃₅ _ _ _ _	O ₁₃₆ 1 <input type="checkbox"/>	O ₁₃₇ _ _ _ _
50	(138) 138 1 <input type="checkbox"/>	O ₁₃₉ _ _ _ _	O ₁₄₀ 1 <input type="checkbox"/>	O ₁₄₁ _ _ _ _

3. Test using Keeney reading cards (both eyes) - Put horizontal line through words read correctly.

Selection (a)	Attempted (b)	Distance (cm) (c)	Smallest selection read satisfactorily Mark (X) one (d)	Number wrong (e)
130	O ₁₄₂ 1 <input type="checkbox"/>	O ₁₄₃ _ _ _ _	O ₁₄₄ 1 <input type="checkbox"/>	O ₁₄₅ _ _ _ _
120	O ₁₄₆ 1 <input type="checkbox"/>	O ₁₄₇ _ _ _ _	O ₁₄₈ 1 <input type="checkbox"/>	(149) 149 _ _ _ _
85	O ₁₅₀ 1 <input type="checkbox"/>	O ₁₅₁ _ _ _ _	O ₁₅₂ 1 <input type="checkbox"/>	O ₁₅₃ _ _ _ _
65	(154) 154 1 <input type="checkbox"/>	O ₁₅₅ _ _ _ _	O ₁₅₆ 1 <input type="checkbox"/>	O ₁₅₇ _ _ _ _
50	(158) 158 1 <input type="checkbox"/>	O ₁₅₉ _ _ _ _	O ₁₆₀ 1 <input type="checkbox"/>	O ₁₆₁ _ _ _ _
40	(162) 162 1 <input type="checkbox"/>	O ₁₆₃ _ _ _ _	O ₁₆₄ 1 <input type="checkbox"/>	O ₁₆₅ _ _ _ _
30	O ₁₆₆ 1 <input type="checkbox"/>	O ₁₆₇ _ _ _ _	O ₁₆₈ 1 <input type="checkbox"/>	O ₁₆₉ _ _ _ _
20	(170) 170 1 <input type="checkbox"/>	O ₁₇₁ _ _ _ _	(172) 1 <input type="checkbox"/>	O ₁₇₃ _ _ _ _

4. Conditions interfering with test:

- 1 Cannot read English 3 Difficulty speaking
 2 Cannot read 4 Other - Specify _____

C. NEAR VISION (FOR NON-ENGLISH OR ILLITERATES)

1 With or without correction:

175

1 Wears glasses for test

3 Forgot (glasses, contact lenses)

2 Wears contact lenses for test

4 Does not wear either glasses or contact lenses

2. Test using Sloan letters (both eyes)

Selection (a)	Distance (cm) (b)	Sloan letters (c)	Errors allowed (d)	Score Mark (X) one (e)
		<i>Draw a diagonal line through every letter missed. Draw a horizontal line through sections of line not attempted and through top full line not attempted.</i>		
500	1776	IT IS VY HT IN TE SN TY	4	177 1 <input type="checkbox"/>
350	178	CR TE TP WH CR CS AD BN	4	179 179 <input type="checkbox"/>
250	180	HE YU MD TE LR YU WE TO	4	181 181 <input type="checkbox"/>
200	182	OE IN LG WE AS GT TT HE	4	183 1 <input type="checkbox"/>
150	184	TE WR BU FS CR TS FR TT	4	185 1 <input type="checkbox"/>
125	186	TE FS AE ED TO CE FM TE	4	187 1 <input type="checkbox"/>
100	188	OE DY MY NR AD ME IF HD	4	189 1 <input type="checkbox"/>
75	190	VS TO FA CS GE AE ON AD	4	191 191 <input type="checkbox"/>
50	192	BW TS AE OF TO KS TE TT	4	193 193 <input type="checkbox"/>

3. Test using Keeney letters (both eyes)

Selection (a)	Distance (cm) (b)	Keeney letters (c)	Errors al lowed (d)	Score Murk (X) one (e)
		<i>Draw a diagonal line through every letter missed. Draw a horizontal line through sections of line not attempted and through top full line not attempted.</i>		
130	194	WN IN TE CE GF HN ES IT	4	195 1 <input type="checkbox"/>
120	196	OE PE TO DE TE PL BS WH	4	197 197 <input type="checkbox"/>
85	198	WH AR AD TO AE AG TE PS	4	199 199 <input type="checkbox"/>
60	200	WH TE LS OF NE AD OF NS	4	201 1 <input type="checkbox"/>
so	202	CS WH IL TM TO TE SN WE	4	203 1 <input type="checkbox"/>
40	204	RS TT AG TE AE LE LY AD	4	205 1 <input type="checkbox"/>
30	206	TT WR AY FO OF GT BS DE	4	207 1 <input type="checkbox"/>
20	208	ET TR SY AD HS PE ID WL	4	209 1 <input type="checkbox"/>

