

APPENDIX B

1992 Interval Questionnaire

Project No. 4563

AIR FORCE HEALTH STUDY
Third Followup Examinations
1992-1993

Study Subject
Health Interval Questionnaire

O.M.B. NUMBER
07010095
Approval Expires
May 1988

AIR FORCE HEALTH STUDY

Third Followup Examinations
1992-1993

Study Subject Health Interval Questionnaire

OTHER MATERIALS REQUIRED FOR THIS INTERVIEW ARE:

- PARTICIPANT INFORMATION SHEET
- CHILDREN'S RECORD FORM
- SUPPLEMENTARY CHILDREN'S RECORD FORM
- PRIVACY ACT STATEMENT
- INTERVAL SUPPLEMENTAL RECORDING BOOK
- RESPONDENT HAND CARDS A-Z, AA -- FF
- AFSC CODES LIST
- SELF-ADMINISTERED FORM 1
- SELF-ADMINISTERED FORM 2
- MEDICAL AUTHORIZATION FORMS
- HEALTH CARE PROVIDER FORMS
- DIETARY SELF-ADMINISTERED FORM
- CALENDAR

AIR FORCE HEALTH STUDY
Third Followup Examinations
1992-1993
Health Interval Questionnaire

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TIME BEGAN : AM/PM

10-13/

**SECTION A: INTRODUCTION AND
BACKGROUND****FOR THIS SECTION YOU WILL NEED:**

- PARTICIPANT INFORMATION SHEET
- HAND CARD A

Before I begin the interview, let me make sure that I have your correct name and rank. Is your name (READ NAME FROM INFORMATION SHEET) and is your rank (READ RANK FROM SHEET)?

IF INCORRECT, RE-ASK, CORRECT ON SHEET AND CONTINUE. IF YOU HAVE THE WRONG PERSON, END INTERVIEW AND TALK TO SUPERVISOR.

This part of the physical examination schedule will be an interview about your health and the health of your family. There will be some questions about your education, non-military employment, military experience, and health habits.

SAY TO PARTICIPANTS WHO PARTICIPATED IN PREVIOUS ROUNDS OF THE SURVEY: According to my records, you participated during the previous rounds of this survey. This time the interview will be comparable to the last one with a few additional questions.

The interview should last about two hours.

At various points during the interview, we will use the term "biological" to describe family relationships. For example, we may ask about your "biological" children. When using this term, we are referring to people who are related to you by blood. We do not mean your step-children or step-parents or people related to you through adoption.

You may refuse to answer any question you choose. However, we and the Air Force ask that you answer as many of the questions as you can, so the results will accurately and fully tell your story. We also need as accurate a picture as possible. So when we ask you about the dates of events in your life, please try to think carefully and remember as much as you possibly can.

HAVE PARTICIPANT FILL OUT PRIVACY ACT STATEMENT.

IF R IS NEW TO THE STUDY: (HE JUST COMPLETED THE BASELINE IN LA JOLLA THIS WEEK), HIS DATE OF LAST INTERVIEW IS DECEMBER 31, 1982. USE DECEMBER 31, 1982 AS THE REFERENCE DATE WHILE ADMINISTERING THE HEALTH INTERVAL QUESTIONNAIRE. IF R IS NEW TO STUDY, SKIP TO QUESTION 4A, ON PAGE A-3.

1. First I have a few background questions to ask you. My records indicate that your date of birth is (READ DATE OF BIRTH FROM ITEM 1, INFORMATION SHEET). Is that correct?

YES (CONTINUE) 1 14/

NO (ASK DOB, CORRECT ITEM 1,
INFORMATION SHEET, GO TO Q.2) 2

2. My records indicate that you were previously interviewed in (READ DATE OF LAST INTERVIEW FROM INFORMATION SHEET). Is that correct?

YES (SKIP TO QUESTION 3) 1

NO (ASK Q.2A) 2

2A. IF R CANNOT REMEMBER DATE OF LAST INTERVIEW, USE THE FOLLOWING PROBES. Were you here at Scripps five years ago?

YES (ASK Q.2A1) 1

NO (SKIP TO Q.2B) 2

2A1. Was it in 1988 or 1987?

YES (RECORD YEAR AND GO TO Q.2C) 1

NO (ASK Q.2B) 2

2B. Was it in 1986, 1985, 1982, OR 1981? (RECORD OR CORRECT INFORMATION SHEET)

2C. What month did the interview take place? (RECORD OR CORRECT INFORMATION SHEET)

2D. IF R CANNOT REMEMBER MONTH, USE THE FOLLOWING PROBE:

Was it in the Spring, Summer, Fall or Winter?

