

Appendix III

Bradenton, Florida,

Supplement on Aging

Pretest Questionnaire

OMB No. 0937-0H2 Approval Expires September 30, 1983

<p>FORM HIS-1(SA)X (1983) (3 10 83)</p> <p style="text-align: center;">U. S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR THE U. S. PUBLIC HEALTH SERVICE</p> <p style="text-align: center;">SUPPLEMENT ON AGING NATIONAL HEALTH INTERVIEW SURVEY</p>	<p>NOTICE: Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; padding: 2px;">1. <input type="text"/> Book <input type="text"/> of <input type="text"/> books</td> <td style="width:33%; padding: 2px;">2. R.O. Number <input type="text"/></td> <td style="width:33%; padding: 2px;">3. Sample <input type="text"/></td> </tr> <tr> <td style="padding: 2px;">4. Control number <input type="text"/> PSU</td> <td style="padding: 2px;">Segment <input type="text"/></td> <td style="padding: 2px;">Serial <input type="text"/></td> </tr> <tr> <td colspan="3" style="padding: 2px;">5. Sample Person Name <input type="text"/></td> </tr> <tr> <td colspan="2" style="padding: 2px;">Age <input type="text"/></td> <td style="padding: 2px;">Person No. <input type="text"/></td> </tr> </table>	1. <input type="text"/> Book <input type="text"/> of <input type="text"/> books	2. R.O. Number <input type="text"/>	3. Sample <input type="text"/>	4. Control number <input type="text"/> PSU	Segment <input type="text"/>	Serial <input type="text"/>	5. Sample Person Name <input type="text"/>			Age <input type="text"/>		Person No. <input type="text"/>																																
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<p>6. Interviewer identification</p> <p>Name <input type="text"/> Code <input type="text"/></p>	<p>9. Length of interview</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">Time began <input type="text"/></td> <td style="width:33%;">Time ended <input type="text"/></td> <td style="width:33%;">Number of minutes <input type="text"/></td> </tr> <tr> <td style="text-align: center;">a.m. p.m.</td> <td style="text-align: center;">a.m. p.m.</td> <td></td> </tr> </table>	Time began <input type="text"/>	Time ended <input type="text"/>	Number of minutes <input type="text"/>	a.m. p.m.	a.m. p.m.																																							
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a.m. p.m.	a.m. p.m.																																												
<p>7. Type of interview</p> <p>1 <input type="checkbox"/> Self-personal } (9) 2 <input type="checkbox"/> Self-telephone } 3 <input type="checkbox"/> Proxy-personal 4 <input type="checkbox"/> Proxy-telephone</p>	<p>10. Reason for supplement noninterview — Mark box, describe situation below</p> <p>1 <input type="checkbox"/> Refused</p> <p>2 <input type="checkbox"/> Sample person temporarily absent and no proxy available</p> <p>3 <input type="checkbox"/> Sample person incapable and no proxy available</p> <p>4 <input type="checkbox"/> Other (Specify) _____</p> <p>Describe situation — _____</p> <p>_____</p> <p>_____</p>																																												
<p>8. Proxy information — Fill for all proxy interviews</p> <p>a. Name/relationship to sample person</p> <p>_____</p> <p>b. Reason for proxy interview</p> <p>_____</p>																																													
SUPPLEMENT ON AGING SAMPLE SELECTION																																													
<p>1 <input type="checkbox"/> Sample selection completed on previous booklet</p> <p>11. Are there any nondeleted persons 65 years old or older in the family?</p>	<p>1 <input type="checkbox"/> Yes (Mark "SP" box on HIS-1 for each, THEN 12)</p> <p>2 <input type="checkbox"/> No</p>																																												
<p>12. Are there any nondeleted persons 55—64 years old in the family?</p>	<p>1 <input type="checkbox"/> Yes (13)</p> <p>2 <input type="checkbox"/> No (Begin supplement interview(s) if any family members 65 or older, otherwise end interview.)</p>																																												
<p>13. List by age (youngest to oldest) each nondeleted family member 55—64 years of age. Then mark the "SP" box on the HIS-1 for each listed person with an "X" in the sample person column and begin supplement interview(s).</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;">Age</th> <th style="width:60%;">Name</th> <th style="width:10%;">Person number</th> <th style="width:20%;">Sample person</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">X</td></tr> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">X</td></tr> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">X</td></tr> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">X</td></tr> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">X</td></tr> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">X</td></tr> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">X</td></tr> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">X</td></tr> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">X</td></tr> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">X</td></tr> </tbody> </table>	Age	Name	Person number	Sample person				X				X				X				X				X				X				X				X				X				X
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Section M. FAMILY STRUCTURE, RELATIONSHIPS, SUPPORT, AND LIVING ARRANGEMENTS

Read to respondent – We are interested in obtaining further information about the health of people 55 years of age and older in the United States. I will ask you some (additional) questions about your family, social activities, any health problems you may have and how you deal with them. First I'd like to ask about your family.

Ask or verify for each HH member		Person No. on HIS-1	Age on HIS-1	Relationship to Sample Person
1. How is (name on HIS-1) related to you?				
Enter "Sample Person" on appropriate line.		1		
Enter "Unrelated" for persons not related to the sample person.		2		
Enter "Deleted" for any deleted persons, except AF members living at home and babies born during interview week.		3		
Enter ages from HIS-1.		4		
		5		
		6		
		7		
		8		
		9		
		10		

M1	Refer to marital status (page 46) on HIS-1	<input type="checkbox"/> Sample person is now married (2a)
		<input type="checkbox"/> Sample person is now widowed, divorced, separated (2b)
		<input type="checkbox"/> Sample person has never been married (4)

2a. Earlier [you told me/I was told] that you are now married. How long have you been married (to (name of spouse))?	<input type="checkbox"/> Less than one year _____ Number of years } (3)
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b. Earlier [you told me/I was told] that you are now [widowed/divorced/separated]. How long have you been [widowed/divorced/separated]?	<input type="checkbox"/> Less than one year _____ Number of years
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Mark box if S.P. has children 18+ in HH. 3a. Do you have any living children 18 years old or older? Include stepchildren and adopted children.	<input type="checkbox"/> Sample person has children 18+ in HH <input type="checkbox"/> Yes <input type="checkbox"/> No (4)
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b. How many of your children 18 years old or older are sons and how many are daughters? (Include stepchildren and adopted children.)	_____ Number of sons 18+ _____ Number of daughters 18+ <input type="text"/> Total number of children 18+ <i>Verify total with respondent</i>
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Skip to 3e if no sons 18+, otherwise mark box or ask c. [How many of your sons are/Is your son] now married?	<input type="checkbox"/> All sons 18+ live in HH (3e) _____ Number of married sons
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d. [How many of your sons/Does your son] live close enough to get here within one hour, by the usual way? (Include (names of sons 18+ living in HH) as well as sons not living here.)	_____ Number of close sons
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Skip to 4 if no daughters 18+, otherwise mark box or ask e. [How many of your daughters are/Is your daughter] now married?	<input type="checkbox"/> All daughters 18+ live in HH (4) _____ Number of married daughters
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f. [How many of your daughters/Does your daughter] live close enough to get here within one hour, by the usual way? (Include (names of daughters 18+ living in the HH) as well as daughters not living here.)	_____ Number of close daughters
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FOOTNOTES

Section M. FAMILY STRUCTURE, RELATIONSHIPS, SUPPORT AND LIVING ARRANGEMENTS, Continued

<p>Mark box if S.P. has brother(s) in HH</p> <p>4a. Do you have any living brothers, including step brothers?</p>		<p>1 <input type="checkbox"/> Sample person has brother(s) in HH</p> <p>2 <input type="checkbox"/> Yes</p> <p>3 <input type="checkbox"/> No (4d)</p>
<p>b. How many living brothers do you have altogether? (Include step brothers.)</p>		<p>_____ Number of brothers</p>
<p>c. Mark box if all brothers live in HH [How many/Does he] live close enough to get here within one hour, by the usual way? (Include (names of brothers living in HH) as well as brothers not living here.)</p>		<p><input type="checkbox"/> All brothers live in HH</p> <p>_____ Number of close brothers</p>
<p>Mark box if S.P. has sister(s) in HH</p> <p>d. Do you have any living sisters, including step sisters?</p>		<p>1 <input type="checkbox"/> Sample person has sister(s) in HH</p> <p>2 <input type="checkbox"/> Yes</p> <p>3 <input type="checkbox"/> No (M2)</p>
<p>e. How many living sisters do you have altogether? (Include step sisters.)</p>		<p>_____ Number of sisters</p>
<p>f. Mark box if all sisters live in HH [How many/Does she] live close enough to get here within one hour, by the usual way? (Include (names of sisters living in HH) as well as sisters not living here.)</p>		<p><input type="checkbox"/> All sisters live in HH</p> <p>_____ Number of close sisters</p>
M2	Refer to age	<p>1 <input type="checkbox"/> Sample person is 75 or older (M3)</p> <p>2 <input type="checkbox"/> All other (5)</p>
<p>Mark box if S.P. has mother in HH</p> <p>5a. Is your mother still living?</p>		<p>1 <input type="checkbox"/> Sample person's mother in HH (5c)</p> <p>2 <input type="checkbox"/> Yes</p> <p>3 <input type="checkbox"/> No (5c)</p>
<p>b. Does your mother live close enough to get here within one hour, by the usual way?</p>		<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>
<p>Mark box if S.P. has father in HH</p> <p>c. Is your father still living?</p>		<p>1 <input type="checkbox"/> Sample person's father in HH (M3)</p> <p>2 <input type="checkbox"/> Yes</p> <p>3 <input type="checkbox"/> No (M3)</p>
<p>d. Does your father live close enough to get here within one hour, by the usual way?</p>		<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p>
M3	Refer to 3-5	<p>1 <input type="checkbox"/> Any relatives in 3-5 (M4)</p> <p>2 <input type="checkbox"/> No relatives in 3-5 (Next page)</p>
M4	Refer to relationship roster in 1 and 3-5	<p>1 <input type="checkbox"/> All relatives in 3-5 are HH members (Next page)</p> <p>2 <input type="checkbox"/> Other (6)</p>
<p>6a. (NOT including anyone living here) About how often do you see any of the relatives you just told me about?</p>		<p>1 <input type="checkbox"/> Every day</p> <p>2 <input type="checkbox"/> 2-6 times a week</p> <p>3 <input type="checkbox"/> Once a week</p> <p>4 <input type="checkbox"/> 2 or 3 times a month</p> <p>5 <input type="checkbox"/> Once a month</p> <p>6 <input type="checkbox"/> Less than once a month</p> <p>7 <input type="checkbox"/> Never</p> <p>8 <input type="checkbox"/> DK</p>
<p>b. (NOT including anyone living here) About how often do you talk on the telephone with any of the relatives you just told me about?</p>		<p>1 <input type="checkbox"/> Every day</p> <p>2 <input type="checkbox"/> 2-6 times a week</p> <p>3 <input type="checkbox"/> Once a week</p> <p>4 <input type="checkbox"/> 2 or 3 times a month</p> <p>5 <input type="checkbox"/> Once a month</p> <p>6 <input type="checkbox"/> Less than once a month</p> <p>7 <input type="checkbox"/> Never</p> <p>8 <input type="checkbox"/> DK</p>
<p>FOOTNOTES</p>		