NAME _____

SAMPLE NUMBER _____

NEAR VISION TEST CARD

130 WHEN IN THE COURSE OF HUMAN EVENTS, IT BECOMES NECESSARY FOR
120 ONE PEOPLE TO DISSOLVE THE POLITICAL BANDS WHICH HAVE CONNECTED THEM
85 WITH ANOTHER, AND TO ASSUME AMONG THE POWERS OF THE EARTH, THE SEPARATE
AND EQUAL STATION TO
60 WHICH THE LAWS OF NATURE AND OF NATURE'S GOD ENTITLE THEM, A DECENT
RESPECT TO THE OPINIONS OF MANKIND REQUIRES THAT THEY SHOULD DECLARE THE
50 CAUSES WHICH IMPEL THEM TO THE SEPARATION. WE HOLD THESE TRUTHS TO BE
SELF-EVIDENT, THAT ALL MEN ARE CREATED EQUAL, THAT THEY ARE ENDOWED BY
THEIR CREATOR WITH CERTAIN UNALIENABLE
40 RIGHTS, THAT AMONG THESE ARE LIFE, LIBERTY, AND THE PURSUIT OF HAPPINESS.
THAT TO SECURE THESE RIGHTS, GOVERNMENTS ARE INSTITUTED AMONG MEN,
DERIVING THEIR JUST POWERS FROM THE CONSENT OF THE GOVERNED
30 THAT, WHENEVER ANY FORM OF GOVERNMENT BECOMES DESTRUCTIVE OF THESE ENDS,
IT IS THE RIGHT OF THE PEOPLE TO ALTER OR TO ABOLISH IT, AND TO
INSTITUTE NEW GOVERNMENT, LAYING ITS FOUNDATION ON SUCH PRINCIPLES AND
ORGANIZING ITS POWERS IN SUCH FORM, AS TO THEM SHALL SEEM MOST LIKELY TO
20 EFFECT THEIR SAFETY AND HAPPINESS. PRUDENCE INDEED, WILL DICTATE
THAT GOVERNMENTS LONG ESTABLISHED SHOULD NOT BE CHANGED FOR LIGHT AND
TRANSIENT CAUSES, AND ACCORDINGLY ALL EXPERIENCE HATH SHOWN, THAT
MANKIND ARE MORE DISPOSED TO SUFFER, WHILE EVILS ARE SUFFERABLE, THAN
TO RIGHT THEMSELVES BY ABOLISHING THE FORMS TO WHICH THEY ARE ACCUSTOMED.
BUT WHEN A LONG TRAIN OF ABUSES AND USURPATIONS

NAME _____

SAMPLE NUMBER _____

SLOAN NEAR VISION TEST CARD

500 IT IS VERY HOT IN THE SUN TODAY

350 COVER THE TOP WITH CRACKER CRUMBS AND BROWN IN A HOT OVEN.

250 HAVE YOU MAILED THE LETTER YOU WROTE TO YOUR NEPHEW? HE WILL EXPECT TO HEAR FROM YOU TOMORROW.

200 ONCE IN A LONG WHILE, AS A GREAT TREAT, HE TOOK ME DOWN TO HIS OFFICE. THIS COULD HAPPEN ONLY ON A SATURDAY MORNING WHEN THERE WAS NO SCHOOL.

150 THE WEATHER BUREAU FORECASTS COLDER TEMPERATURES FOR TONIGHT AND TOMORROW, WITH A WARMING TREND SETTING IN BY THURSDAY. LOW TEMPERATURES TONIGHT WILL BE IN THE LOW 30'S IN THIS AREA. TOMORROW'S HIGH WILL HIT ABOUT 37 DEGREES.

125 THE FUNDS ARE EXPECTED TO COME FROM THE SALE OF A TRACT OF LAND IN HERRING PARK. THE MONEY WILL NOT BECOME AVAILABLE UNTIL THE FIRST OF NEXT YEAR BUT OFFICIALS STATE THAT THEY CAN BEGIN ON SOME PARTS OF THE PROJECT AT ONCE.

100 ONE DAY MY NEIGHBOR ASKED ME IF I HAD MET THE WIDOW WHO HAD JUST MOVED INTO THE NEXT BLOCK. THAT NIGHT I HOBBLING DOWN THE STREET AND KNOCKED UPON HER DOOR. I EXPECTED TO FIND SOME SWEET, ALTHOUGH TOTTERING, LADY OF 80, BUT WHAT OPENED THE DOOR WAS THIS BLONDE. I PROPOSED TO HER IMMEDIATELY. SHE HAD A BETTER TELEVISION SET IN HER HOUSE THAN THE ONE I HAD IN MY COTTAGE.

75 VISITORS TO A FLORIDA CITRUS GROVE ARE OFTEN AMAZED TO SEE FULLY RIPE ORANGES BEING PICKED FROM A TREE WHICH IS ALSO FILLED WITH CLUSTERS OF FRAGRANT WHITE ORANGE BLOSSOMS--A GRAPHIC ILLUSTRATION OF THE TIME NATURE REQUIRES TO PRODUCE CITRUS FRUIT. UNLIKE MOST OTHER TYPES OF FRUIT, WHICH USUALLY NEED ONLY THREE TO FOUR MONTHS TO COMPLETE THEIR CYCLE FROM BLOSSOM TO MATURITY, CITRUS FRUITS REQUIRE TEN TO TWELVE MONTHS--AND THEY HAVE TO BE MONTHS OF SUNSHINE. THAT IS WHY A RELATIVELY SMALL SECTION, KNOWN AS THE "CITRUS BELT," WHICH EXTENDS ACROSS THE WAIST OF FLORIDA--AND WHERE THE SUN SHINES ALMOST EVERY DAY IN THE YEAR--PRODUCES NEARLY TWO-THIRDS OF ALL THE CITRUS FRUIT CONSUMED IN THE U.S.