IF SPRING, CONVERT TO MONTH OF MARCH ON INFORMATION SHEET

IF SUMMER, CONVERT TO MONTH OF JUNE ON INFORMATION SHEET

IF FALL, CONVERT TO SEPTEMBER ON INFORMATION SHEET

IF WINTER, CONVERT TO DECEMBER ON INFORMATION SHEET

3. IF R WAS INTERVIEWED IN 88, 87, 86 OR 85, SKIP TO SECTION B: EDUCATION, PAGE B-1.

4A. RESPONDENT	4B. MOTHER	4C. FATHER
SHOW PARTICIPANT HAND CARD A. Please read Card A. To which of the following racial or ethnic groups do you belong? (CODE ALL THAT APPLY) (PROBE: What others?)	CONTINUE WITH HAND CARD A. To which of the following racial or ethnic groups does your biological mother belong? (CODE ALL THAT APPLY) (PROBE: What others?)	CONTINUE WITH HAND CARD A. To which of the following racial or ethnic groups does your biological father belong? (CODE ALL THAT APPLY) (PROBE: What others?)
ENGLISH/WELSH . . . 01 15-16/	ENGLISH/WELSH . . . 01 51-52/	ENGLISH/WELSH . 01 16-17/
SCOTTISH 02 17-18/	SCOTTISH 02 53-54	SCOTTISH 02 18-19/
GERMAN 03 19-20/	GERMAN 03 55-56/	GERMAN 03 20-21/
IRISH 04 21-22/	IRISH 04 57-58/	IRISH 04 22-23/
SCANDINAVIAN . . . 05 23-24/	SCANDINAVIAN . . . 05 59-60/	SCANDINAVIAN . . 05 24-25/
POLISH 06 25-26/	POLISH 06 61-62/	POLISH 06 26-27/
RUSSIAN 07 27-28/	RUSSIAN 07 63-64/	RUSSIAN 07 28-29/
OTHER SLAVIC . . . 08 29-30/	OTHER SLAVIC . . . 08 65-66/	OTHER SLAVIC . . 08 30-31/
JEWISH 09 31-32/	JEWISH 09 67-68/	JEWISH 09 32-33/
FRENCH 10 33-34/	FRENCH 10 69-70/	FRENCH 10 34-35/
ITALIAN 11 35-36/	ITALIAN 11 71-72/	ITALIAN 11 36-37/
SPANISH 12 37-38/	SPANISH 12 73-74/	SPANISH 12 38-39/
MEXICAN 13 39-40/	MEXICAN 13 75-76/	MEXICAN 13 40-41/
GREEK 14 41-42/	GREEK 14 77-78/	GREEK 14 42-43/
AMERICAN INDIAN 15 43-44/	AMERICAN INDIAN 15 79-80/	AMERICAN INDIAN 15 44-45/
BEGIN DECK 02		
ASIAN 16 45-46/	ASIAN 16 10-11/	ASIAN 16 46-47/
AFRICAN (OR BLACK AMERICAN) 17 47-48/	AFRICAN (OR BLACK AMERICAN) 17 12-13/	AFRICAN (OR BLACK AMERICAN) 17 48-49/
OTHER (SPECIFY) _____	OTHER (SPECIFY) _____	OTHER (SPECIFY) _____
_____ 18 49-50/	_____ 18 14-15/	_____ 18 50-51/

SECTION B: EDUCATION

FOR THIS SECTION YOU WILL NEED:

- PARTICIPANT INFORMATION SHEET
- HAND CARD B

1A. My records show that when you were last interviewed you had received a (READ LAST DEGREE OBTAINED FROM ITEM 2 OF INFORMATION SHEET). Is that correct?

- YES 1
- NO (CORRECT INFORMATION SHEET AND GO TO Q.1B) 2
- MISSING (ASK AND RECORD ON INFORMATION SHEET) .. 3

1B. SHOW PARTICIPANT HAND CARD B. Have you received any (additional) regular school certificates, diplomas or degrees since (DATE OF LAST INTERVIEW)?

- YES ... (ASK Q.1C AND Q.1D) 1
- NO (SKIP TO Q.2, NEXT PAGE) 2

52/

1C. What certificates, diplomas, and/or degrees did you get? (CODE ALL THAT APPLY)

1D. INTERVIEWER: FOR EACH DEGREE CODED IN Q.1C, ASK Q.1D. In what year did you receive (DEGREE IN 1C.)? RECORD YEAR

HIGH SCHOOL DIPLOMA	01	53-54/	19|_|_|	55-56/
			YEAR	
HIGH SCHOOL EQUIVALENCY DIPLOMA ...	02	57-58/	19|_|_|	59-60/
			YEAR	
ASSOCIATE OF ARTS (A.A.)	03	61-62/	19|_|_|	63-64/
			YEAR	
BACHELOR OF ARTS (B.A.) OR BACHELOR OF SCIENCE (B.S.)	04	65-66/	19|_|_|	67-68/
			YEAR	
MASTERS (M.A. OR M.S.)	05	69-70/	19|_|_|	71-72/
			YEAR	
DOCTORATE (Ph.D., M.D., Ed.D., Sc.D.)	06	73-74/	19|_|_|	75-76/
			YEAR	
OTHERS (SPECIFY)				
_____	07	77-78/	19|_|_|	79-80/
			YEAR	
NO CERTIFICATE, DIPLOMA, OR DEGREE (VOLUNTEERED)	08	BEGIN DECK 03 10-11/		

2. Since (DATE OF LAST INTERVIEW) have you participated in any civilian job training programs (other than the formal schooling that we discussed), that prepared you for a major change in your occupation?

- YES (ASK Q.2A) 1 12/
- NO (SKIP TO Q.3, PAGE B-5) 2

FIRST PROGRAM: CIVILIAN JOB TRAINING

2A. For what kind of work was your first civilian training program preparing you?
PROBE: What would your main duties be if you went into this line of work?

13-15/

2B. In what month and year did you start this training?

		--		
MONTH			YEAR	

16-19/

2C. In what month and year did you complete this training?

		--		
MONTH			YEAR	

20-23/

CURRENTLY IN TRAINING 1

2D. Have you participated in any other civilian job training program that prepared you for a major change in your occupation?

- YES (ASK Q.2E, NEXT PAGE) 1 24/
- NO (SKIP TO Q.3, PAGE B-5) 2

SECOND PROGRAM: CIVILIAN JOB TRAINING

2E. For what kind of work was your second civilian training program preparing you?
PROBE: What would your main duties be if you went into this line of work?

25-27/

2F. In what month and year did you start this training?

| | - | |
 MONTH YEAR

28-31/

2G. In what month and year did you complete this training?

| | - | |
 MONTH YEAR

32-35/

CURRENTLY IN TRAINING 1

2H. Have you participated in any other civilian job training program that prepared you for a major change in your occupation?

YES (ASK Q.2I, NEXT PAGE) 1

36/

NO (SKIP TO Q.3, PAGE B-5) 2

THIRD PROGRAM: CIVILIAN JOB TRAINING

2I. For what kind of work was your third civilian training program preparing you?
PROBE: What would your main duties be if you went into this line of work?

37-39/

2J. In what month and year did you start this training?

 | | | | -- | | | |
MONTH YEAR

40-43/

2K. In what month and year did you complete this training?

 | | | | -- | | | |
MONTH YEAR

44-47/

CURRENTLY IN TRAINING 1

2L. Have you participated in any other civilian job training program that prepared you for a major change in your occupation?

- YES (GO TO NEW QUEX) 1 48/
- NO 2

3. Have you served in the military full-time on active duty since (DATE OF LAST INTERVIEW).
IF NEW TO STUDY, USE DECEMBER 31, 1982).