FORM HIS 115A(X) (1983) (3 TO 83)

Section M. FAMILY STRUCTURE, RELATIONSHIPS, SUPPORT AND LIVING ARRANGEMENTS, Continued

<p><i>Note — Ask 8 immediately after receiving a "yes" in 7. Repeat question 7 when resuming the list.</i></p>	<p>Read to respondent — I'm going to read a list of things that people sometimes get help with.</p>	
	<p>7. Do you usually receive —</p>	<p>8. Who usually gives this help, a (spouse), relative, friend, neighbor or some other person? Anyone else?</p>
<p>a. Help with fixing things around the house, such as home repairs or yard work?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't apply } (Next activity)</p>	<p>1 <input type="checkbox"/> Spouse 2 <input type="checkbox"/> Relative (Specify) _____ 3 <input type="checkbox"/> Friend/neighbor 4 <input type="checkbox"/> Other (Specify) _____</p>
<p>b. Help with housekeeping or housework, such as mending, sewing, or laundry?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't apply } (Next activity)</p>	<p>1 <input type="checkbox"/> Spouse 2 <input type="checkbox"/> Relative (Specify) _____ 3 <input type="checkbox"/> Friend/neighbor 4 <input type="checkbox"/> Other (Specify) _____</p>
<p>c. Help with cooking or preparing your meals?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't apply } (Next activity)</p>	<p>1 <input type="checkbox"/> Spouse 2 <input type="checkbox"/> Relative (Specify) _____ 3 <input type="checkbox"/> Friend/neighbor 4 <input type="checkbox"/> Other (Specify) _____</p>
<p>d. Help when you are ill?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't apply } (Next activity)</p>	<p>1 <input type="checkbox"/> Spouse 2 <input type="checkbox"/> Relative (Specify) _____ 3 <input type="checkbox"/> Friend/neighbor 4 <input type="checkbox"/> Other (Specify) _____</p>
<p>e. Help taking your medication?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't apply } (Next activity)</p>	<p>1 <input type="checkbox"/> Spouse 2 <input type="checkbox"/> Relative (Specify) _____ 3 <input type="checkbox"/> Friend/neighbor 4 <input type="checkbox"/> Other (Specify) _____</p>
<p>f. Help with your personal care, such as washing hair or clipping toe nails?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't apply } (Next activity)</p>	<p>1 <input type="checkbox"/> Spouse 2 <input type="checkbox"/> Relative (Specify) _____ 3 <input type="checkbox"/> Friend/neighbor 4 <input type="checkbox"/> Other (Specify) _____</p>
<p>g. REGULAR financial assistance or financial contributions?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't apply } (Next activity)</p>	<p>1 <input type="checkbox"/> Spouse 2 <input type="checkbox"/> Relative (Specify) _____ 3 <input type="checkbox"/> Friend/neighbor 4 <input type="checkbox"/> Other (Specify) _____</p>
<p>h. Money GIFTS?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't apply } (Next activity)</p>	<p>1 <input type="checkbox"/> Spouse 2 <input type="checkbox"/> Relative (Specify) _____ 3 <input type="checkbox"/> Friend/neighbor 4 <input type="checkbox"/> Other (Specify) _____</p>
<p>i. Other gifts, such as clothing or food?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't apply } (Next activity)</p>	<p>1 <input type="checkbox"/> Spouse 2 <input type="checkbox"/> Relative (Specify) _____ 3 <input type="checkbox"/> Friend/neighbor 4 <input type="checkbox"/> Other (Specify) _____</p>
<p>j. Regular vacations, excursions or holiday trips provided by someone else?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't apply } (Next activity)</p>	<p>1 <input type="checkbox"/> Spouse 2 <input type="checkbox"/> Relative (Specify) _____ 3 <input type="checkbox"/> Friend/neighbor 4 <input type="checkbox"/> Other (Specify) _____</p>
<p>k. Transportation, that is, does anyone regularly drive you to the doctor, grocery, or send a taxi?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't apply } (Next activity)</p>	<p>1 <input type="checkbox"/> Spouse 2 <input type="checkbox"/> Relative (Specify) _____ 3 <input type="checkbox"/> Friend/neighbor 4 <input type="checkbox"/> Other (Specify) _____</p>
<p>l. Help with managing money?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't apply } (Next activity)</p>	<p>1 <input type="checkbox"/> Spouse 2 <input type="checkbox"/> Relative (Specify) _____ 3 <input type="checkbox"/> Friend/neighbor 4 <input type="checkbox"/> Other (Specify) _____</p>
<p>m. Help in any other way?</p>	<p>1 <input type="checkbox"/> Yes What ways? Anything else? (Specify) _____ _____ _____ 2 <input type="checkbox"/> No</p>	

Section M. FAMILY STRUCTURE, RELATIONSHIPS, SUPPORT AND LIVING ARRANGEMENTS, Continued

Read to respondent — Now I'm going to ask some questions about your living arrangements.

9. How long have you been living here, in this [house/apartment]?

Number

- 1 Days
- 2 Weeks
- 3 Months
- 4 Years

M5

Mark first appropriate box

- 1 Sample person lives alone
 - 2 Sample person lives ONLY with spouse and/or any children under 18 years old
 - 3 All other (M6)
- } (11)

M6

Refer to 9

- 1 Sample person has lived here less than 5 years (10a)
- 2 Sample person has lived here 5 years or more (10e)

10a. Did you move in with other HOUSEHOLD members who were already living here?

- 1 Yes
- 2 No (10c)

b. Did you move in because of health, finances, or for some other reason?

Any other reason?

If unclear ask — Whose [health/finances] — yours or someone else's?

- Health
- 1 Sample person
 - 2 Other person
- Finances
- 3 Sample person
 - 4 Other person
 - 5 Other (Specify) _____

c. Did any other HOUSEHOLD members move in with you after you were already living here?

- 1 Yes
- 2 No (10e)

d. Did the other household members move in because of health, finances, or for some other reason?

Any other reason?

If unclear ask — Whose [health/finances] — yours or someone else's?

- Health
- 1 Sample person
 - 2 Other person
- Finances
- 3 Sample person
 - 4 Other person
 - 5 Other (Specify) _____

e. What is the MAIN reason you are NOW living together? Is it for health, finances, or some other reason?

If unclear ask — Whose [health/finances] — yours or someone else's?

- Health
- 1 Sample person
 - 2 Other person
- Finances
- 3 Sample person
 - 4 Other person
 - 5 Other (Specify) _____

Read to respondent — Many things influence a person's choice of a place to live. I'm going to read you a list of reasons that people have said are important in deciding whether or not to live in a particular home.

11a. Which of these statements are reasons why you are NOW living in THIS [house/apartment] —

- (1) It is close to needed services
- (2) It has features I need for health reasons
- (3) It has features ANOTHER household member needs for health reasons
- (4) It is close to friends or relatives
- (5) It is the only place I can afford
- (6) Some other reason

- | | |
|--|-------------------------------|
| <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |
| <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |
| <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |
| <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No |
| <input type="checkbox"/> 1 Yes (Specify) ✓ | <input type="checkbox"/> 2 No |

Mark box if only one "Yes" in 11a

b. If you had to choose, which of those reasons would you say is the MAIN reason you are NOW living in THIS [house/apartment]? Circle main reason.

- 0 Only one "Yes" in 11a
- 1 2 3 4 5 6 (Specify) ✓

FOOTNOTES

Section M. FAMILY STRUCTURE, RELATIONSHIPS, SUPPORT AND LIVING ARRANGEMENTS, Continued

12a. Is this [house/apartment] now —	
(1) Owned or being bought by you (or someone in the household)?	1 <input type="checkbox"/> Yes (12b) 2 <input type="checkbox"/> No
(2) Rented for cash?	1 <input type="checkbox"/> Yes (1,2f) 2 <input type="checkbox"/> No
(3) Occupied without payment of cash rent?	1 <input type="checkbox"/> Yes (Section N)
b. Who owns or is buying it?	1 <input type="checkbox"/> Sample person and/or spouse 2 <input type="checkbox"/> Sample person and/or spouse with other HH members 3 <input type="checkbox"/> Others in HH (Specify) _____
c. Is this place fully paid for or is there a mortgage being paid?	1 <input type="checkbox"/> Fully paid for (12e) 2 <input type="checkbox"/> Mortgage being paid 3 <input type="checkbox"/> DK (12e)
d. How much principal is still owed on the mortgage?	\$ _____ Amount 0 <input type="checkbox"/> DK
<i>Hand card SM12</i> e. What is the present value of this place, that is, about how much would it bring if you sold it on today's market?	1 <input type="checkbox"/> Under \$20,000 2 <input type="checkbox"/> \$20,000 — 34,999 3 <input type="checkbox"/> 35,000 — 49,999 4 <input type="checkbox"/> 50,000 — 74,999 5 <input type="checkbox"/> 75,000 — 99,999 6 <input type="checkbox"/> 100,000 and over 7 <input type="checkbox"/> DK } (Section N)
f. Who is paying rent for it?	1 <input type="checkbox"/> Sample person and/or spouse 2 <input type="checkbox"/> Sample person and/or spouse with other HH members 3 <input type="checkbox"/> Others in HH (Specify) _____