50 BOWTIES ARE OF TWO KINDS, THOSE THAT ARE READY TIED AND THOSE THAT HAVE TO BE TIED. BOW TIES THAT HAVE TO BE TIED ARE PREFERRED, SINCE THE READY TIED ARE TOO PERFECT. IMPERFECTIONS IN THE TIE THAT HAS TO BE TIED SHOW THAT IT IS NOT MACHINE-MADE BUT HAND-WROUGHT. WHILE THE TIE THAT HAS TO BE TIED IS IMPERFECT IT SHOULD NOT BE TOO IMPERFECT. THAT IS TO SAY, ONE SIDE SHOULD NOT BE LONGER THAN THE OTHER SIDE, AND THE TIE SHOULD SIT HORIZONTALLY AND NOT AT AN ANGLE OF 45 DEGREES. TYING A BOW TIE DOES NOT COME NATURALLY.

HRA-12-23A
(7/74)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION
NATIONAL CENTER FOR HEALTH STATISTICS

ASSURANCE OF CONFIDENTIALITY
All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of this survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).

**SPEECH TEST
HEALTH EXAMINATION SURVEY**

a. Name (Last, first, middle)			b. Deck No. 242		INSTRUCTIONS Draw a horizontal line through all correct words. If after completing a list six or more words are missed, proceed to next list and increase decibel level by 10 until level 70 is reached. When 70 is reached go to Deck 243 (Blue paper).			
c. Sample No.	d. Segment No.	e. Serial No.	f. Column No.					
g. List No. 01	h. Decibels - Mark (X) one 102 1 <input type="checkbox"/> 20 3 <input type="checkbox"/> 40 5 <input type="checkbox"/> 60 2 <input type="checkbox"/> 30 4 <input type="checkbox"/> 50		i. Ear tested 103 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left		j. List No. 02	k. Decibels - Mark (X) one 116 1 <input type="checkbox"/> 20 3 <input type="checkbox"/> 40 5 <input type="checkbox"/> 60 2 <input type="checkbox"/> 30 4 <input type="checkbox"/> 50		l. Ear tested 117 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left
104 * 1 2 3 4	1. WALKING'S MY FAVORITE EXERCISE.		118 * 1 2 3 4		1. the WATER'S TOO COLD for SWIMMING.			
105 * 1 2 3 4	2. HERE'S a NICE QUIET PLACE to REST.		119 * 1 2 3 4 5 6		2. WHY SHOULD I GET up SO EARLY?			
106 * 1 2 3 4 5 6	3. OUR JANITOR SWEEPS the FLOORS EVERY NIGHT.		120 * 1 2 3 4 5		3. SHINE YOUR own SHOES THIS TIME.			
107 * 1 2 3 4 5 6	4. it WOULD be MUCH EASIER IF EVERYONE would HELP.		121 * 1 2 3 4		4. IT'S RAINING right HERE in the ROOM.			
108 * 1 2 3 4 5	5. WE say GOOD MORNING and BEGIN to WORK.		122 * 1 2 3 4		5. WHERE ARE you GOING this MORNING?			
109 * 1 2 3 4 5	6. OPEN the WINDOW BEFORE you GO to BED.		123 * 1 2 3 4 5 6		6. YOU SHOULD COME HERE WHEN I CALL.			
110 * 1 2 3 4 5 6	7. DO you THINK SHE SHOULD STAY HERE?		124 * 1 2 3 4 5 6		7. DO you TRY to GET OUT OF IT.			
111 * 1 2 3 4	8. HOW DO you FEEL about CHANGING?		125 * 1 2 3 4 5 6		8. WE LET LITTLE CHILDREN GO to the MOVIES.			
112 * 1 2 3 4	9. WHEN the TIME comes WE will GO.		126 * 1 2 3 4 5		9. THERE ISN'T ENOUGH PAINT to FINISH.			
113 * 1 2 3 4 5	10. IT'S too LATE to MOVE OUT of the WAY.		127 * 1 2 3 4		10. DO you WANT EGGS for BREAKFAST?			
RECORDER: Mark (X) only if this is the final level given.			Enter number of words missed →		RECORDER: Mark (X) only if this is the final level given.			Enter number of words missed →
114 1 <input type="checkbox"/>					128 <input type="checkbox"/>			