YES	1	49/
-----------	---	-----

NO ... (SKIP TO SECTION C, PAGE C-1) 2

4. Are you currently serving in the military on active duty?

YES	1	50/
-----------	---	-----

NO 2

5. Now let's talk about any military and specialized training programs that prepared you for a major change in your occupation. Since (DATE OF LAST INTERVIEW), (and besides the formal schooling and job training programs you've told me about), have you participated in any military technical or specialized training programs that prepared you for a major change in your career?

YES .. (ASK Q.5A, NEXT PAGE) 1 51/

NO ... (SKIP TO SECTION C, PAGE C-1) 2

FIRST PROGRAM (LEAST RECENT): MILITARY TRAINING PROGRAM

5A. For what kind of work was your first military training program preparing you?
PROBE: What would your main duties be if you went into this line of work?

5B. What is the AFSC for that job?

52-56/

5C. In what month and year did you start this training?

--
MONTH YEAR

57-60/

5D. In what month and year did you complete this training?

--
MONTH YEAR

61-64/

CURRENTLY IN TRAINING 1

5E. Have you participated in any other military job training program that prepared you for a major change in your occupation?

YES .. (ASK Q.5F, NEXT PAGE) 1 65/

NO ... (SKIP TO SECTION C, PAGE C-1) 2

SECOND PROGRAM: MILITARY TRAINING PROGRAM

5F. For what kind of work was your second military training program preparing you?
PROBE: What would your main duties be if you went into this line of work?

5G. What is the AFSC for that job?

66-70/

5H. In what month and year did you start this training?

-
MONTH YEAR

71-74/

5I. In what month and year did you complete this training?

-
MONTH YEAR

75-78/

CURRENTLY IN TRAINING 1

5J. Have you participated in any other military job training program that prepared you for a major change in your occupation?

YES .. (ASK Q.5K, NEXT PAGE) 1 79/

NO ... (SKIP TO SECTION C, PAGE C-1) 2

THIRD PROGRAM (MOST RECENT): MILITARY TRAINING PROGRAM

5K. For what kind of work was your third military training program preparing you?
PROBE: What would your main duties be if you went into this line of work?

5L. What is the AFSC for that job?

BEGIN DECK 04

10-14/

5M. In what month and year did you start this training?

| | | | - - | | | |
 MONTH YEAR

15-18/

5N. In what month and year did you complete this training?

| | | | - - | | | |
 MONTH YEAR

19-22/

CURRENTLY IN TRAINING 1

5O. Have you participated in any other military job training program that prepared you for a major change in your occupation?

YES .. (GO TO NEW QUEx) 1

23/

NO ... (GO TO SECTION C, NEXT PAGE) 2

24-27/R

SECTION C: EMPLOYMENT (NON-MILITARY)

FOR THIS SECTION YOU WILL NEED:

- INTERVAL SUPPLEMENTAL RECORDING BOOK (I.S.R.B.)
- HAND CARD C
- HAND CARD D
- HAND CARD E

CURRENT OR MOST RECENT JOB

1. Now I have some questions about working. Please tell me about any jobs you've had that lasted for 3 months or longer since (DATE OF LAST INTERVIEW). Include current or newly found jobs. If you had more than one job at the same time, please tell me about each job separately. *Count changes of jobs for the same employer as separate jobs. Do not include jobs in the military.* Let's start with the most recent regular job you've had and work back in time to (DATE OF LAST INTERVIEW).

In what month and year did you start your current job, or if you don't have a current job, your most recent job that lasted 3 months or longer?

_ _	--	_ _	
MONTH		YEAR	28-31/

NO CIVILIAN JOBS:

ONLY MILITARY JOBS. . .	(SKIP TO Q.IS.1 IN I.S.R.B. ON PAGE 2)	. . . 1	32/
-------------------------	--	---------	-----

1A. What (is/was) the name of your employer?

_____ 33-57/

1B. (Is/Was) this a full-time or part-time job?

FULL-TIME	1	58/
PART-TIME	2	

1C. What kind of business (is/was) that--what (do/did) they make or do there?
RECORD VERBATIM

_____ 59-61/

1D. What (do/did) you actually do on the job--what (are/were) some of your main duties?
RECORD VERBATIM

_____ 62-64/

CURRENT OR MOST RECENT JOB (Continued)

3. While you were on that job, how often (do/did) you wash to remove the (SUBSTANCES) or use protective gear -- would you say all of the time, some of the time, or never?

- ALL OF THE TIME 1 32/
- SOME OF THE TIME 2
- NEVER (SKIP TO Q.5) 3

4. SHOW PARTICIPANT HAND CARD E. Which of the following (do/did) you use on that job?
CODE ALL THAT APPLY

- Air filter 01 33-34/
- Goggles 02 35-36/
- Face shield 03 37-38/
- Special clothing 04 39-40/
- Washing facilities 05 41-42/
- Self-contained or supplied air breathing apparatus 06 43-44/
- NONE 07 45-46/

5. Did you have another job before the job with (EMPLOYER NAME IN Q.1A) since (DATE OF LAST INTERVIEW) that lasted 3 months or longer?

- YES 1 47/
- NO **(SKIP TO Q.15.1 IN I.S.R.B. ON PAGE 2)** 2

SECOND MOST RECENT JOB

6. In what month and year did you start that job?

 |_|_| -- |_|_|
 MONTH YEAR

48-51/

6A. What was the name of your employer?

52-76/

6B. I have to ask you the same questions for this employer. Was this a full-time or part-time job?

FULL-TIME 1

PART-TIME 2

77/

BEGIN DECK 06

6C. What kind of business was that--what did they make or do there?
RECORD VERBATIM

10-12/

6D. What did you actually do on the job--what were some of your main duties?
RECORD VERBATIM

13-15/

SECOND MOST RECENT JOB (Continued)

6E. SHOW PARTICIPANT HAND CARD C. Please look at this card and tell me which number best describes the kind of industry you worked in?

WRITE IN NUMBER: 16-17/

6F. In what month and year did this job end?