FOOTNOTES

Section N. COMMUNITY AND SOCIAL SUPPORT

Section N. COMMUNITY AND SOCIAL SUPPORT			
<p><i>Note — Ask 2–5 immediately after receiving a “Yes” in 1. Then resume reading list.</i></p>	<p>Read to respondent — The next questions are about community services for older people.</p>		
	<p>1. Which of the following services are available in this area?</p> <p>When resuming list — Is (service) available in this area?</p>	<p>2. Have you ever used it?</p>	<p>3. When did you last use (service)?</p>
<p>a. A senior center?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next service) 3 <input type="checkbox"/> DK</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5) 3 <input type="checkbox"/> DK (Next service)</p>	<p>Number { 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago (5)</p>
<p>b. Transportation for the elderly?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next service) 3 <input type="checkbox"/> DK</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5) 3 <input type="checkbox"/> DK (Next service)</p>	<p>Number { 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago (5)</p>
<p>c. Meals on wheels or meals brought into the home?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next service) 3 <input type="checkbox"/> DK</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5) 3 <input type="checkbox"/> DK (Next service)</p>	<p>Number { 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago (5)</p>
<p>d. Group meals or meals outside the home?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next service) 3 <input type="checkbox"/> DK</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5) 3 <input type="checkbox"/> DK (Next service)</p>	<p>Number { 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago (5)</p>
<p>e. Advice about nutrition?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next service) 3 <input type="checkbox"/> DK</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5) 3 <input type="checkbox"/> DK (Next service)</p>	<p>Number { 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago (5)</p>
<p>f. Homemaker service to help with household chores like cleaning, shopping, and cooking?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next service) 3 <input type="checkbox"/> DK</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5) 3 <input type="checkbox"/> DK (Next service)</p>	<p>Number { 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago (5)</p>
<p>g. Routine telephone call service to check on your health or well-being?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next service) 3 <input type="checkbox"/> DK</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5) 3 <input type="checkbox"/> DK (Next service)</p>	<p>Number { 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago (5)</p>
<p>h. Visiting nurse service?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next service) 3 <input type="checkbox"/> DK</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5) 3 <input type="checkbox"/> DK (Next service)</p>	<p>Number { 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago (5)</p>
<p>i. A health aide who comes into the home?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next service) 3 <input type="checkbox"/> DK</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5) 3 <input type="checkbox"/> DK (Next service)</p>	<p>Number { 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago (5)</p>
<p>j. Adult day care or day care for the elderly?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next service) 3 <input type="checkbox"/> DK</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5) 3 <input type="checkbox"/> DK (Next service)</p>	<p>Number { 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago (5)</p>
<p>k. Geriatric Day Rehabilitation Center, that is, a place for physical therapy?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next service) 3 <input type="checkbox"/> DK</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5) 3 <input type="checkbox"/> DK (Next service)</p>	<p>Number { 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago (5)</p>
<p>l. Legal services for the elderly?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (Next service) 3 <input type="checkbox"/> DK</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5) 3 <input type="checkbox"/> DK (Next service)</p>	<p>Number { 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago (5)</p>
<p>m. A hospice for the terminally ill or an in-home hospice service?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (6) 3 <input type="checkbox"/> DK</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5) 3 <input type="checkbox"/> DK (6)</p>	<p>Number { 1 <input type="checkbox"/> Days ago 2 <input type="checkbox"/> Weeks ago 3 <input type="checkbox"/> Months ago 4 <input type="checkbox"/> Years ago } (5)</p>

Section N. COMMUNITY AND SOCIAL SUPPORT, Continued

4. How often do you use it — every day, at least once a week, at least once a month, or less than once a month?		Hand card SN5 5. Who is the sponsor of the program — the local health department, some other State or local government agency, a religious group, or some other organization? Anyone else?	
a.	<input type="checkbox"/> Every day <input type="checkbox"/> At least once a week <input type="checkbox"/> At least once a month <input type="checkbox"/> Less than once a month	<input type="checkbox"/> Local health department <input type="checkbox"/> Other State/local government agency <input type="checkbox"/> Religious group	<input type="checkbox"/> Some other organization (<i>Specify</i>) _____ <input type="checkbox"/> DK
b.	<input type="checkbox"/> Every day <input type="checkbox"/> At least once a week <input type="checkbox"/> At least once a month <input type="checkbox"/> Less than once a month	<input type="checkbox"/> Local health department <input type="checkbox"/> Other State/local government agency <input type="checkbox"/> Religious group	<input type="checkbox"/> Some other organization (<i>Specify</i>) _____ <input type="checkbox"/> DK
c.	<input type="checkbox"/> Every day <input type="checkbox"/> At least once a week <input type="checkbox"/> At least once a month <input type="checkbox"/> Less than once a month	<input type="checkbox"/> Local health department <input type="checkbox"/> Other State/local government agency <input type="checkbox"/> Religious group	<input type="checkbox"/> Some other organization (<i>Specify</i>) _____ <input type="checkbox"/> DK
d.	<input type="checkbox"/> Every day <input type="checkbox"/> At least once a week <input type="checkbox"/> At least once a month <input type="checkbox"/> Less than once a month	<input type="checkbox"/> Local health department <input type="checkbox"/> Other State/local government agency <input type="checkbox"/> Religious group	<input type="checkbox"/> Some other organization (<i>Specify</i>) _____ <input type="checkbox"/> DK
e.	<input type="checkbox"/> Every day <input type="checkbox"/> At least once a week <input type="checkbox"/> At least once a month <input type="checkbox"/> Less than once a month	<input type="checkbox"/> Local health department <input type="checkbox"/> Other State/local government agency <input type="checkbox"/> Religious group	<input type="checkbox"/> Some other organization (<i>Specify</i>) _____ <input type="checkbox"/> DK
f.	<input type="checkbox"/> Every day <input type="checkbox"/> At least once a week <input type="checkbox"/> At least once a month <input type="checkbox"/> Less than once a month	<input type="checkbox"/> Local health department <input type="checkbox"/> Other State/local government agency <input type="checkbox"/> Religious group	<input type="checkbox"/> Some other organization (<i>Specify</i>) _____ <input type="checkbox"/> DK
g.	<input type="checkbox"/> Every day <input type="checkbox"/> At least once a week <input type="checkbox"/> At least once a month <input type="checkbox"/> Less than once a month	<input type="checkbox"/> Local health department <input type="checkbox"/> Other State/local government agency <input type="checkbox"/> Religious group	<input type="checkbox"/> Some other organization (<i>Specify</i>) _____ <input type="checkbox"/> DK
h.	<input type="checkbox"/> Every day <input type="checkbox"/> At least once a week <input type="checkbox"/> At least once a month <input type="checkbox"/> Less than once a month	<input type="checkbox"/> Local health department <input type="checkbox"/> Other State/local government agency <input type="checkbox"/> Religious group	<input type="checkbox"/> Some other organization (<i>Specify</i>) _____ <input type="checkbox"/> DK
i.	<input type="checkbox"/> Every day <input type="checkbox"/> At least once a week <input type="checkbox"/> At least once a month <input type="checkbox"/> Less than once a month	<input type="checkbox"/> Local health department <input type="checkbox"/> Other State/local government agency <input type="checkbox"/> Religious group	<input type="checkbox"/> Some other organization (<i>Specify</i>) _____ <input type="checkbox"/> DK
j.	<input type="checkbox"/> Every day <input type="checkbox"/> At least once a week <input type="checkbox"/> At least once a month <input type="checkbox"/> Less than once a month	<input type="checkbox"/> Local health department <input type="checkbox"/> Other State/local government agency <input type="checkbox"/> Religious group	<input type="checkbox"/> Some other organization (<i>Specify</i>) _____ <input type="checkbox"/> DK
k.	<input type="checkbox"/> Every day <input type="checkbox"/> At least once a week <input type="checkbox"/> At least once a month <input type="checkbox"/> Less than once a month	<input type="checkbox"/> Local health department <input type="checkbox"/> Other State/local government agency <input type="checkbox"/> Religious group	<input type="checkbox"/> Some other organization (<i>Specify</i>) _____ <input type="checkbox"/> DK
l.	<input type="checkbox"/> Every day <input type="checkbox"/> At least once a week <input type="checkbox"/> At least once a month <input type="checkbox"/> Less than once a month	<input type="checkbox"/> Local health department <input type="checkbox"/> Other State/local government agency <input type="checkbox"/> Religious group	<input type="checkbox"/> Some other organization (<i>Specify</i>) _____ <input type="checkbox"/> DK
m.		<input type="checkbox"/> Local health department <input type="checkbox"/> Other State/local government agency <input type="checkbox"/> Religious group	<input type="checkbox"/> Some other organization (<i>Specify</i>) _____ <input type="checkbox"/> DK

FORM HIS-1ISAIX (1983) (3-10-83)

Section N. COMMUNITY AND SOCIAL SUPPORT, Continued

Read to respondent – We are interested in learning how often people participate in certain activities.

6. In the past week, (that would be from last <u>day</u> through today,) did you –		
a. Get together with neighbors at each other's residence or outside the home?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
b. Talk with any neighbors on the telephone?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
c. Get together with friends, OTHER THAN NEIGHBORS, at each other's residence or outside the home?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
d. Talk with friends, OTHER THAN NEIGHBORS, on the telephone?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
e. Get together with ANY relatives at each other's residence or outside the home?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
f. Talk with ANY relatives on the telephone?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
g. Watch television with another person?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
h. Go to church or temple for services?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
i. Go to church or temple for other activities?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
j. Go to the grocery store?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
k. Go to a show or movie, sports event, club meeting, classes or other group event?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
l. Exercise or participate in sports?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
m. Take an overnight trip away from home?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
7a. At the present time, do you do any volunteer work such as helping in charity work, working in a shop for a nonprofit organization, working in a hospital or nursing home without pay, or doing community work without pay?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (B)	
b. About how often do you do any volunteer work – every day, at least once a week, at least once a month or less than once a month?	1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> At least once a week 3 <input type="checkbox"/> At least once a month 4 <input type="checkbox"/> Less than once a month (B)	
c. About how many hours [per day/each week/each month] do you do volunteer work?	_____ Hours	
8. At the present time do you ever participate in any ORGANIZED senior citizen activities?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
N1 <i>Respondent</i>	1 <input type="checkbox"/> Self (9) 2 <input type="checkbox"/> Proxy (Section O)	
9. Regarding your present social activities, do you feel that you are doing about enough, too much, or would you like to be doing more?	1 <input type="checkbox"/> About enough 2 <input type="checkbox"/> Too much 3 <input type="checkbox"/> Would like to do more	

FOOTNOTES

Section O. OCCUPATION AND RETIREMENT

Read to respondent — Now I would like to ask you some questions about your work background. This includes work for pay or profit, unpaid work in a family farm or business, or military service.

1a. Have you EVER worked at a job or business full or part time?

- 1 Yes
2 No (3)

b. Did you work at all at a job or business in the past 12 months, that is, since (12 month date) a year ago?

- 1 Yes
2 No (2)

c. Since (12 month date) a year ago, in how many weeks did you work, either full or part time, not counting work around the house? Include paid vacations and paid sick leave?

62 All year — 52 weeks

_____ Weeks

d. In the weeks that you worked, how many hours a week did you USUALLY work at ALL jobs?

_____ Hours

2a. Now, think about ALL of your work experience, including work for pay or profit, unpaid work in a family farm or business, or military service. What KIND of work did you do for the LONGEST period of time? (What was your occupation?)

For example, electrical engineer, stock clerk.

_____ Occupation

b. What were your most important activities or duties as a (occupation)?

For example, typed, kept account books, filed, sold cars, operated a printing press, finished concrete.

_____ Activities/Duties

c. Altogether, for how many years did you work as a (occupation)?

- 0 Less than one month
Number { 1 Months
2 Years

d. For WHOM did you work as a (occupation) the LONGEST?

Enter name of company, business, organization, or other employer. If military service, enter "Armed Forces," THEN skip to 3.

_____ Name of longest employer

e. What kind of business or industry is this?

For example, TV and radio manufacturing, retail shoe store, state labor department, etc.

_____ Industry

f. Were you —

An employee of a PRIVATE company, business or individual for wages or commission?

1 P

A FEDERAL government employee?

2 F

A STATE government employee?

3 S

A LOCAL government employee?

4 L

Self-employed in OWN business, professional practice, or farm?

Ask: Is this business incorporated?

Yes

5 I

No

6 SE

Working without pay in family business or farm?

7 WP

3a. At this time, do you consider yourself completely retired, partly retired or not retired at all?

- 1 Completely retired
2 Partly retired
3 Not retired at all
4 Never worked } (4)

b. About how long ago did you retire?