Q. Speech Test (20-60 decibels)

m. List No. (129) 03	n. Decibels - Mark (X) one (130) 1 <input type="checkbox"/> 20 3 <input type="checkbox"/> 40 s <input type="checkbox"/> 60 2 <input type="checkbox"/> 30 4 <input type="checkbox"/> 50	o. Ear tested (131) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left	p. List No. (143) 04	q. Decibels - Mark (X) one (144) 1 <input type="checkbox"/> 20 3 <input type="checkbox"/> 40 s <input type="checkbox"/> 60 2 <input type="checkbox"/> 30 4 <input type="checkbox"/> 50	r. Ear tested (145) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left		
(132) -	1 2 3 4		(146) *	1 2 3 4			
1. EVERYBODY should BRUSH TEETH BEFORE MEALS.			1. IF you WAIT to GO IT'S all right.				
(133) -	1 2 3 4		(147) *	1 2 3 4 5 6			
2. ONCE a YEAR EVERYTHING'S all RIGHT.			2. THROW THESE OLD TIME MAGAZINES OUT.				
(134) -	1 2 3 4 5 6		(148) *	1 2 3 4 5			
3. DON'T USE UP ALL the LETTER PAPER.			3. DO you WANT to WASH UP in the STREAM?				
(135) -	1 2 3 4 5 6		(149) *	1 2 3 4 5 6			
4. ANYTHING like THAT'S all RIGHT with me.			4. it's a REAL DARK NIGHT SO WATCH your DRIVING.				
(136) -	1 2 3 4 5 6		(150) *	1 2 3 4 5			
5. THOSE PEOPLE OUTSIDE OUGHT to SEE a DOCTOR.			5. I'LL CARRY YOUR PACKAGE for YOU.				
(137) -	1 2 3 4 5 6		(151) *	1 2 3 4 5 6			
6. the WINDOWS are SO DIRTY this MONTH i CAN'T see.			6. DON'T YOU FORGET to SHUT OFF the WATER.				
(138) +	1 2 3 4 5		(152) *	1 2 3 4 5			
7. PLEASE PASS the BREAD and BUTTER FIRST.			7. MOUNTAIN FISHING is my IDEA of a GOOD TIME.				
(139) -	1 2 3 4 5 6		(153) *	1 2 3 4 5			
8. DON'T FORGET to WRITE and PAY YOUR BILL.			8. FATHERS USED to SPEND more TIME with their CHILDREN.				
(140) -	1 2 3 4 5		(154) *	1 2 3 4 5			
9. DON'T LET the DOG OUT of the HOUSE.			9. BE CAREFUL NOT to BREAK the GLASSES.				
(141) -	1 2 3 4		(155) *	1 2 3			
10. THERE'S a GOOD BALLGAME this AFTERNOON.			10. I'M SORRIER THAN you for the mistake.				
RECORDER: (142) <input type="checkbox"/> ← <i>Mark (X) only if this is the final level given.</i>			Enter number of words missed →	RECORDER: (156) <input type="checkbox"/> ← <i>Mark (X) only if this is the final level given.</i>			Enter number of words missed →

s. List No.	t. Decibels - Mark (X) one	u. Ear tested	v. List No.	w. Decibels - Mark (X) one	x. Ear tested
(157) 05	(158) 1 <input type="checkbox"/> 20 3 <input type="checkbox"/> 40 5 <input type="checkbox"/> 60 2 <input type="checkbox"/> 30 4 <input type="checkbox"/> 50	(159) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left	(171) 06	(172) 1 <input type="checkbox"/> 20 3 <input type="checkbox"/> 40 5 <input type="checkbox"/> 60 2 <input type="checkbox"/> 30 4 <input type="checkbox"/> 50	(173) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left
(160) * 1 2 3 4 5 6 1. YOU CAN CATCH the BUS ACROSS the STREET.	(174) * 1 2 3 4 5 6 1. MUSIC ALWAYS MAKES me ω EER U:				
(161) * 1 2 3 4 5 6 2. TELL HER the NEWS on the PHONE.	(175) * 1 2 3 4 5 6 2. my BROTHER'S in TOWN for a SHORT WHILE.				
(162) * 1 2 3 4 5 6 3. I'LL CATCH UP with YOU LATER.	(176) * 1 2 3 4 5 6 3. WE 'VE a FEW MILES off the MAIN ROAD.				
(163) * 1 2 3 4 5 6 4. I'LL THINK it OVER AND CALL HER.	(177) * 1 2 3 4 5 6 4. THIS SUIT NEEDS to GO to the CLEANERS.				
(164) * 1 2 3 4 5 6 5. I DON'T WANT to GO to the MOVIES.	(178) * 1 2 3 4 5 6 5. THEY ATE ENOUGH GREEN APPLES.				
(165) * 1 2 3 4 5 6 6. SEE a DENTIST IF YOUR TOOTH HURTS.	(179) * 1 2 3 4 5 6 6. have YOU BEEN SICK ALL THIS WEEK?				
(166) * 1 2 3 4 5 6 7. PUT THAT COOKI≅ BACK in the BOX.	(180) * 1 2 3 4 5 6 7. WHERE HAV≅ YOU been WORKING LATELY?				
(167) * 1 2 3 4 5 6 8. you OUGHT to STOP FOOLING AROUND s∞ MUCH.	(181) * 1 2 3 4 5 6 8. there's NOT ENOUω TABLE ROOM in the KITω ≅~?				
(168) * 1 2 3 4 5 6 9. TONIGHT THAT extra TIME'S U:	(182) * 1 2 3 4 5 6 9. it's 'ARD to see WHERE '≅ IS.				
(169) * 1 2 3 4 5 6 10. HOW do you SPELL YOUR NAME?	(183) * 1 2 3 4 5 6 10. LOOK OUT FOR NEW BUSINESS.				
RECORDER: (170) 1 Mark (X) only if this is the final level given.	Enter number of words missed →	RECORDER: (184) 1 <input type="checkbox"/> ← final level given.	Enter number of words missed →		