--
 MONTH YEAR 18-21/

CURRENT JOB (SKIP TO Q.7, BELOW) 1

6G. What was the main reason you stopped working on your job?
 RECORD VERBATIM

22-23/

7. SHOW PARTICIPANT HAND CARD D. While working at (EMPLOYER NAMED IN Q.6A) did you come in contact with any of the substances on this card? By contact I mean that you inhaled, tasted, had skin contact with these fibers and chemicals or were exposed to ionizing or nuclear radiation. CODE ALL THAT APPLY

7A. FOR EACH SUBSTANCE CODED IN Q.7, ASK Q.7A.

In general, how many days a month did you come in contact with (SUBSTANCE)?

- | | | | | | |
|---|----|--------|--|---------------------------------|--------|
| Asbestos | 01 | 24-25/ | <input type="text"/> <input type="text"/> DAYS | Less than once a month . . . 95 | 26-27/ |
| Ionizing or nuclear radiation | 02 | 28-29/ | <input type="text"/> <input type="text"/> DAYS | Less than once a month . . . 95 | 30-31/ |
| Industrial chemicals | 03 | 32-33/ | <input type="text"/> <input type="text"/> DAYS | Less than once a month . . . 95 | 34-35/ |
| Insecticides or pesticides | 04 | 36-37/ | <input type="text"/> <input type="text"/> DAYS | Less than once a month . . . 95 | 38-39/ |
| Degreasing chemicals | 05 | 40-41/ | <input type="text"/> <input type="text"/> DAYS | Less than once a month . . . 95 | 42-43/ |
| Defoliants or herbicides | 06 | 44-45/ | <input type="text"/> <input type="text"/> DAYS | Less than once a month . . . 95 | 46-47/ |
| NONE OF THE ABOVE
(SKIP TO Q.10, PAGE C-6) | 07 | 48-49/ | | | |

SECOND MOST RECENT JOB (Continued)

8. While you were on that job, how often did you wash to remove the (SUBSTANCES) or use protective gear -- would you say all of the time, some of the time, or never?

- ALL OF THE TIME 1 50/
- SOME OF THE TIME 2
- NEVER (SKIP TO Q.10) 3

9. SHOW PARTICIPANT HAND CARD E. Which of the following did you use on that job?
CODE ALL THAT APPLY

- Air filter 01 51-52/
- Goggles 02 53-54/
- Face shield 03 55-56/
- Special clothing 04 57-58/
- Washing facilities 05 59-60/
- Self-contained or supplied air breathing apparatus 06 61-62/
- NONE 07 63-64/

10. Did you have another job before the job with (EMPLOYER NAME IN Q.6A) since (DATE OF LAST INTERVIEW)?

- YES 1 65/
- NO (SKIP TO Q.JS.1 IN LS.R.B. ON PAGE 2) 2

THIRD MOST RECENT JOB

11. In what month and year did you start that job?

 |_|_| - |_|_|
 MONTH - YEAR

66-69/

11A. What was the name of your employer?

BEGIN DECK 07

10-34/

11B. Was this a full-time or part-time job?

FULL-TIME 1

35/

PART-TIME 2

11C. What kind of business was that--what did they make or do there?
RECORD VERBATIM

36-38/

11D. What did you actually do on the job--what were some of your main duties?
RECORD VERBATIM

39-41/

THIRD MOST RECENT JOB (Continued)

11E. SHOW PARTICIPANT HAND CARD C. Please look at this card and tell me which number best describes the kind of industry you worked in?

WRITE IN NUMBER: 42-43/

11F. In what month and year did this job end?

--
MONTH YEAR

CURRENT JOB (SKIP TO Q.12, BELOW) 1 44-47/

11G. What was the main reason you stopped working on your job?
RECORD VERBATIM

_____ 48-49/

12. SHOW PARTICIPANT HAND CARD D. While working at (EMPLOYER NAMED IN Q.11A) did you come in contact with any of the substances on this card? By contact I mean that you inhaled, tasted, had skin contact with these fibers and chemicals or were exposed to ionizing or nuclear radiation. CODE ALL THAT APPLY

12A. FOR EACH SUBSTANCE CODED IN Q.12, ASI 12A.

In general, how many days a month did you come in contact with (SUBSTANCE)?

- Asbestos 01 50-51/
- Ionizing or nuclear radiation 02 54-55/
- Industrial chemicals 03 58-59/
- Insecticides or pesticides 04 62-63/
- Degreasing chemicals 05 66-67/
- Defoliants or herbicides 06 70-71/
- NONE OF THE ABOVE
(SKIP TO Q.15, PAGE C-9) 07 74-75/

- DAYS Less than once a month . . 95 52-5
- DAYS Less than once a month . . 95 56-5
- DAYS Less than once a month . . 95 60-6
- DAYS Less than once a month . . 95 64-6
- DAYS Less than once a month . . 95 68-6
- DAYS Less than once a month . . 95 72-7

THIRD MOST RECENT JOB (Continued)

13. While you were on that job, how often did you wash to remove the (SUBSTANCES) or use protective gear – would you say all of the time, some of the time, or never?

- ALL OF THE TIME 1 76/
- SOME OF THE TIME 2
- NEVER (SKIP TO Q.15, BELOW) 3

14. SHOW PARTICIPANT HAND CARD E. Which of the following did you use on that job?
CODE ALL THAT APPLY

- | | | |
|--|----|---------------|
| | | BEGIN DECK 08 |
| Air filter | 01 | 10-11/ |
| Goggles | 02 | 12-13/ |
| Face shield | 03 | 14-15/ |
| Special clothing | 04 | 16-17/ |
| Washing facilities | 05 | 18-19/ |
| Self-contained or supplied air breathing apparatus | 06 | 20-21/ |
| NONE | 07 | 22-23/ |

15. Did you have another job before the job with (EMPLOYER NAME IN Q.11A) since (DATE OF LAST INTERVIEW)?

- YES 1 24/
- NO (SKIP TO Q.IS.1 IN I.S.R.B. ON PAGE 2) 2

FOURTH MOST RECENT JOB

16. In what month and year did you start that job?

 |_|_| - |_|_|
 MONTH YEAR

25-28/

16A. What was the name of your employer?