- 0 Less than one month ago
Number { 1 Months ago
2 Years ago

Hand card SO3

Read categories if telephone interview

c. Why did you retire?

Any other reason?

- 1 Because of your health
2 Because of a family member's health
3 Forced to retire because of age (compulsory retirement)
4 Company moved away
5 Job was eliminated
6 Wanted to retire
7 Other (Specify)

Mark box if only one reason in 3c.

d. If you had to choose, which of those reasons would you say was the MAIN reason you retired? Circle main reason.

- 0 Only one reason
1 2 3 4 5 6 7 (Specify)

Section O. OCCUPATION AND RETIREMENT, Continued

NOTE — Ask 4a–j before asking 5–8

NOTE — Ask 5–8, as appropriate, for each "Yes" in 4a–j

4. During the past 12 months, did you receive any payments or benefits from—	5. How long have you been receiving (source in 4)?	6. Did you receive it because you qualified for the payment, or because you are a dependent or survivor of someone else?	7. Is the (source in 4) received because of a disability YOU may have?	8. What was the main condition or health problem for which you received benefits or payments from (source in 4)?
a. A private union or employer pension? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	1 <input type="checkbox"/> Own 2 <input type="checkbox"/> Someone else (Next source) 3 <input type="checkbox"/> Both	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Next source)	
b. A (Federal, state, or local) government employee pension? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	1 <input type="checkbox"/> Own 2 <input type="checkbox"/> Someone else (Next source) 3 <input type="checkbox"/> Both	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Next source)	
c. Military Retirement? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	1 <input type="checkbox"/> Own 2 <input type="checkbox"/> Someone else (Next source) 3 <input type="checkbox"/> Both	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Next source)	
d. Railroad Retirement? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	1 <input type="checkbox"/> Own 2 <input type="checkbox"/> Someone else (Next source) 3 <input type="checkbox"/> Both	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Next source)	
e. Social Security? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	1 <input type="checkbox"/> Own 2 <input type="checkbox"/> Someone else (Next source) 3 <input type="checkbox"/> Both	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Next source)	
f. Workman's compensation? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	1 <input type="checkbox"/> Own (B) 2 <input type="checkbox"/> Someone else (Next source) 3 <input type="checkbox"/> Both (B)		
g. Supplemental Security Income, known as SSI (from Federal, state, or local government)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	1 <input type="checkbox"/> Own 2 <input type="checkbox"/> Someone else (Next source) 3 <input type="checkbox"/> Both	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Next source)	
h. The Veterans Administration? Use when asking 5 and 7: Payment or benefit from the VA? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	1 <input type="checkbox"/> Own 2 <input type="checkbox"/> Someone else (Next source) 3 <input type="checkbox"/> Both	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Next source)	
i. State public welfare or assistance? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	1 <input type="checkbox"/> Own 2 <input type="checkbox"/> Someone else (Next source) 3 <input type="checkbox"/> Both	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Next source)	
j. During the past 12 months, did you receive any payments or benefits from any (other) source because of a DISABILITY to you or someone else? If "Yes," ask: What was the source? Specify all types, fill 5–8 for first one mentioned.	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	1 <input type="checkbox"/> Own (B) 2 <input type="checkbox"/> Someone else (Next page) 3 <input type="checkbox"/> Both (B)		

Section O. OCCUPATION AND RETIREMENT, Continued

Read to respondent — The next questions deal with your ability to do certain things that some people have difficulty with when they work at a job or business, or do chores around the house.

Hand card S09

Please tell me how much difficulty, if any, you have doing EACH activity, by yourself, and not using any aids.

9. Do you have no difficulty, some difficulty, much difficulty or are you unable at all to —	(1) Walk for a quarter of a mile, {which is about 2 or 3 city blocks,} without resting?	(2) Walk up and down one flight of stairs without resting?	(3) Stand for long periods, {about 2 hours}?	(4) Sit for long periods, {about 2 hours}?
	1 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Much 4 <input type="checkbox"/> Unable	1 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Much 4 <input type="checkbox"/> Unable	1 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Much 4 <input type="checkbox"/> Unable	1 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Much 4 <input type="checkbox"/> Unable
Ask 10a—e for each activity marked "much" or "unable" in 9.				
10a. For how long have you [had much difficulty/been unable to] [activity]?	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years
b. What (other) condition causes you to [have much difficulty/be unable to] [activity]? Ask if injury or operation: When did (the [injury] occur/[you have the operation])? Enter injury if over 3 months ago. Ask or reask 10c, if 0—3 months injury or operation. Ask if operation over 3 months ago: For what condition did you have the operation? Enter condition.	1 <input type="checkbox"/> Old age (10d) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	1 <input type="checkbox"/> Old age (10d) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	1 <input type="checkbox"/> Old age (10d) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	1 <input type="checkbox"/> Old age (10d) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
c. Besides (condition) is there any other condition which causes this?	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No (10e)	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No (10e)	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No (10e)	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No (10e)
d. Is this caused by any (other) specific condition?	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No
Ask if multiple conditions, including old age, are listed in 10b. Otherwise, mark appropriate box or transcribe the only listed condition.	1 <input type="checkbox"/> 0—3 Inj/Op. ONLY 2 <input type="checkbox"/> Old age } 10 for next activity with "much"/"unable"	1 <input type="checkbox"/> 0—3 Inj/Op. ONLY 2 <input type="checkbox"/> Old age } 10 for next activity with "much"/"unable"	1 <input type="checkbox"/> 0—3 Inj/Op. ONLY 2 <input type="checkbox"/> Old age } 10 for next activity with "much"/"unable"	1 <input type="checkbox"/> 0—3 Inj/Op. ONLY 2 <input type="checkbox"/> Old age } 10 for next activity with "much"/"unable"
e. Which of these conditions, that is (read conditions) would you say is the MAIN cause of the trouble?	Condition — Enter on Condition Summary Chart, THEN ask 10 for next activity with "much"/"unable."	Condition — Enter on Condition Summary Chart, THEN ask 10 for next activity with "much"/"unable."	Condition — Enter on Condition Summary Chart, THEN ask 10 for next activity with "much"/"unable."	Condition — Enter on Condition Summary Chart, THEN ask 10 for next activity with "much"/"unable."

FOOTNOTES

Section O. OCCUPATION AND RETIREMENT, Continued

(5)	(6)	(7)	(8)	(9)	(10)
Reask 9 Stoop, crouch, or kneel? 1 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Much 4 <input type="checkbox"/> Unable	Reach up (as if to get something from a shelf)? 1 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Much 4 <input type="checkbox"/> Unable	Reach out (as if to shake someone's hand)? 1 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Much 4 <input type="checkbox"/> Unable	Use fingers to grasp or handle? 1 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Much 4 <input type="checkbox"/> Unable	Reask 9 Lift or carry something as heavy as 25 lbs., (such as two full bags of groceries)? 1 <input type="checkbox"/> No difficulty (10) 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Much 4 <input type="checkbox"/> Unable	Lift or carry something as heavy as 10 lbs., (such as a 10 lb. sack of potatoes)? 1 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Much 4 <input type="checkbox"/> Unable
Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years	Number { 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months 4 <input type="checkbox"/> Years
1 <input type="checkbox"/> Old age (10d)	1 <input type="checkbox"/> Old age (10d)	1 <input type="checkbox"/> Old age (10d)	1 <input type="checkbox"/> Old age (10d)	1 <input type="checkbox"/> Old age (10d)	1 <input type="checkbox"/> Old age (10d)
1.	1.	1.	1.	1.	1.
2.	2.	2.	2.	2.	2.
3.	3.	3.	3.	3.	3.
4.	4.	4.	4.	4.	4.
5.	5.	5.	5.	5.	5.
1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No (10e)	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No (10e)	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No (10e)	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No (10e)	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No (10e)	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No (10e)
1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes (Reask 10b and c) 2 <input type="checkbox"/> No
1 <input type="checkbox"/> 0-3 Inj/Op. ONLY } 2 <input type="checkbox"/> Old age } 10 for next activity with "much"/"unable"	1 <input type="checkbox"/> 0-3 Inj/Op. ONLY } 2 <input type="checkbox"/> Old age } 10 for next activity with "much"/"unable"	1 <input type="checkbox"/> 0-3 Inj/Op. ONLY } 2 <input type="checkbox"/> Old age } 10 for next activity with "much"/"unable"	1 <input type="checkbox"/> 0-3 Inj/Op. ONLY } 2 <input type="checkbox"/> Old age } 10 for next activity with "much"/"unable"	1 <input type="checkbox"/> 0-3 Inj/Op. ONLY } 2 <input type="checkbox"/> Old age } 10 for next activity with "much"/"unable"	1 <input type="checkbox"/> 0-3 Inj/Op. ONLY } (Next page) 2 <input type="checkbox"/> Old age }
Condition - Enter on Condition Summary Chart, THEN ask 10 for next activity with "much"/"unable."	Condition - Enter on Condition Summary Chart, THEN ask 10 for next activity with "much"/"unable."	Condition - Enter on Condition Summary Chart, THEN ask 10 for next activity with "much"/"unable."	Condition - Enter on Condition Summary Chart, THEN ask 10 for next activity with "much"/"unable."	Condition - Enter on Condition Summary Chart, THEN ask 10 for next activity with "much"/"unable."	Condition - Enter on Condition Summary Chart, THEN next page.

FOOTNOTES

Section O. OCCUPATION AND RETIREMENT, Continued

Read to respondent — We would like to know how health practices and conditions are related to how long people live. The following information will only be used to check against the vital statistics records maintained by the National Center for Health Statistics of the U.S. Public Health Service. The results will only be used for statistical purposes and no individual will be identified.

11 a. To make sure that our records are complete, what is your full name, including middle name?

First

Middle

Last

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

Month	Day	Year
-------	-----	------

Verify/transfer from HIS-1

c. In what State were you born?

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

_____ State

- 1 Puerto Rico
- 2 Virgin Islands
- 3 Guam
- 4 Canada
- 5 Cuba
- 6 Mexico
- 7 All other

d. What is your father's last name?

Verify spelling. DO NOT write "Same."

_____ Father's last name

Read to respondent — We would like to have your Social Security Number. This will have no effect in any way on your benefits. It will not be given to anyone in any other government or nongovernment agency. This information is voluntary and is collected under the authority of the Public Health Service Act and Title 42, United States Code, section 242k.

<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Social Security Number

e. What is your Social Security Number?

1 DK

FOOTNOTES

Section P. CONDITIONS AND IMPAIRMENTS

Read to respondent — Now I am going to read a list of eye conditions. Tell me if you have any of these conditions, even if you have mentioned them before.