y. List No.	z. Decibels - Mark (X) one	aa. Ear tested	bb. List No.	cc. Decibels - Mark (X) one	dd. Ear tested
185 07	186 1 <input type="checkbox"/> 20 3 <input type="checkbox"/> 40 5 <input type="checkbox"/> 60 2 <input type="checkbox"/> 30 4 <input type="checkbox"/> 50	187 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left	199 08	200 1 <input type="checkbox"/> 20 3 <input type="checkbox"/> 40 5 <input type="checkbox"/> 60 2 <input type="checkbox"/> 30 4 <input type="checkbox"/> 50	201 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left
188* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 1. I'LL SEE YOU RIGHT AFTER LUNCH.			202* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 1. BELIEVE ME it's TOO LATE.		
189* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 2. I'LL SEE YOU LATER this AFTERNOON.			203* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 2. LET'S GET THAT CUP of COFFEE.		
190* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 3. WHITE SHOES are AWFUL to KEEP CLEAN.			204* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 3. LET'S get OUT of HERE BEFORE long.		
191* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 4. YOU STAND OVER THERE UNTIL I MOVE.			205* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 4. I HATE DRIVING IF IT'S at NIGHT.		
192* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 5. THERE'S a PIECE of CAKE LEFT for DINNER TONIGHT.			206* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 5. THERE WAS WATER in the CELLAR YESTERDAY.		
193* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 6. DON'T WAIT for ME AT the FRONT CORNER.			207* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 6. SHE'LL ONLY be GONE a FEW MINUTES.		
194* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 7. IT'S NO TROUBLE at ALL to TELL.			208* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 7. HOW do YOU KNOW WE'LL HAVE it SOON?		
195* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 8. HURRY UP with the MORNING PAPER.			209* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 8. CHILDREN LIKE CANDY AFTER HEAVY meals.		
196* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 9. it DIDN'T SAY ANYTHING about a BIG RAIN.			210* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 9. NO GRASS grows when we DON'T GET RAIN.		
197* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 10. that DRUGSTORE PHONE CALL'S for YOU.			211* <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 10. THEY'RE NOT LISTED in the NEW PHONE BOOK.		
RECORDER: 198 1 <input type="checkbox"/> ← <i>Mark (X) only if this is the final level given.</i>	Enter number of words missed →		RECORDER: 212 1 <input type="checkbox"/> ← <i>Mark (X) only if this is the final level given.</i>	Enter number of words missed →	

ee. List No. (213) 09	ff. Decibels - Mark (X) one (214) 1 <input type="checkbox"/> 20 3 <input type="checkbox"/> 40 5 <input type="checkbox"/> 60 2 <input type="checkbox"/> 30 4 <input type="checkbox"/> 50	gg. Ear tested (215) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left	hh. List No. (227) 10	ii. Decibels - Mark (X) one (228) 1 <input type="checkbox"/> 20 3 <input type="checkbox"/> 40 5 <input type="checkbox"/> 60 2 <input type="checkbox"/> 30 4 <input type="checkbox"/> 50	jj. Ear tested (229) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left
(216)* 1. WHERE CAN I FIND a PLACE to PARK?			(230)* 1. BUT we WON'T be READY to START.		
(217)* 2. I LIKE THOSE BIG RED APPLES.			(231)* 2. I DON'T KNOW what's WRONG WITH the CAR.		
(218)* 3. YOU'LL get FAT by EATING CANDY.			(232)* 3. It SURE TAKES a SHARP KNIFE to CUT MEAT.		
(219)* 4. the COLOR SHOWS OVER in the FALL.			(233)* 4. I HAVEN'T READ a NEWS PAPER SINCE we got TELEVISION.		
(220)* 5. WHY DON'T they PAINT THEIR OTHER WALLS?			(234)* 5. the WEEDS ARE SPOILING THIS YARD.		
(221)* 6. HOW COME you ALWAYS GET to GO FIRST?			(235)* 6. CALL ME a LITTLE LATER for BREAKFAST.		
(222)* 7. WHAT ARE you HIDING UNDER your COAT?			(236)* 7. DO you HAVE CHANGE for a FIVE-DOLLAR BILL?		
(223)* 8. I SHOULD ALWAYS buy NEW cars.			(237)* 8. HOW ARE the things WE BOUGHT?		
(224)* 9. WHAT'S wrong with SUGAR and CREAM in my COFFEE?			(238)* 9. I'D LIKE SOME ICE cream WITH MY PIE.		
(225)* 10. I'LL WAIT JUST ONE MINUTE.			(239)* 10. I DON'T THINK I'LL HAVE DESSERT.		
RECORDER: (226) 1 <input type="checkbox"/> ← Mark (X) only if this is the final level given.	Enter number of words missed →		RECORDER: (240) 1 <input type="checkbox"/> ← Mark (X) only if this is the final level given.	Enter number of words missed →	