29-53/

16B. Was this a full-time or part-time job?

FULL-TIME 1

54/

PART-TIME 2

16C. What kind of business was that--what did they make or do there?
RECORD VERBATIM

55-57/

16D. What did you actually do on the job--what were some of your main duties?
RECORD VERBATIM

58-60/

FOURTH MOST RECENT JOB (Continued)

16E. SHOW PARTICIPANT HAND CARD C. Please look at this card and tell me which number best describes the kind of industry you worked in?

WRITE IN NUMBER:

61-62/

16F. In what month and year did this job end?

--
MONTH YEAR

63-66/

CURRENT JOB (SKIP TO Q.17, BELOW) 1

16G. What was the main reason you stopped working on your job?
RECORD VERBATIM

67-68/

17. SHOW PARTICIPANT HAND CARD D. While working at (EMPLOYER NAMED IN Q.16A) did you come in contact with any of the substances on this card? By contact I mean that you inhaled, tasted, had skin contact with these fibers and chemicals or were exposed to ionizing or nuclear radiation. CODE ALL THAT APPLY

17A. FOR EACH SUBSTANCE CODED IN Q.17, ASK Q.17A.

In general, how many days a month did you come in contact with (SUBSTANCE)?

Asbestos 01 69-70/

DAYS Less than once a month .. 95 71-72/

Ionizing or nuclear radiation 02 73-74/

DAYS Less than once a month .. 95 75-76/

Industrial chemicals 03 77-78/

DAYS Less than once a month .. 95 79-80/

BEGIN DECK 09

Insecticides or pesticides 04 10-11/

DAYS Less than once a month .. 95 12-13/

Degreasing chemicals 05 14-15/

DAYS Less than once a month .. 95 16-17/

Defoliants or herbicides 06 18-19/

DAYS Less than once a month .. 95 20-21/

NONE OF THE ABOVE
(SKIP TO Q.20, PAGE C-12) 07 22-23/

FOURTH MOST RECENT JOB (Continued)

18. While you were on that job, how often did you wash to remove the (SUBSTANCES) or use protective gear – would you say all of the time, some of the time, or never?

- ALL OF THE TIME 1 24/
- SOME OF THE TIME 2
- NEVER (SKIP TO Q.20, BELOW) 3

19. SHOW PARTICIPANT HAND CARD E. Which of the following did you use on that job?
CODE ALL THAT APPLY

- Air filter 01 25-26/
- Goggles 02 27-28/
- Face shield 03 29-30/
- Special clothing 04 31-32/
- Washing facilities 05 33-34/
- Self-contained or supplied air breathing apparatus 06 35-36/
- NONE 07 37-38/

20. Did you have another job before the job with (EMPLOYER NAME IN Q.16A) since (DATE OF LAST INTERVIEW)?

- YES (USE NEW QUEx) 1 39/
- NO (SKIP TO Q.15.1 IN I.S.R.B. ON PAGE 2) 2

21. During the past six months, did *illness or injury* keep you from working, not counting work around the house?

- YES 1 40/
- NO (SKIP TO SECTION D) 2
- RETIRED (SKIP TO SECTION D) 3
- UNEMPLOYED (SKIP TO SECTION D) 4

22. Altogether, how many days did illness or injury keep you from working during the past six months?
REFERS TO "WORKING DAYS" ONLY

ENTER NUMBER OF DAYS:

41-43/

23. What illnesses or injuries caused you to miss work? (PROBE: What others?)

44/



SECTION D: MILITARY EXPERIENCE
FOR THIS SECTION YOU WILL NEED:

- PARTICIPANT INFORMATION SHEET
- HAND CARD D
- HAND CARD E
- HAND CARD F

1. WAS R INTERVIEWED IN 1985, 1986 OR 1987, 1988? SEE INFORMATION SHEET.
- YES (SKIP TO Q.3) 1
- NO (GO TO Q.2) 2
2. SHOW PARTICIPANT HAND CARD F. Which of the following statements best describes your assignment during the Vietnam War? Were you ... (READ CHOICES)? CODE ONE.
- A crew member in Vietnam who was on flying status 1 45/
- Not a crew member, but flew one or more missions in Vietnam 2
- A crew member, but did not log flying time in Vietnam 3
- Not a crew member 4
3. INTERVIEWER: HAS R SERVED IN MILITARY ON ACTIVE DUTY SINCE DATE OF LAST INTERVIEW? INTERVIEWER CHECK: GO TO SECTION B, PAGE B-5. IS QUESTION 3 CODED "YES"?
- YES (GO TO Q.3A) 1 46/
- NO (SKIP TO SECTION E, PAGE E-1) 2
- 3A. I am going to ask you about some of your experience in the military since (READ DATE OF LAST INTERVIEW).
- 3B. According to your records, your last branch of service was (BRANCH FROM ITEM 3)? Is that correct?
- YES 1
- NO (CORRECT INFORMATION SHEET) 2
- MISSING. (ASK LAST BRANCH OF SERVICE, RECORD AT ITEM 3 ON INFORMATION SHEET) 3