1. Do you NOW have —		
a. Blindness in one or both eyes?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
b. Cataracts?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
c. Glaucoma?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
d. Color blindness?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
e. A detached retina?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
f. Any other condition of the retina?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
g. Trouble with close vision EVEN when wearing glasses?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
h. Trouble with distance vision EVEN when wearing glasses?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
i. Any other trouble seeing with one or both eyes EVEN when wearing glasses?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
P1	Refer to answers in 1a–i	1 <input type="checkbox"/> All "No" in 1a–i (2) 2 <input type="checkbox"/> Other — Enter "Yes" responses in Condition Summary Chart, THEN 2
2a. Do you use prescription eyeglasses, including bifocals?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (3)
b. Did you get or replace your eyeglasses in the past 12 months, that is, since (12 month date) a year ago?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (3)
c. Was this because of a new or changed prescription?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
3a. Do you use contact lenses?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (4)
b. Did you get or replace your contact lenses in the past 12 months, that is, since (12 month date) a year ago?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (4)
c. Was this because of a new or changed prescription?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
4a. Do you have intraocular lenses?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)
b. Did you get your intraocular lenses in the past 12 months, that is, since (12 month date) a year ago?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
5. Do you use a magnifying glass to read or to do other close work?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

FOOTNOTES

Section P. CONDITIONS AND IMPAIRMENTS, Continued

<p>▶ <i>Read to respondent — The next few questions are about how well you can see (using your [glasses/(or) contacts] when you have to).</i></p>	
<p>6a. Can you see well enough to see ordinary newsprint?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>b. Can you see well enough to recognize the features of people you know if they are two or three feet away?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>c. Can you see moving objects, such as cars moving or people walking?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>d. Can you see well enough to step off a curb or down a step?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>e. Can you see well enough to recognize a friend walking on the other side of the street?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>P2 Refer to answers in 6a–e</p>	<p>1 <input type="checkbox"/> All "No" in 6a–e (7a) 2 <input type="checkbox"/> Other (7b)</p>
<p>7a. Can you see well enough to tell if a light is on?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>b. Which statement best describes your vision, (wearing [glasses/(or) contact lenses] when you have to), — good, a little trouble seeing, a lot of trouble seeing, or blind?</p>	<p>1 <input type="checkbox"/> Good 2 <input type="checkbox"/> Little trouble 3 <input type="checkbox"/> Lot of trouble 4 <input type="checkbox"/> Blind</p>
<p>▶ <i>Read to respondent — These next questions are about hearing.</i></p>	
<p>8. Do you NOW have —</p>	<p>1 <input type="checkbox"/> Yes — Enter on Condition Summary Chart, THEN 9 2 <input type="checkbox"/> No</p>
<p>a. Deafness in one or both ears?</p>	<p>1 <input type="checkbox"/> Yes — Enter on Condition Summary Chart, THEN 9 2 <input type="checkbox"/> No</p>
<p>b. Any other trouble hearing?</p>	
<p>9a. Do you use a hearing aid?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (9d)</p>
<p>b. Did you get or replace your hearing aid in the past 12 months, that is, since (12 month date) a year ago?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (9d)</p>
<p>c. Was this because of a new or changed prescription?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>d. (With your hearing aid) Can you hear well enough to hear MOST of the things a person says without seeing his or her face?</p>	<p>1 <input type="checkbox"/> Yes (9f) 2 <input type="checkbox"/> No</p>
<p>e. (With your hearing aid) Can you hear ONLY A FEW WORDS a person says or only LOUD noises?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>f. Which statement best describes your hearing (when wearing a hearing aid) — good, a little trouble hearing, a lot of trouble hearing, or deaf?</p>	<p>1 <input type="checkbox"/> Good 2 <input type="checkbox"/> Little trouble 3 <input type="checkbox"/> Lot of trouble 4 <input type="checkbox"/> Deaf</p>
<p>FOOTNOTES</p>	

Section P. CONDITIONS AND IMPAIRMENTS, Continued

Note — Ask 11 immediately after receiving a "Yes" in 10, then reask 10 when resuming list.

Read to respondent — I'm going to read a list of **OTHER** medical conditions. Please tell me if you have **EVER** had any of these conditions, even if you have mentioned them before.

	10. Have you EVER had --	11. Are you NOW prevented in any way from doing any activities because of (condition)?
a. Arthritis of any kind or rheumatism?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } Next condition 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } Reask 10 and resume list 2 <input type="checkbox"/> No
b. Osteoporosis, sometimes called brittle or soft bones? (os tee o po ro' sis)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } Next condition 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } Reask 10 and resume list 2 <input type="checkbox"/> No
c. A broken hip?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } Next condition 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } Reask 10 and resume list 2 <input type="checkbox"/> No
d. Diabetes?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } Next condition 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } Reask 10 and resume list 2 <input type="checkbox"/> No
e. An aneurysm? (an'yoo rizm)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } Next condition 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } Reask 10 and resume list 2 <input type="checkbox"/> No
f. Any blood clots?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } Next condition 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } Reask 10 and resume list 2 <input type="checkbox"/> No
g. Varicose veins?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } Next condition 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } Reask 10 and resume list 2 <input type="checkbox"/> No
h. Hypertension, sometimes called high blood pressure?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } Next condition 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } Reask 10 and resume list 2 <input type="checkbox"/> No
i. Rheumatic fever?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } Next condition 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } Reask 10 and resume list 2 <input type="checkbox"/> No
j. Rheumatic heart disease?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } Next condition 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } Reask 10 and resume list 2 <input type="checkbox"/> No
k. Coronary heart disease?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } Next condition 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } Reask 10 and resume list 2 <input type="checkbox"/> No
l. Angina pectoris? (pek'to ris)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } Next condition 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } Reask 10 and resume list 2 <input type="checkbox"/> No
m. A myocardial infarction?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } Next condition 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } Reask 10 and resume list 2 <input type="checkbox"/> No
n. Any other heart attack?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } Next condition 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } Reask 10 and resume list 2 <input type="checkbox"/> No
o. Cancer of any kind?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } P3 3 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

P3

Refer to answers in 10a - o

- All "No" or "DK" in 10a - o (12)
- Other — Enter "Yes" responses in Condition Summary Chart, THEN 12

Section P. CONDITIONS AND IMPAIRMENTS, Continued

12a. Do you sometimes feel dizzy?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (12c)
b. Are you prevented in any way from doing any activities because of dizziness?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
c. Have you fallen in the past month?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (13)
d. Did you fall because you felt dizzy or for some other reason?	1 <input type="checkbox"/> Felt dizzy 2 <input type="checkbox"/> Other reason
13a. Do you now have all, most, only a few, or none of your own teeth?	1 <input type="checkbox"/> All (Section Q) 2 <input type="checkbox"/> Most 3 <input type="checkbox"/> Only a few 4 <input type="checkbox"/> None 5 <input type="checkbox"/> DK (Section Q)
b. Do you now have false teeth?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Section Q)
c. Do you have an upper plate, a lower plate, or something else?	1 <input type="checkbox"/> Upper 2 <input type="checkbox"/> Lower 3 <input type="checkbox"/> Both 4 <input type="checkbox"/> Other (Specify) _____
d. Did you get or replace your false teeth in the past 12 months, that is, since (12 month date) a year ago?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK

FOOTNOTES

Section Q. HOUSING STRUCTURAL CHARACTERISTICS, ADL'S AND SPECIAL AIDS

Read to respondent – Now I will ask you some questions about housing. It is easier for people to get around in some homes than in others because of certain features.

1a. Do you HAVE to climb ANY steps to get into this [house/apartment] from the outside?	1 <input type="checkbox"/> No Yes – If not mentioned ask: How many? 2 <input type="checkbox"/> 1 step 3 <input type="checkbox"/> More than 1 step
b. Does this [house/apartment] have more than 1 floor or level? Count basements and step down living areas as separate levels.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

<i>Note – Ask 2a–e before asking 3a–e.</i>	2. Does this [house/apartment] now have –	3. Because of a health or physical problem, do you NEED –
a. A walk-in shower?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
b. Your bedroom and a bath on the same floor?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
c. A bath or half bath ON THE FLOOR where you spend most of your time?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
d. A bedroom ON THE FLOOR where you spend most of your time?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
e. A kitchen on the same floor as your bedroom?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

Read to respondent – Some people receive or need help to do certain daily activities.	
4a. Because of a health or physical problem, do you RECEIVE help from another person when you go up or down steps? Ask if "doesn't do": Is this because of a HEALTH or PHYSICAL problem?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do because of a health/physical problem (5) 4 <input type="checkbox"/> Doesn't do for other reason (5)
b. Do you NEED help going up or down steps?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

FOOTNOTES

Section Q. HOUSING STRUCTURAL CHARACTERISTICS, ADL'S AND SPECIAL AIDS, Continued

<p>5a. Because of a health or physical problem, do you RECEIVE help from another person to bathe, shower, or take a sponge bath? Ask if "doesn't do": Is this because of a HEALTH or PHYSICAL problem?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do because of health/physical problem (5a) 4 <input type="checkbox"/> Doesn't do for other reason (6)</p>
<p>b. Do you NEED help from another person to bathe, shower, or take a sponge bath?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5d)</p>
<p>c. Do you NEED this help most of the time, some of the time or once in a while?</p>	<p>1 <input type="checkbox"/> Most of the time 2 <input type="checkbox"/> Some of the time 3 <input type="checkbox"/> Once in a while</p>
<p>d. Because of a health or physical problem do you USE any special equipment to do this?</p>	<p>1 <input type="checkbox"/> Yes (5e) 2 <input type="checkbox"/> No</p>
<p>Q1 Refer to 5b</p>	<p>1 <input type="checkbox"/> Yes in 5b (5e) 2 <input type="checkbox"/> Other (6)</p>
<p>5e. What (other) condition causes you to need [help/(and) special equipment] to bathe, shower, or take a sponge bath? Ask if injury or operation: When did [the (injury) occur/you have the operation]? Enter injury if over 3 months ago. Ask or reask 5f if 0-3 months injury or operation. Ask if operation over 3 months ago: For what condition did you have the operation? Enter condition.</p>	<p>1 <input type="checkbox"/> Old age (5g) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____</p>
<p>f. Besides (condition), is there any other condition that causes this?</p>	<p>1 <input type="checkbox"/> Yes (Reask 5e and f) 2 <input type="checkbox"/> No (5h)</p>
<p>g. Is this caused by any (other) specific condition? Ask if multiple conditions, including old age, are listed in 5e. Otherwise, mark appropriate box or transcribe the only listed condition.</p>	<p>1 <input type="checkbox"/> Yes (Reask 5e and f) 2 <input type="checkbox"/> No</p>
<p>h. Which of these conditions, that is (read conditions), would you say is the MAIN condition that causes you to need [help/(and) special equipment] to bathe, shower, or take a sponge bath?</p>	<p>1 <input type="checkbox"/> 0-3 months injury/operation ONLY } (6) 2 <input type="checkbox"/> Old age _____ Condition Enter on Condition Summary Chart, THEN 6.</p>
<p>6a. Because of a health or physical problem, do you RECEIVE help from another person to dress? Ask if "doesn't do": Is this because of a HEALTH or PHYSICAL problem?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do because of health/physical problem (6f) 4 <input type="checkbox"/> Doesn't do for other reason (7)</p>
<p>b. Do you usually dress in street clothes?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>c. Do you NEED help from another person to dress?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6e)</p>
<p>d. Do you NEED this help most of the time, some of the time or once in a while?</p>	<p>1 <input type="checkbox"/> Most of the time 2 <input type="checkbox"/> Some of the time 3 <input type="checkbox"/> Once in a while</p>
<p>e. Because of a health or physical problem do you USE any special equipment to do this?</p>	<p>1 <input type="checkbox"/> Yes (6f) 2 <input type="checkbox"/> No</p>
<p>Q2 Refer to 6c</p>	<p>1 <input type="checkbox"/> Yes in 6c (6f) 2 <input type="checkbox"/> Other (7).</p>
<p>6f. What (other) condition causes you to need [help/(and) special equipment] to dress? Ask if injury or operation: When did [the (injury) occur/you have the operation]? Enter injury if over 3 months ago. Ask or reask 6g if 0-3 months injury or operation. Ask if operation over 3 months ago: For what condition did you have the operation? Enter condition.</p>	<p>1 <input type="checkbox"/> Old age (6h) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____</p>
<p>g. Besides (condition), is there any other condition that causes this?</p>	<p>1 <input type="checkbox"/> Yes (Reask 6f and g) 2 <input type="checkbox"/> No (6i)</p>
<p>h. Is this caused by any (other) specific condition? Ask if multiple conditions, including old age, are listed in 6f. Otherwise, mark appropriate box or transcribe the only listed condition.</p>	<p>1 <input type="checkbox"/> Yes (Reask 6f and g) 2 <input type="checkbox"/> No</p>
<p>i. Which of these conditions, that is (read conditions), would you say is the MAIN condition that causes you to need [help/(and) special equipment] to dress?</p>	<p>1 <input type="checkbox"/> 0-3 months injury/operation ONLY } (7) 2 <input type="checkbox"/> Old age _____ Condition Enter on Condition Summary Chart, THEN 7.</p>