HRA-12-238 7-741		DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH RESOURCES ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS		ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).	
a. Name (Last, first, middle)			b. Deck No. 243		INSTRUCTIONS Draw a horizontal line through all correct words. If after completing a list six or more words are missed, proceed to next list and increase decibel level by 10 until level 80 is reached. After 80 is complete (END TEST).
c. Sample No.		d. Segment No.	e. Serial No.	f. Column No.	
g. List No. (301) 01	h. Decibels - mark (X) one (302) 1 <input type="checkbox"/> 70 2 <input type="checkbox"/> 80	i. Ear tested (303) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left	j. List No. (315) 02	k. Decibels - mark (X) one (316) 1 <input type="checkbox"/> 70 2 <input type="checkbox"/> 80	l. Ear tested (317) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left
(304)* 1 2 3 4 5 6 7 8 9 10 1. WALKING'S MY FAVORITE EXERCISE.			(318)* 1 2 3 4 5 6 7 8 9 10 1. the WATER'S TOO COLD for SWIMMING.		
(305)* 1 2 3 4 5 6 7 8 9 10 2. THERE'S a NICE QUIET PLACE to REST.			(319)* 1 2 3 4 5 6 7 8 9 10 2. WHY SHOULD I GET up SO EARLY?		
(306)* 1 2 3 4 5 6 7 8 9 10 3. OUR JANITOR SWEEPS the FLOORS EVERY NIG T.			(320)* 1 2 3 4 5 6 7 8 9 10 3. SHINE YOUR own SHOES THIS TIME.		
(307)* 1 2 3 4 5 6 7 8 9 10 4. It WOULD be MUCH EASER IF EVERYONE would HELP.			(321)* 1 2 3 4 5 6 7 8 9 10 4. IT'S RAINING right HERE in the ROOM.		
(308)* 1 2 3 4 5 6 7 8 9 10 5. WE say GOOD MORNING and BEGIN to WORK.			(322)* 1 2 3 4 5 6 7 8 9 10 5. WHERE ARE you GOING this MORNING?		
(309)* 1 2 3 4 5 6 7 8 9 10 6. OPEN the WINDOW BEFORE you GO to BED.			(323)* 1 2 3 4 5 6 7 8 9 10 6. YOU SHOULD COME HERE WHEN i CALL.		
(310)* 1 2 3 4 5 6 7 8 9 10 7. DO you THINK SHE SHOULD STAY HERE?			(324)* 1 2 3 4 5 6 7 8 9 10 7. DON'T TRY to GET OUT OF IT.		
(311)* 1 2 3 4 5 6 7 8 9 10 8. HOW DO you FEEL about CHANGING?			(325)* 1 2 3 4 5 6 7 8 9 10 8. WE LET LITTLE CHILDREN GO to the MOVIES		
(312)* 1 2 3 4 5 6 7 8 9 10 9. WHEN the TIME comes WE will GO.			(326)* 1 2 3 4 5 6 7 8 9 10 9. THERE ISN'T ENOUGH PAINT to FINISH.		
(313)* 1 2 3 4 5 6 7 8 9 10 10. IT'S too LATE to MOVE OUT of the WAY.			(327)* 1 2 3 4 5 6 7 8 9 10 10. DO you WANT EGGS for BREAKFAST?		
RECORDER (314) 1 <input type="checkbox"/> ← final level given.		Enter number of words missed →		RECORDER: (328) 1 <input type="checkbox"/> ← final level given.	
				Enter number of words missed →	