BEGIN DECK 10

FIRST COUNTRY	SECOND COUNTRY	THIRD COUNTRY
<p>5A. Since (READ DATE OF LAST INTERVIEW), in what country were you next stationed while on active duty? Please include temporary duties of greater than 90 days.</p> <p>_____</p> <p>1ST COUNTRY 55-56/</p>	<p>5L. Since (READ DATE OF LAST INTERVIEW), in what other country were you next stationed while on active duty? Please include temporary duties of greater than 90 days.</p> <p>_____</p> <p>1ST COUNTRY 10-11/</p>	<p>5W. Since (READ DATE OF LAST INTERVIEW), in what other country were you next stationed while on active duty? Please include temporary duties of greater than 90 days.</p> <p>_____</p> <p>1ST COUNTRY 35-36/</p>
<p>5B. In what month and year did you begin and end active duty in (COUNTRY)?</p> <p>BEGIN</p> <p>____|____|____|____| -- ____|____|____|____|</p> <p>MONTH YEAR 57-60/</p> <p>END</p> <p>____|____|____|____| -- ____|____|____|____|</p> <p>MONTH YEAR 61-64/</p> <p>CURRENT (NO END DATE) 1</p>	<p>5M. In what month and year did you begin and end active duty in (COUNTRY)?</p> <p>BEGIN</p> <p>____|____|____|____| -- ____|____|____|____|</p> <p>MONTH YEAR 12-15/</p> <p>END</p> <p>____|____|____|____| -- ____|____|____|____|</p> <p>MONTH YEAR 16-19/</p> <p>CURRENT (NO END DATE) 1</p>	<p>5X. In what month and year did you begin and end active duty in (COUNTRY)?</p> <p>BEGIN</p> <p>____|____|____|____| -- ____|____|____|____|</p> <p>MONTH YEAR 37-40/</p> <p>END</p> <p>____|____|____|____| -- ____|____|____|____|</p> <p>MONTH YEAR 41-44/</p> <p>CURRENT (NO END DATE) 1</p>
<p>5C. What specific job assignments (do/did) you have in (COUNTRY) since (DATE OF LAST INTERVIEW)? Can you give me the Air Force Speciality Code? (PROBE: What others?)</p> <p>1. ____|____|____|____|____| 65-69/</p> <p>2. ____|____|____|____|____| 70-74/</p> <p>3. ____|____|____|____|____| 75-79/</p> <p>(GO TO Q5.D ON PAGE D-4)</p>	<p>5N. What specific job assignments (do/did) you have in (COUNTRY) since (DATE OF LAST INTERVIEW)? Can you give me the Air Force Speciality Code? (PROBE: What others?)</p> <p>1. ____|____|____|____|____| 20-24/</p> <p>2. ____|____|____|____|____| 25-29/</p> <p>3. ____|____|____|____|____| 30-34/</p> <p>(GO TO Q5.O ON PAGE D-4)</p>	<p>5Y. What specific job assignments (do/did) you have in (COUNTRY) since (DATE OF LAST INTERVIEW)? Can you give me the Air Force Speciality Code? (PROBE: What others?)</p> <p>1. ____|____|____|____|____| 45-49/</p> <p>2. ____|____|____|____|____| 50-54/</p> <p>3. ____|____|____|____|____| 55-59/</p> <p>(GO TO Q.5Z ON PAGE D-4)</p>

BEGIN DECK 12

FIRST COUNTRY	SECOND COUNTRY	THIRD COUNTRY
<p>5G. SHOW PARTICIPANT HAND CARD D. In your job assignments while stationed in (COUNTRY), (do/did) you come in contact with any of the substances on this card? By contact I mean that you inhaled, tasted, had skin contact with these fibers and chemicals, or were exposed to ionizing or nuclear radiation. CODE ALL THAT APPLY.</p> <p>Asbestos 01 50-51/</p> <p>Ionizing or nuclear radiation . . . 02 52-53/</p> <p>Industrial chemicals . 03 54-55/</p> <p>Insecticides or pesticides 04 56-57/</p> <p>Degreasing chemicals 05 58-59/</p> <p>Defoliants or herbicides 06 60-61/</p> <p>NONE OF THE ABOVE (SKIP TO SECOND COUNTRY Q.5K ON PAGE D-7) 07 62-63/</p>	<p>5R. SHOW PARTICIPANT HAND CARD D. In your job assignments while stationed in (COUNTRY), (do/did) you come in contact with any of the substances on this card? By contact I mean that you inhaled, tasted, had skin contact with these fibers and chemicals, or were exposed to ionizing or nuclear radiation. CODE ALL THAT APPLY.</p> <p>Asbestos 01 64-65/</p> <p>Ionizing or nuclear radiation . . . 02 66-67/</p> <p>Industrial chemicals . 03 68-69/</p> <p>Insecticides or pesticides 04 70-71/</p> <p>Degreasing chemicals 05 72-73/</p> <p>Defoliants or herbicides 06 74-75/</p> <p>NONE OF THE ABOVE (SKIP TO THIRD COUNTRY Q.5V ON PAGE D-7) 07 76-77/</p>	<p>5CC. SHOW PARTICIPANT HAND CARD D. In your job assignments while stationed in (COUNTRY), (do/did) you come in contact with any of the substances on this card? By contact I mean that you inhaled, tasted, had skin contact with these fibers and chemicals, or were exposed to ionizing or nuclear radiation. CODE ALL THAT APPLY.</p> <p>Asbestos 01 10-11/</p> <p>Ionizing or nuclear radiation 02 12-13/</p> <p>Industrial chemicals . 03 14-15/</p> <p>Insecticides or pesticides 04 16-17/</p> <p>Degreasing chemicals 05 18-19/</p> <p>Defoliants or herbicides 06 20-21/</p> <p>NONE OF THE ABOVE (SKIP TO FOURTH COUNTRY Q.5GG ON PAGE D-7) 07 22-23/</p>