Section Q. HOUSING STRUCTURAL CHARACTERISTICS, ADL'S AND SPECIAL AIDS, Continued

<p>7a. Because of a health or physical problem, do you RECEIVE help from another person to eat? Ask if "doesn't do": Is this because of a HEALTH or PHYSICAL problem?</p>	<p>1 <input type="checkbox"/> Yes (7b) 2 <input type="checkbox"/> No (7c) 3 <input type="checkbox"/> Doesn't do because of health/physical problem (7f) 4 <input type="checkbox"/> Doesn't do for other reason (8)</p>
<p>b. Are you fed totally by another person?</p>	<p>1 <input type="checkbox"/> Yes (7e) 2 <input type="checkbox"/> No</p>
<p>c. Do you NEED help from another person to eat?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (7e)</p>
<p>d. Do you NEED this help most of the time, some of the time or once in a while?</p>	<p>1 <input type="checkbox"/> Most of the time 2 <input type="checkbox"/> Some of the time 3 <input type="checkbox"/> Once in a while</p>
<p>e. Because of a health or physical problem do you USE any special equipment to do this?</p>	<p>1 <input type="checkbox"/> Yes (7f) 2 <input type="checkbox"/> No</p>

Q3

Refer to 7c

- 1 Yes in 7c (7f)
 2 Other (8)

<p>7f. What (other) condition causes you to need [help/(and) special equipment] to eat? Ask if injury or operation: When did [the (injury) occur/you have the operation]? Enter injury if over 3 months ago. Ask or reask 7g if 0-3 months injury or operation. Ask if operation over 3 months ago: For what condition did you have the operation? Enter condition.</p>	<p>1 <input type="checkbox"/> Old age (7h) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____</p>
<p>g. Besides (condition), is there any other condition that causes this?</p>	<p>1 <input type="checkbox"/> Yes (Reask 7f and g) 2 <input type="checkbox"/> No (7i)</p>
<p>h. Is this caused by any (other) specific condition?</p>	<p>1 <input type="checkbox"/> Yes (Reask 7f and g) 2 <input type="checkbox"/> No</p>
<p>Ask if multiple conditions, including old age, are listed in 7f. Otherwise, mark appropriate box or transcribe the only listed condition.</p>	<p>1 <input type="checkbox"/> 0-3 months injury/operation ONLY } (8) 2 <input type="checkbox"/> Old age</p>
<p>i. Which of these conditions, that is (read conditions), would you say is the MAIN condition that causes you to need [help/(and) special equipment] to eat?</p>	<p>_____ Condition Enter on Condition Summary Chart, THEN 8.</p>

<p>8a. Because of a health or physical problem, do you RECEIVE help from another person to use the toilet, including getting to the toilet? Ask if "doesn't do": Is this because of a HEALTH or PHYSICAL problem?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do because of health/physical problem (8e) 4 <input type="checkbox"/> Doesn't do for other reason (9)</p>
<p>b. Do you NEED help from another person to use the toilet, including getting to the toilet?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (8d)</p>
<p>c. Do you NEED this help most of the time, some of the time or once in a while?</p>	<p>1 <input type="checkbox"/> Most of the time 2 <input type="checkbox"/> Some of the time 3 <input type="checkbox"/> Once in a while</p>
<p>d. Because of a health or physical problem do you USE any special equipment to do this?</p>	<p>1 <input type="checkbox"/> Yes (8e) 2 <input type="checkbox"/> No</p>

Q4

Refer to 8b

- 1 Yes in 8b (8e)
 2 Other (9)

<p>8e. What (other) condition causes you to need [help/(and) special equipment] to use the toilet, including getting to the toilet? Ask if injury or operation: When did [the (injury) occur/you have the operation]? Enter injury if over 3 months ago. Ask or reask 8f if 0-3 months injury or operation. Ask if operation over 3 months ago: For what condition did you have the operation? Enter condition.</p>	<p>1 <input type="checkbox"/> Old age (8g) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____</p>
<p>f. Besides (condition), is there any other condition that causes this?</p>	<p>1 <input type="checkbox"/> Yes (Reask 8e and f) 2 <input type="checkbox"/> No (8h)</p>
<p>g. Is this caused by any (other) specific condition?</p>	<p>1 <input type="checkbox"/> Yes (Reask 8e and f) 2 <input type="checkbox"/> No</p>
<p>Ask if multiple conditions, including old age, are listed in 8e. Otherwise, mark appropriate box or transcribe the only listed condition.</p>	<p>1 <input type="checkbox"/> 0-3 months injury/operation ONLY } (9) 2 <input type="checkbox"/> Old age</p>
<p>h. Which of these conditions, that is (read conditions), would you say is the MAIN condition that causes you to need [help/(and) special equipment] to use the toilet, including getting to the toilet?</p>	<p>_____ Condition Enter on Condition Summary Chart, THEN 9.</p>

Section Q. HOUSING STRUCTURAL CHARACTERISTICS, ADL'S AND SPECIAL AIDS, Continued

<p>9a. Because of a health or physical problem, do you RECEIVE help from another person to get about the [house/apartment], that is, going from one room to another on the same floor or level? <i>Ask if "doesn't do": Is this because of a HEALTH or PHYSICAL problem?</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do because of health/physical problem (9e) 4 <input type="checkbox"/> Doesn't do for other reason (10)</p>
<p>b. Do you NEED help from another person to get about the [house/apartment], (that is, going from one room to another on the same floor or level)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (9d)</p>
<p>c. Do you NEED this help most of the time, some of the time or once in a while?</p>	<p>1 <input type="checkbox"/> Most of the time 2 <input type="checkbox"/> Some of the time 3 <input type="checkbox"/> Once in a while</p>
<p>d. Because of a health or physical problem do you USE any special equipment to do this?</p>	<p>1 <input type="checkbox"/> Yes (9e) 2 <input type="checkbox"/> No</p>
<p>Q5 <i>Refer to 9b</i></p>	<p>1 <input type="checkbox"/> Yes in 9b (9e) 2 <input type="checkbox"/> Other (10)</p>
<p>9e. What (other) condition causes you to need [help/(and) special equipment] to get about the [house/apartment], (that is, going from one room to another on the same floor or level)? <i>Ask if injury or operation: When did [the (injury) occur/you have the operation]? Enter injury if over 3 months ago. Ask or reask 9f if 0-3 months injury or operation. Ask if operation over 3 months ago: For what condition did you have the operation? Enter condition.</i></p>	<p>1 <input type="checkbox"/> Old age (9g) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____</p>
<p>f. Besides (condition), is there any other condition that causes this?</p>	<p>1 <input type="checkbox"/> Yes (Reask 9e and f) 2 <input type="checkbox"/> No (9h)</p>
<p>g. Is this caused by any (other) specific condition? <i>Ask if multiple conditions, including old age, are listed in 9e. Otherwise, mark appropriate box or transcribe the only listed condition.</i></p>	<p>1 <input type="checkbox"/> Yes (Reask 9e and f) 2 <input type="checkbox"/> No</p>
<p>h. Which of these conditions, that is (read conditions), would you say is the MAIN condition that causes you to need [help/(and) special equipment] to get about the [house/apartment], (that is, going from one room to another on the same floor or level)?</p>	<p>1 <input type="checkbox"/> 0-3 months injury/operation ONLY } (10) 2 <input type="checkbox"/> Old age } _____ Condition <i>Enter on Condition Summary Chart, THEN 10.</i></p>
<p>10a. Because of a health or physical problem, do you RECEIVE help from another person to get in and out of bed or chairs? <i>Ask if "doesn't do": Is this because of a HEALTH or PHYSICAL problem?</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do because of health/physical problem (10e) 4 <input type="checkbox"/> Doesn't do for other reason (11)</p>
<p>b. Do you NEED help from another person to get in and out of bed or chairs ?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (10d)</p>
<p>c. Do you NEED this help most of the time, some of the time or once in a while?</p>	<p>1 <input type="checkbox"/> Most of the time 2 <input type="checkbox"/> Some of the time 3 <input type="checkbox"/> Once in a while</p>
<p>d. Because of a health or physical problem do you USE any special equipment to do this?</p>	<p>1 <input type="checkbox"/> Yes (10e) 2 <input type="checkbox"/> No</p>
<p>Q6 <i>Refer to 10b</i></p>	<p>1 <input type="checkbox"/> Yes in 10b (10e) 2 <input type="checkbox"/> Other (11)</p>
<p>10e. What (other) condition causes you to need [help/(and) special equipment] to get in and out of bed or chairs ? <i>Ask if injury or operation: When did [the (injury) occur/you have the operation]? Enter injury if over 3 months ago. Ask or reask 10f if 0-3 months injury or operation. Ask if operation over 3 months ago: For what condition did you have the operation? Enter condition.</i></p>	<p>1 <input type="checkbox"/> Old age (10g) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____</p>
<p>f. Besides (condition), is there any other condition that causes this?</p>	<p>1 <input type="checkbox"/> Yes (Reask 10e and f) 2 <input type="checkbox"/> No (10h)</p>
<p>g. Is this caused by any (other) specific condition? <i>Ask if multiple conditions, including old age, are listed in 10e. Otherwise, mark appropriate box or transcribe the only listed condition.</i></p>	<p>1 <input type="checkbox"/> Yes (Reask 10e and f) 2 <input type="checkbox"/> No</p>
<p>h. Which of these conditions, that is (read conditions), would you say is the MAIN condition that causes you to need [help/(and) special equipment] to get in and out of bed or chairs?</p>	<p>1 <input type="checkbox"/> 0-3 months injury/operation ONLY } (11) 2 <input type="checkbox"/> Old age } _____ Condition <i>Enter on Condition Summary Chart, THEN 11.</i></p>