R. Speech Test (70-80 decibels)

m. List No. (329) 03	n. Decibels - Mark (X) one 1 <input type="checkbox"/> 70 2 <input type="checkbox"/> 80	o. Ear tested 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left	p. List No. (343) 04	q. Decibels - Mark (X) one 1 <input type="checkbox"/> 70 2 <input type="checkbox"/> 80	r. Ear tested (345) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left
(332) * 1 2 3 4 5 1. EVERYBODY should BRUSH TEETH BEFORE MEALS.	1 2 3 4 5	1 2 3 4 5	(346) * 1 2 3 4 5 6 1. IF you WANT to GO IT'S all right.	1 2 3 4 5 6	1 2 3 4 5 6
(333) * 1 2 3 4 5 6 2. ONCE a YEAR EVERYTHING'S all RIGHT.	1 2 3 4 5 6	1 2 3 4 5 6	(347) * 1 2 3 4 5 6 2. THROW THESE OLD TIME MAGAZINES OUT.	1 2 3 4 5 6	1 2 3 4 5 6
(334) * 1 2 3 4 5 6 3. DON'T USE UP ALL the LETTER PAPER.	1 2 3 4 5 6	1 2 3 4 5 6	(348) * 1 2 3 4 5 6 3. DO you WANT to WASH UP in the STREAM?	1 2 3 4 5 6	1 2 3 4 5 6
(335) * 1 2 3 4 5 6 4. ANYTHING like THAT'S all RIGHT with me.	1 2 3 4 5 6	1 2 3 4 5 6	(349) * 1 2 3 4 5 6 4. it's a REAL DARK NIGHT SO WATCH your DRIVING.	1 2 3 4 5 6	1 2 3 4 5 6
(336) * 1 2 3 4 5 6 5. THOSE PEOPLE OUTSIDE OUGHT to SEE a DOCTOR.	1 2 3 4 5 6	1 2 3 4 5 6	(350) * 1 2 3 4 5 6 5. I'LL CARRY YOUR PACKAGE for YOU.	1 2 3 4 5 6	1 2 3 4 5 6
(337) * 1 2 3 4 5 6 6. the WINDOWS are SO DIRTY this MONTH I CAN'T see.	1 2 3 4 5 6	1 2 3 4 5 6	(351) * 1 2 3 4 5 6 6. DON'T YOU FORGET to SHUT OFF the WATER.	1 2 3 4 5 6	1 2 3 4 5 6
(338) * 1 2 3 4 5 6 7. PLEASE PASS the BREAD and BUTTER FIRST.	1 2 3 4 5 6	1 2 3 4 5 6	(352) * 1 2 3 4 5 6 7. MOUNTAIN FISHING is my IDEA of a GOOD TIME.	1 2 3 4 5 6	1 2 3 4 5 6
(339) * 1 2 3 4 5 6 8. DON'T FORGET to WRITE and RY YOUR BILL.	1 2 3 4 5 6	1 2 3 4 5 6	(353) * 1 2 3 4 5 6 8. FATHERS USED to SPEND more TIME with their CHILDREN.	1 2 3 4 5 6	1 2 3 4 5 6
(340) * 1 2 3 4 5 6 9. DON'T LET the DOG OUT of th HOUSE.	1 2 3 4 5 6	1 2 3 4 5 6	(354) * 1 2 3 4 5 6 9. BE CAREFUL NOT to BREAK the GLASSES.	1 2 3 4 5 6	1 2 3 4 5 6
(341) * 1 2 3 4 5 6 10. THERE'S a GOOD BALLGAME thi AFTERNOON.	1 2 3 4 5 6	1 2 3 4 5 6	(355) * 1 2 3 4 5 6 10. I'M SORRIER THAN you for the mistake.	1 2 3 4 5 6	1 2 3 4 5 6
RECORDER: (342) 1 <input type="checkbox"/> ← <i>Mark (X) only if this is the final level given.</i>	Enter number of words missed →		RECORDER: (356) 1 <input type="checkbox"/> ← <i>Mark (X) only if this is the final level given.</i>	Enter number of words missed →	

s. List No.	t. Decibels - Mark (X) one	u. Ear tested	v. List No.	w. Decibels - Mark (X) one	x. Ear tested
(357) 05	(358) 1 <input type="checkbox"/> 70 2 <input type="checkbox"/> 80	(359) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left	(371) 06	(372) 1 <input type="checkbox"/> 70 2 <input type="checkbox"/> 80	(373) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left
(360)*	1 2 3 4 5 6		(374)*	1 2 3 4 5	
1. YOU CAN CATCH the BUS ACROSS the STREET.			1. MUSIC ALWA ^y MAKES me CHEER UP.		
(361)*	1 2 3 4		(375)*	1 2 3 4	
2. TELL HER th ^e NEWS on the PHONE.			2. my BROTHER'S in TOWN for a SHCRT WHILE.		
(362)*	1 2 3 4 5		(376)*	1 2 3 4 5 6	
3. I'LL CATCH UP with YOU LATER.			3. WE LIVE a FEW MILES off the MAIN ROAD.		
(363)*	1 2 3 4 5 6		(377)*	1 2 3 4 5 6	
4. I'LL THINK it OVER AND CALL HER.			4. THIS SUIT NEEDS to GO to the CLEANERS.		
(364)*	1 2 3 4 5		(378)*	1 2 3 4 5 6	
5. I DON'T WANT to GO to the MOVIES.			5. THEY ATE ENOUGH GREEN APPLES.		
(365)*	1 2 3 4 5 6		(379)*	1 2 3 4 5 6	
6. SEE a DENTIST IF YOUR TOOTH HURTS.			6. have YOU BEEN SICK ALL THIS WEEK?		
(366)*	1 2 3 4 5		(380)*	1 2 3 4 5	
7. PUT THAT COOKIE BACK in the BOX.			7. WHERE HAVE YOU been WORKNG LATELY?		
(367)*	1 2 3 4 5		(381)*	1 2 3 4 5	
8. you OUGHT to STOP FOOLING AROUND so MUCH.			8. there's NOT ENOUGH TABLE ROOM in the KITCHEN.		
(368)*	1 2 3 4		(382)*	1 2 3 4	
9. TONIGHT THAT extra TIME'S UP.			9. it's HARD to see WHERE HE IS.		
(369)*	1 2 3 4		(383)*	1 2 3 4	
10. HOW do you SPELL YOUR NAME?			10. LOOK OUT FOR NEW BUSINESS.		
RECORDER:			RECORDER:		
(370) 1 <input type="checkbox"/> ←	Mark (X) only if this is the final level given.	Enter number of words missed →	(384) 1 <input type="checkbox"/> ←	Mark (X) only if this is the final level given.	Enter number of words missed →