FIRST COUNTRY	SECOND COUNTRY	THIRD COUNTRY
<p>5H. FOR ANY SUBSTANCE CODED IN PREVIOUS QUESTION, ASK: In general, how many days a month (do/did) you come in contact with (SUBSTANCE)?</p> <p>Asbestos <input type="text"/> <input type="text"/> 24-25/ less than once a month 95</p> <p>Ionizing or nuclear radiation <input type="text"/> <input type="text"/> 26-27/ less than once a month 95</p> <p>Industrial chemicals <input type="text"/> <input type="text"/> 28-29/ less than once a month 95</p> <p>Insecticides or pesticides <input type="text"/> <input type="text"/> 30-31/ less than once a month 95</p> <p>Degreasing chemicals <input type="text"/> <input type="text"/> 32-33/ less than once a month 95</p> <p>Defoliant or herbicides <input type="text"/> <input type="text"/> 34-35/ less than once a month 95</p>	<p>5S. FOR ANY SUBSTANCE CODED IN PREVIOUS QUESTION, ASK: In general, how many days a month (do/did) you come in contact with (SUBSTANCE)?</p> <p>Asbestos <input type="text"/> <input type="text"/> 37-38/ less than once a month 95</p> <p>Ionizing or nuclear radiation <input type="text"/> <input type="text"/> 39-40/ less than once a month 95</p> <p>Industrial chemicals <input type="text"/> <input type="text"/> 41-42/ less than once a month 95</p> <p>Insecticides or pesticides <input type="text"/> <input type="text"/> 43-44/ less than once a month 95</p> <p>Degreasing chemicals <input type="text"/> <input type="text"/> 45-46/ less than once a month 95</p> <p>Defoliant or herbicides <input type="text"/> <input type="text"/> 47-48/ less than once a month 95</p>	<p>5DD. FOR ANY SUBSTANCE CODED IN PREVIOUS QUESTION, ASK: In general, how many days a month (do/did) you come in contact with (SUBSTANCE)?</p> <p>Asbestos <input type="text"/> <input type="text"/> 50-51/ less than once a month 95</p> <p>Ionizing or nuclear radiation <input type="text"/> <input type="text"/> 52-53/ less than once a month 95</p> <p>Industrial chemicals <input type="text"/> <input type="text"/> 54-55/ less than once a month 95</p> <p>Insecticides or pesticides <input type="text"/> <input type="text"/> 56-57/ less than once a month 95</p> <p>Degreasing chemicals <input type="text"/> <input type="text"/> 58-59/ less than once a month 95</p> <p>Defoliant or herbicides <input type="text"/> <input type="text"/> 60-61/ less than once a month 95</p>
<p>5I. When you washed to remove the (SUBSTANCES) or used protective clothing or gear when stationed in (COUNTRY) was it all the time, some of the time, or never? 36/</p> <p>ALL THE TIME 1</p> <p>SOME OF THE TIME ... 2</p> <p>NEVER. (SKIP TO Q.5K PAGE D-7) 3</p>	<p>5T. When you washed to remove the (SUBSTANCES) or used protective clothing or gear when stationed in (COUNTRY) was it all the time, some of the time, or never? 49/</p> <p>ALL THE TIME 1</p> <p>SOME OF THE TIME 2</p> <p>NEVER. (SKIP TO Q.5V PAGE D-7) 3</p>	<p>5EE. When you washed to remove the (SUBSTANCES) or used protective clothing or gear when stationed in (COUNTRY) was it all the time, some of the time, or never? 62/</p> <p>ALL THE TIME 1</p> <p>SOME OF THE TIME 2</p> <p>NEVER. (SKIP TO Q5.GG PAGE D-7) 3</p>

BEGIN DECK 13

FIRST COUNTRY	SECOND COUNTRY	THIRD COUNTRY
<p>5J. SHOW PARTICIPANT HAND CARD E. Which of the following did you use on that job? CODE ALL THAT APPLY.</p> <p>Air filter 01 63-64/ Goggles 02 65-66/ Face Shield . 03 67-68/ Special clothing 04 69-70/ Washing facilities 05 71-72/ Self contained or supplied air breathing apparatus . . 06 73-74/ NONE 07 75-76/</p>	<p>5U. SHOW PARTICIPANT HAND CARD E. Which of the following did you use on that job? CODE ALL THAT APPLY.</p> <p>Air filter 01 10-11/ Goggles 02 12-13/ Face Shield . . 03 14-15/ Special clothing 04 16-17/ Washing facilities 05 18-19/ Self contained or supplied air breathing apparatus . . . 06 20-21/ NONE 07 22-23/</p>	<p>5FF. SHOW PARTICIPANT HAND CARD E. Which of the following did you use on that job? CODE ALL THAT APPLY.</p> <p>Air filter 01 25-26/ Goggles 02 27-28/ Face Shield . . . 03 29-30/ Special clothing . 04 31-32/ Washing facilities 05 33-34/ Self contained or supplied air breathing apparatus 06 35-36/ NONE 07 37-38/</p>
SECOND COUNTRY	THIRD COUNTRY	FOURTH COUNTRY
<p>5K. Are there any other countries that you have been stationed in since (DATE OF LAST INTERVIEW)?</p> <p>YES. . .(GO BACK TO Q.5L: SECOND COUNTRY ON PAGE D-3) . 1 77/ NO. . .(SKIP TO SECTION E, PAGE E-1) . . 2</p>	<p>5V. Are there any other countries that you have been stationed in since (DATE OF LAST INTERVIEW)?</p> <p>YES. . .(GO BACK TO Q.5W: THIRD COUNTRY ON PAGE D-3) 1 24/ NO. . .(SKIP TO SECTION E, PAGE E-1) . . 2</p>	<p>5GG. Are there any other countries that you have been stationed in since (DATE OF LAST INTERVIEW)?</p> <p>YES. . .(USE NEW QUEX) 1 39/ NO. . .(SKIP TO SECTION E, PAGE E-1) . . . 2</p>

1B. IF NOT LIVING WITH PARTNER AT TIME OF LAST INTERVIEW, SKIP TO 1C, OTHERWISE ASK: When we talked with you during the last interview, you said you were living with a partner. Is that correct?

YES (GO TO Q.1C) 1

NO (UPDATE ITEM 5, GO TO Q.1C) 2

1C. WAS RESPONDENT "LIVING WITH PARTNER" AT TIME OF LAST INTERVIEW?

YES (ASK Q.1D) 1 42/

NO (SKIP TO Q.3, PAGE E-5) 2

1D. What is the name of the person you were living with at the time of the last interview? RECORD BELOW

LAST NAME

FIRST NAME

1E. In what month and year did you start living with (READ NAME FROM Q.1D)?
(RECORD MONTH AND YEAR)

ENTER MONTH AND YEAR

____ -- ____
MONTH YEAR

43-46/

SKIP TO QUESTION 2, PAGE E-3

1F. According to our records, you were married to (NAME OF SPOUSE FROM ITEM 6 ON INFORMATION SHEET). Is that correct?

YES 1 47/

NO (REASK NAME OF SPOUSE, UPDATE ITEM 6) ... 2

MISSING . . (ASK NAME OF SPOUSE, RECORD AT ITEM 6) . . 3

2C. During this (marriage/relationship), how many times were you living apart from (NAME OF SPOUSE OR PARTNER) for 3 months or more since (DATE OF LAST INTERVIEW)? Each separation must have lasted at least 3 months or more. DO NOT INCLUDE A CURRENT MARITAL SEPARATION.