Section Q. HOUSING STRUCTURAL CHARACTERISTICS, ADL'S AND SPECIAL AIDS, Continued

<p>11a. Because of a health or physical problem, do you RECEIVE help from another person to prepare your own meals? Ask if "doesn't do": Is this because of a HEALTH or PHYSICAL problem?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do because of health/physical problem (11d) 4 <input type="checkbox"/> Doesn't do for other reason (12)</p>
<p>b. Do you NEED help from another person to prepare your own meals?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (12)</p>
<p>c. Do you NEED this help most of the time, some of the time or once in a while?</p>	<p>1 <input type="checkbox"/> Most of the time 2 <input type="checkbox"/> Some of the time 3 <input type="checkbox"/> Once in a while</p>
<p>d. What (other) condition causes you to need help preparing your own meals? Ask if injury or operation: When did [the (injury) occur/you have the operation]? Enter injury if over 3 months ago. Ask or reask 11e if 0-3 months injury or operation. Ask if operation over 3 months ago: For what condition did you have the operation? Enter condition.</p>	<p>1 <input type="checkbox"/> Old age (11f) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____</p>
<p>e. Besides (condition), is there any other condition that causes this?</p>	<p>1 <input type="checkbox"/> Yes (Reask 11d and e) 2 <input type="checkbox"/> No (11g)</p>
<p>f. Is this caused by any (other) specific condition?</p>	<p>1 <input type="checkbox"/> Yes (Reask 11d and e) 2 <input type="checkbox"/> No</p>
<p>Ask if multiple conditions, including old age, are listed in 11d. Otherwise, mark appropriate box or transcribe the only listed condition. g. Which of these conditions, that is (read conditions), would you say is the MAIN condition that causes you to need help to prepare your own meals?</p>	<p>1 <input type="checkbox"/> 0-3 months injury/operation ONLY } (12) 2 <input type="checkbox"/> Old age _____ Condition Enter on Condition Summary Chart, THEN 12.</p>
<p>12a. Because of a health or physical problem, do you RECEIVE help from another person to shop for personal items, such as toilet items or medicines? Ask if "doesn't do": Is this because of a HEALTH or PHYSICAL problem?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do because of health/physical problem (12d) 4 <input type="checkbox"/> Doesn't do for other reason (13)</p>
<p>b. Do you NEED help from another person to shop for personal items, (such as toilet items or medicines)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (13)</p>
<p>c. Do you NEED this help most of the time, some of the time or once in a while?</p>	<p>1 <input type="checkbox"/> Most of the time 2 <input type="checkbox"/> Some of the time 3 <input type="checkbox"/> Once in a while</p>
<p>d. What (other) condition causes you to need help to shop for personal items, (such as toilet items or medicines)? Ask if injury or operation: When did [the (injury) occur/you have the operation]? Enter injury if over 3 months ago. Ask or reask 12e if 0-3 months injury or operation. Ask if operation over 3 months ago: For what condition did you have the operation? Enter condition.</p>	<p>1 <input type="checkbox"/> Old age (12f) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____</p>
<p>e. Besides (condition), is there any other condition that causes this?</p>	<p>1 <input type="checkbox"/> Yes (Reask 12d and e) 2 <input type="checkbox"/> No (12g)</p>
<p>f. Is this caused by any (other) specific condition?</p>	<p>1 <input type="checkbox"/> Yes (Reask 12d and e) 2 <input type="checkbox"/> No</p>
<p>Ask if multiple conditions, including old age, are listed in 12d. Otherwise, mark appropriate box or transcribe the only listed condition. g. Which of these conditions, that is (read conditions), would you say is the MAIN condition that causes you to need help from another person to shop for personal items, (such as toilet items or medicines)?</p>	<p>1 <input type="checkbox"/> 0-3 months injury/operation ONLY } (13) 2 <input type="checkbox"/> Old age _____ Condition Enter on Condition Summary Chart, THEN 13.</p>

Section Q. HOUSING STRUCTURAL CHARACTERISTICS, ADL'S AND SPECIAL AIDS, Continued

<p>13a. Because of a health or physical problem, do you RECEIVE help from another person to do light housework, like doing dishes, straightening up, or light cleaning? Ask if "doesn't do": Is this because of a HEALTH or PHYSICAL problem?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do because of health/physical problem (13d) 4 <input type="checkbox"/> Doesn't do for other reason (14)</p>
<p>b. Do you NEED help from another person to do light housework, (like doing dishes, straightening up, or light cleaning)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (14)</p>
<p>c. Do you NEED this help most of the time, some of the time or once in a while?</p>	<p>1 <input type="checkbox"/> Most of the time 2 <input type="checkbox"/> Some of the time 3 <input type="checkbox"/> Once in a while</p>
<p>d. What (other) condition causes you to need help to do light housework, (like doing dishes, straightening up, or light cleaning)? Ask if injury or operation: When did [the (injury) occur/you have the operation]? Enter injury if over 3 months ago. Ask or reask 13e if 0-3 months injury or operation. Ask if operation over 3 months ago: For what condition did you have the operation? Enter condition.</p>	<p>1 <input type="checkbox"/> Old age (13f) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____</p>
<p>e. Besides (condition), is there any other condition that causes this?</p>	<p>1 <input type="checkbox"/> Yes (Reask 13d and e) 2 <input type="checkbox"/> No (13g)</p>
<p>f. Is this caused by any (other) specific condition? Ask if multiple conditions, including old age, are listed in 13d. Otherwise, mark appropriate box or transcribe the only listed condition.</p>	<p>1 <input type="checkbox"/> Yes (Reask 13d and e) 2 <input type="checkbox"/> No 1 <input type="checkbox"/> 0-3 months injury/operation ONLY } (14) 2 <input type="checkbox"/> Old age _____ Condition Enter on Condition Summary Chart, THEN 14.</p>
<p>14a. Because of a health or physical problem, do you RECEIVE help from another person to do heavy housework like vacuuming, scrubbing floors, or washing windows? Ask if "doesn't do": Is this because of a HEALTH or PHYSICAL problem?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do because of health/physical problem (14d) 4 <input type="checkbox"/> Doesn't do for other reason (15)</p>
<p>b. Do you NEED help from another person to do heavy housework (like vacuuming, scrubbing floors, or washing windows)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (15)</p>
<p>c. Do you NEED this help most of the time, some of the time or once in a while?</p>	<p>1 <input type="checkbox"/> Most of the time 2 <input type="checkbox"/> Some of the time 3 <input type="checkbox"/> Once in a while</p>
<p>d. What (other) condition causes you to need help to do heavy housework (like vacuuming, scrubbing floors, or washing windows)? Ask if injury or operation: When did [the (injury) occur/you have the operation]? Enter injury if over 3 months ago. Ask or reask 14e if 0-3 months injury or operation. Ask if operation over 3 months ago: For what condition did you have the operation? Enter condition.</p>	<p>1 <input type="checkbox"/> Old age (14f) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____</p>
<p>e. Besides (condition), is there any other condition that causes this?</p>	<p>1 <input type="checkbox"/> Yes (Reask 14d and e) 2 <input type="checkbox"/> No (14g)</p>
<p>f. Is this caused by any (other) specific condition? Ask if multiple conditions, including old age, are listed in 14d. Otherwise, mark appropriate box or transcribe the only listed condition.</p>	<p>1 <input type="checkbox"/> Yes (Reask 14d and e) 2 <input type="checkbox"/> No 1 <input type="checkbox"/> 0-3 months injury/operation ONLY } (15) 2 <input type="checkbox"/> Old age _____ Condition Enter on Condition Summary Chart, THEN 15.</p>

Section Q. HOUSING STRUCTURAL CHARACTERISTICS, ADL'S AND SPECIAL AIDS, Continued

<p>15a. Because of a health or physical problem, do you RECEIVE help from another person to dial the telephone or to receive calls on the telephone?</p> <p>Ask if "doesn't do": Is this because of a HEALTH or PHYSICAL problem?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do because of health/physical problem (15d) 4 <input type="checkbox"/> Doesn't do for other reason (16)</p>
<p>b. Do you NEED help from another person to dial the telephone or to receive calls on the telephone?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (16)</p>
<p>c. Do you NEED this help most of the time, some of the time or once in a while?</p>	<p>1 <input type="checkbox"/> Most of the time 2 <input type="checkbox"/> Some of the time 3 <input type="checkbox"/> Once in a while</p>
<p>d. What (other) condition causes you to need help to dial the telephone or to receive calls on the telephone?</p> <p>Ask if injury or operation: When did (the injury) occur/you have the operation? Enter injury if over 3 months ago. Ask or reask 15e if 0-3 months injury or operation. Ask if operation over 3 months ago: For what condition did you have the operation? Enter condition.</p>	<p>1 <input type="checkbox"/> Old age (15f) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____</p>
<p>e. Besides (condition), is there any other condition that causes this?</p>	<p>1 <input type="checkbox"/> Yes (Reask 15d and e) 2 <input type="checkbox"/> No (15g)</p>
<p>f. Is this caused by any (other) specific condition?</p>	<p>1 <input type="checkbox"/> Yes (Reask 15d and e) 2 <input type="checkbox"/> No</p>
<p>g. Which of these conditions, that is (read conditions), would you say is the MAIN condition that causes you to need help to dial the telephone or to receive calls on the telephone?</p>	<p>1 <input type="checkbox"/> 0-3 months injury/operation ONLY } (16) 2 <input type="checkbox"/> Old age</p> <p>_____ Condition Enter on Condition Summary Chart, THEN 16.</p>
<p>16a. Because of a health or physical problem, do you RECEIVE help from another person to get outside?</p> <p>Ask if "doesn't do": Is this because of a HEALTH or PHYSICAL problem?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do because of health/physical problem (16d) 4 <input type="checkbox"/> Doesn't do for other reason (Q7)</p>
<p>b. Do you NEED help from another person to get outside?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Q7)</p>
<p>c. Do you NEED this help most of the time, some of the time or once in a while?</p>	<p>1 <input type="checkbox"/> Most of the time 2 <input type="checkbox"/> Some of the time 3 <input type="checkbox"/> Once in a while</p>
<p>d. What (other) condition causes you to need help to get outside?</p> <p>Ask if injury or operation: When did (the injury) occur/you have the operation? Enter injury if over 3 months ago. Ask or reask 16e if 0-3 months injury or operation. Ask if operation over 3 months ago: For what condition did you have the operation? Enter condition.</p>	<p>1 <input type="checkbox"/> Old age (16f) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____</p>
<p>e. Besides (condition), is there any other condition that causes this?</p>	<p>1 <input type="checkbox"/> Yes (Reask 16d and e) 2 <input type="checkbox"/> No (16g)</p>
<p>f. Is this caused by any (other) specific condition?</p>	<p>1 <input type="checkbox"/> Yes (Reask 16d and e) 2 <input type="checkbox"/> No</p>
<p>g. Which of these conditions, that is (read conditions), would you say is the MAIN condition that causes you to need help to get outside?</p>	<p>1 <input type="checkbox"/> 0-3 months injury/operation ONLY } (Q7) 2 <input type="checkbox"/> Old age</p> <p>_____ Condition Enter on Condition Summary Chart, THEN Q7.</p>