y. List No. 07	z. Decibels - Mark (X) one 386 1 <input type="checkbox"/> 70 2 <input type="checkbox"/> 80	aa. Ear tested 387 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left	bb. List No. 08	cc. Decibels - Mark (X) one 400 1 <input type="checkbox"/> 70 2 <input type="checkbox"/> 80	dd. Ear tested 401 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left
385 *	1. i'll SEE YOU RIGHT AFTER LUNCH.		399 *	1. BELIEVE ME it's TOO LATE.	
389 *	2. i'll SEE YOU LATER this AFTERNOON.		403 *	2. LET'S GET THAT CUP of COFFEE.	
390 *	3. WHITE SH=ES ar= AWFUL to KEEP CLEAN.		404 *	3. LET'S get OUT of HERE BEFORE long.	
391 *	4. YOU STAND OVER THERE UNTIL I MOVE.		405 *	4. i HATE DRIVING IF IT'S at NIGHT.	
392 *	5. THERE'S a PIECE of CAKE LEFT for DINNER TONIGHT.		406 *	5. THERE WAS WATER in the CELLAR YESTERDAY.	
393 *	6. DON'T WAIT for ME AT the FRONT CORNER.		407 *	6. SHE'LL ONLY be GONE a FEW MINUTES.	
394 *	7. IT'S NO TROUBLE at ALL to TELL.		408 *	7. HOW do YOU KNOW WE'LL HAVE it SOON?	
395 *	8. HURRY UP with the MORNING PAPER.		409 *	8. CHILDREN LIKE CANDY AFTER HEAVY meals.	
396 *	9. it DIDN'T SAY ANYTHING about a BIG RAIN.		410 *	9. NO GRASS grows when we DON'T GET RAIN.	
397 *	10. that DRUGSTORE PH=NE CALL'S for YOU.		411 *	10. THEY'RE NOT LISTED in the NEW PH=NE BO=K.	
RECORDER: 398 1 <input type="checkbox"/> ← <i>Mark (X) only if this is the final level given.</i>		Enter number of words missed →	RECORDER: 412 1 <input type="checkbox"/> ← <i>Mark (X) only if this is the final level given.</i>		Enter number of words missed →

ee. List No. (413) 09	ff. Decibels - Mark (X) one (414) 1 <input type="checkbox"/> 70 2 <input type="checkbox"/> 80	gg. Ear tested (415) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left	hh. List No. (427) 10	ii. Decibels - Mark (X) one (428) 1 <input type="checkbox"/> 70 2 <input type="checkbox"/> 80	jj. Ear tested (429) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left
(416)* 1 2 3 4 5 6 1. WHERE CAN I FIND a PLACE to PARK?			(430)* 1 2 3 4 5 6 1. BUT we WON'T b ^e READY to START.		
(417)* 1 2 3 4 5 6 2. I LIKE THOSE BIG RED APPLES.			(431)* 1 2 3 4 5 2. I DON'T KNOW what's WRONG WITH the CAR.		
(418)* 1 2 3 4 3. YOU'LL get FAT by EATING CANDY.			(432)* 1 2 3 4 5 6 3. it SURE TAKES a SH ^o RP KNIFE t ^o CUT MEAT.		
(419)* 1 2 3 4 4. the COLOR SHOW'S OVER in the FALL.			(433)* 1 2 3 4 5 4. I HAVEN'T READ a NEWSPAPER SINCE we got TELEVISION.		
(420)* 1 2 3 4 5 6 5. WHY DON'T they PAINT THEIR OTHER WALLS?			(434)* 1 2 3 4 5 5. the WEEDS ARE SPOILING THIS YARD.		
(421)* 1 2 3 4 5 6 6. HOW COME you ALWAYS GET to GO FIRST?			(435)* 1 2 3 4 5 6. C ^o LL ME a LI ^t TLE LATER f ^o r BREAKFAST.		
(422)* 1 2 3 4 5 7. WHAT ARE you HIDING UNDER your COAT?			(436)* 1 2 3 4 5 7. D ^o you H ^o AVE C ^h ANGE f ^o r a ^o VE ⁿ OL ^d R BIL ^l ?		
(423)* 1 2 3 4 5 6 8. I SHOULD ALWAYS buy NEW cars.			(437)* 1 2 3 4 8. HOW ARE the things WE BOUGHT?		
(424)* 1 2 3 4 9. WHAT'S wrong with SUGAR and CREAM in my COFFEE?			(438)* 1 2 3 4 5 6 9. I'd LIKE SOME ICE cr ^e am WITH MY PIE.		
(425)* 1 2 3 4 5 10. I'LL WAIT JUST ONE MINUTE.			(439)* 1 2 3 4 5 10. I DON'T THINK I'LL HAVE DESSERT.		
RECORDER: (426) 1 <input type="checkbox"/> ← final level given.	Enter number of words missed →		RECORDER: (440) 1 <input type="checkbox"/> ← final level given.	Enter number of words missed →	

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