Section Q. HOUSING STRUCTURAL CHARACTERISTICS, ADL'S AND SPECIAL AIDS, Continued

Q7	<i>Mark first appropriate box</i>	1 <input type="checkbox"/> Respondent is a proxy 2 <input type="checkbox"/> Sample person is or appears to be confined to a bed or chair 3 <input type="checkbox"/> All other (Q8)
Mark if known 17. Because of a health or physical problem, do you usually — a. Stay in bed all or most of the time? ----- b. Stay in a chair all or most of the time?		1 <input type="checkbox"/> Yes (Q8) 2 <input type="checkbox"/> No ----- 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Q8	<i>Refer to age</i>	1 <input type="checkbox"/> Sample person is 55–69 (20) 2 <input type="checkbox"/> Sample person is 70 or older (18)
18a. Do you have difficulty in controlling your bowels? ----- b. How frequently do you have this difficulty — daily, several times a week, once a week, or less than once a week? ----- c. Does this difficulty restrict your activity, that is, limit your getting around? ----- d. Do you have a colostomy or other device to help control bowel movements? ----- e. Do you need help from another person in taking care of this device? ----- f. How frequently do you RECEIVE this help — everytime you need help, most of the time, some of the time, or once in a while?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (18d) ----- 1 <input type="checkbox"/> Daily 2 <input type="checkbox"/> Several times a week 3 <input type="checkbox"/> Once a week 4 <input type="checkbox"/> Less than once a week 5 <input type="checkbox"/> DK ----- 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No ----- 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (19) ----- 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (19) ----- 1 <input type="checkbox"/> Everytime help is needed 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> Once in a while 5 <input type="checkbox"/> Not at all
19a. Do you have difficulty in controlling your urination? ----- b. How frequently do you have this difficulty — daily, several times a week, once a week, or less than once a week? ----- c. Does this difficulty restrict your activity, that is, limit your getting around? ----- d. Do you have a urinary catheter or other device to help control urination? ----- e. Do you need help from another person in taking care of this device? ----- f. How frequently do you RECEIVE this help — everytime you need help, most of the time, some of the time, or once in a while?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (19d) ----- 1 <input type="checkbox"/> Daily 2 <input type="checkbox"/> Several times a week 3 <input type="checkbox"/> Once a week 4 <input type="checkbox"/> Less than once a week 5 <input type="checkbox"/> DK ----- 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No ----- 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (20) ----- 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (20) ----- 1 <input type="checkbox"/> Everytime help is needed 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> Once in a while 5 <input type="checkbox"/> Not at all
FOOTNOTES		

FORM HS-1(SA)X (1983) (3-10-83)

Section Q. HOUSING STRUCTURAL CHARACTERISTICS, ADL's AND SPECIAL AIDS, Continued

20. Do you NOW use (any of the following special aids) — <i>If known, mark without asking</i>		
a. An artificial arm?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
b. An artificial leg?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
c. A brace of any kind? <i>If "Yes," ask: On what part of the body is the brace worn?</i>	1 <input type="checkbox"/> Yes (Specify) ↓ _____ Part of body 2 <input type="checkbox"/> No	
d. Crutches?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
e. A cane or walking stick?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
f. Orthopedic, corrective shoes?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
g. A wheel chair?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
h. A walker?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
i. A guide dog?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
j. Any other kind of aid for getting around? <i>If "Yes" specify, then ask: Anything else?</i>	1 <input type="checkbox"/> Yes (Specify) ↓ _____ 2 <input type="checkbox"/> No	

FOOTNOTES

Section S. HEALTH OPINIONS AND BEHAVIOR

S1

Respondent

- Self response (1)
- Proxy (9)

▶ **Read to respondent** – The next group of questions asks your personal opinions about health related matters.

- Excellent
- Good
- Fair
- Poor
- Other (Specify) _____

1. How good a job do you feel you are doing in TAKING CARE of your health? Would you say excellent, good, fair, or poor?

2. Compared with two years ago, would you say that your health is now better, worse, or about the same as it was then?

- Better
- Worse
- Same
- Other (Specify) _____

3. Over the PAST YEAR, has your health caused you a great deal of worry, some worry, hardly any worry, or no worry at all?

- A great deal of worry
- Some worry
- Hardly any worry
- No worry at all
- Other (Specify) _____

4. How would you rate your current level of physical activity? Would you say you are very active, active, moderately active, or rarely active?

- Very active
- Active
- Moderately active
- Rarely active (inactive)
- Other (Specify) _____

5. Compared to your level of physical activity two years ago, would you say you are now more active, less active, or about the same?

- More active
- Less active
- About the same
- Other (Specify) _____

6. Do you feel that you get as much exercise as you need, or less than you need?

- As much as I need
- Less than I need
- Other (Specify) _____

7. How much control do you think you have over your health? Would you say you have a great deal of control, some, very little, or none at all?

- A great deal of control
- Some control
- Very little control
- None at all
- Other (Specify) _____

S2

Interview

- Personal interview (8)
- Telephone interview (9)

FOOTNOTES

Section S. HEALTH OPINIONS AND BEHAVIOR, Continued

Hand card SS8

Read to respondent — I am going to read a list of ways you may sometimes feel. Please tell me how often you have felt this way DURING THE PAST WEEK: rarely or none of the time; some or a little of the time; occasionally or a moderate amount of time; or most or all of the time.

8. During the past week, (that would be from last (day) through today,) how often —	Rarely or none of the time (less than 1 day)	Some or a little of the time (1–2 days)	Occasionally or a moderate amount of time (3–4 days)	Most or all of the time (5–7 days)
a. Were you bothered by things that usually don't bother you?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b. Did you not feel like eating; your appetite was poor?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c. Did you feel that you could not shake off the blues even with help from your family or friends?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<i>Reask 8</i>				
d. Did you feel that you were just as good as other people?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e. Did you have trouble keeping your mind on what you were doing?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f. Did you feel depressed?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<i>Reask 8</i>				
g. Did you feel that everything you did was an effort?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h. Did you feel hopeful about the future?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
i. Did you think your life had been a failure?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
j. Did you feel fearful?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<i>Reask 8</i>				
k. Was your sleep restless?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
l. Were you happy?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
m. Did you talk less than usual?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
n. Did you feel lonely?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<i>Reask 8</i>				
o. Were people unfriendly?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
p. Did you enjoy life?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
q. Did you have crying spells?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
r. Did you feel sad?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
s. Did you feel that people disliked you?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
t. Could you not get "going"?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
9. Now I'm going to read you a list of things people have told us they have sometimes done. In the past week, that would be from last (day) through today, —				
a. Did you forget any important things like taking medicine or paying bills?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK			
b. Did you have difficulty remembering dates?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK			
c. Did you have difficulty remembering the time, like the time for an appointment?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK			
d. Did you lose your way or have difficulty finding your way back?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK			
10. Are you now taking any prescription medicine for your nerves, like medicine to calm you down or to help depression?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK			
11. (Besides the medicine) Are you now receiving treatment or counseling for a mental or emotional problem?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK } Go to Condition Summary Chart			

FORM HIS 1(SA)X (1983) (3 10 83)

Section T. SUPPLEMENT CONDITION PAGES

CONDITION A

1. Name of condition _____

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

- | | |
|---|---|
| <input type="checkbox"/> Interview week (Reask 2) | <input type="checkbox"/> 2 yrs., less than 5 yrs. |
| <input type="checkbox"/> 2-wk. ref. pd. | <input type="checkbox"/> 5 yrs. or more |
| <input type="checkbox"/> Over 2 weeks, less than 6 mos. | <input type="checkbox"/> Dr. seen, DK when |
| <input type="checkbox"/> 6 mos., less than 1 yr. | <input type="checkbox"/> DK if Dr. seen } (3b) |
| <input type="checkbox"/> 1 yr., less than 2 yrs. | <input type="checkbox"/> Dr. never seen |

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

- Yes No DK

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

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

- | | |
|---|--|
| <input type="checkbox"/> Color Blindness (NC) | <input type="checkbox"/> Vasectomy (5) |
| <input type="checkbox"/> Cancer (3e) | <input type="checkbox"/> Other (3c) |

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

Mark box if accident or injury. Accident/injury

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

- Yes No

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

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

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

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

f. How does the (allergy/stroke) NOW affect you? (Specify) _____

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

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

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

Show the following detail:

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

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

Infection	Sore	Soreness
-----------	------	----------

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

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

Tumor	Cyst	Growth
-------	------	--------

4. Is this (tumor/cyst/growth) malignant or benign?

- Malignant Benign DK

5. a. When was your (condition in 3b) first noticed?

- 2-wk. ref. pd.
 Over 2 weeks to 3 months
 Over 3 months to 1 year
 Over 1 year to 5 years
 Over 5 years

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

Ask probes as necessary:

(Was it on or since (first date of 2-week ref. period) or was it before that date?)

(Was it less than 3 months or more than 3 months ago?)

(Was it less than 1 year or more than 1 year ago?)

(Was it less than 5 years or more than 5 years ago?)

FOOTNOTES

Section U. CONDITION SUMMARY CHART

INSTRUCTIONS — If no entries in Summary Chart, complete cover page and any additional supplement booklets required.

All conditions in Summary Chart must be accounted for. Compare to C2 in HIS-1 for sample person.

1. If a condition page is already filled, enter the condition number in the diagonal space on the Summary Chart.
2. If a condition page is not filled, complete a lettered supplement condition page and enter the letter in the diagonal space.
3. If the condition wording on the HIS-1 and the Summary Chart are similar but not identical, probe: **Is the (supplement condition) the same condition as the (HIS-1 condition) I was told about earlier?**
If any doubt, fill a supplement condition page.

	JOB TASKS (O)	EYE CL LTR (P)	EAR LTR (P)	OTHER CL LTR (P)	ADL'S (O)
/					
	JOB TASKS (O)	EYE CL LTR (P)	EAR LTR (P)	OTHER CL LTR (P)	ADL'S (O)
/					
	JOB TASKS (O)	EYE CL LTR (P)	EAR LTR (P)	OTHER CL LTR (P)	ADL'S (O)
/					
	JOB TASKS (O)	EYE CL LTR (P)	EAR LTR (P)	OTHER CL LTR (P)	ADL'S (O)
/					
	JOB TASKS (O)	EYE CL LTR (P)	EAR LTR (P)	OTHER CL LTR (P)	ADL'S (O)
/					
	JOB TASKS (O)	EYE CL LTR (P)	EAR LTR (P)	OTHER CL LTR (P)	ADL'S (O)
/					
	JOB TASKS (O)	EYE CL LTR (P)	EAR LTR (P)	OTHER CL LTR (P)	ADL'S (O)
/					
	JOB TASKS (O)	EYE CL LTR (P)	EAR LTR (P)	OTHER CL LTR (P)	ADL'S (O)
/					

FOOTNOTES