ENTER NUMBER OF TIMES: 58-59/

OR

NONE ... (SKIP TO Q.2N, PAGE E-5) 00

2D. For how many months did you live apart the (first/next) time? Each separation must have lasted at least 3 months or more. DO NOT INCLUDE A CURRENT MARITAL SEPARATION.

FIRST/ONLY TIME: 60-61/

SECOND TIME: 62-63/

THIRD TIME: 64-65/

FOURTH TIME: 66-67/

2E. During this (marriage/relationship), [since the (DATE OF LAST INTERVIEW)], did you ever have a problem conceiving a child because of prolonged separation?

YES 1 68/

NO 2

SKIP TO Q.2N, PAGE E-5

2F. QUESTION DELETED.

BEGIN DECK 14
10-34/R

2G. QUESTION DELETED.

35-61/R

2H. QUESTION DELETED.

62-74/R

- 2I. QUESTION DELETED. BEGIN DECK 15
10-44/R
- 2J. QUESTION DELETED. 45-46/R
- 2K. QUESTION DELETED. 47-71/R
- 2L. QUESTION DELETED. BEGIN DECK 16
10-36/R
37-49/R
- 2M. QUESTION DELETED. 50-74/R

2N. HAS R STOPPED LIVING WITH SPOUSE OR PARTNER? IS "YES" CODED AT Q.2 ON PAGE E-3?

YES 1 75/

NO (SKIP TO Q.10, PAGE E-18) 2

3. Since (DATE OF LAST INTERVIEW), have you done one of the following: (1) reconciled or married (again); or (2) lived with a partner for 3 months or more?

YES (ASK Q.3A) 1 76/

DID NEITHER ... (SKIP TO Q.10, PAGE E-18) 2

3A. How many times have you been married or lived with a partner, for at least 3 months since (DATE OF LAST INTERVIEW)?

RECORD NUMBER OF TIMES: 77/

4C. Have you stopped living with (NAME FROM Q.4A, PAGE E-6)?

YES 1 40/

NO (SKIP TO Q.4F) 2

4D. SHOW PARTICIPANT HAND CARD G. How did this (marriage/relationship) end? Choose one of the responses on Card G.

SEPARATION 1 41/

DIVORCE 2

DEATH OF SPOUSE OR PARTNER 3

4E. In what month and year did (RESPONSE FROM Q.4D) occur?

ENTER MONTH AND YEAR --
MONTH YEAR 42-45/

4F. During this (marriage/relationship), how many times were you living apart from (NAME FROM Q.4A) for 3 months or more since (DATE OF LAST INTERVIEW)?

ENTER NUMBER OF TIMES: 46-47/

OR

NONE . (SKIP TO Q.5, PAGE E-9) 00

4G. For how many months did you live apart the (this/first/next) time?

FIRST/ONLY TIME: 48-49/

SECOND TIME: 50-51/

THIRD TIME: 52-53/

FOURTH TIME: 54-55/

4O. QUESTION DELETED.

64-76/R
77/R

4P. QUESTION DELETED.

BEGIN DECK 20
10-34/R

5. IS THERE A SECOND RELATIONSHIP SINCE THE DATE OF LAST INTERVIEW? IS NUMBER OF
TIMES RECORDED IN Q.3A, PAGE E-5, EQUAL TO 2 OR MORE?

YES (GO TO Q.6, NEXT PAGE)	1	35/
NO (SKIP TO Q.10, PAGE E-18)	2	

SECOND RELATIONSHIP (SECOND MOST RECENT)

6. Thinking of the next relationship since (DATE OF LAST INTERVIEW), did you marry this person?

YES 1 36/
NO 2

6A. What is the current full name of this person?

ID #
37-38/

(LAST)

(FIRST) (MIDDLE)

6A-1. RECORD FULL NAME OF (SPOUSE/PARTNER) AT ITEM 7 ON INFORMATION SHEET. RECORD ID# ABOVE.

What was her full maiden name?

_____ 39-58/

6A-2. What was her birthdate? RECORD DATE: 59-64/

MO DA YR

6B. In what month and year did you (reconcile/get married to/start living with) (NAME FROM Q.6A)?

ENTER MONTH AND YEAR --
MONTH YEAR

65-68/

6C. Have you stopped living with (NAME FROM Q.6A)?

YES 1 69/

NO (SKIP TO Q.6F) 2

6D. SHOW PARTICIPANT HAND CARD G. How did this (marriage/relationship) end? Choose one of the responses on Card G.

SEPARATION 1 70/
DIVORCE 2
DEATH OF SPOUSE OR PARTNER 3

6I. QUESTION DELETED.	15-39/R
6J. QUESTION DELETED.	40-66/R
6K. QUESTION DELETED.	67-79/R
6L. QUESTION DELETED.	BEGIN DECK 22 10-29/R 30-44/R
6M. QUESTION DELETED.	45-46/R
6N. QUESTION DELETED.	47-71/R
	BEGIN DECK 23 10-29/R 30-36/R

60. QUESTION DELETED. 37-49/R

6P. QUESTION DELETED. 50/R
51-75/R

7. IS THERE A THIRD RELATIONSHIP SINCE THE DATE OF LAST INTERVIEW?

IS NUMBER OF TIMES RECORDED IN Q.3A, PAGE E-5 EQUAL TO 3 OR MORE?

YES (GO TO Q.8, NEXT PAGE) 1 76/

NO (SKIP TO Q.10, PAGE E-18) 2

THIRD RELATIONSHIP

8. Thinking of the next relationship since (DATE OF LAST INTERVIEW), did you marry this person?

- YES 1 77/
- NO 2

8A. What is the current full name of this person?

ID #
78-79/

(LAST)

(FIRST) (MIDDLE)

8A-1. RECORD FULL NAME OF (SPOUSE/PARTNER) AT ITEM 7 ON INFORMATION SHEET.
RECORD ID# ABOVE.

BEGIN DECK 24

What was her full maiden name?

_____ 10-29/

What was her birthdate? RECORD DATE: 30-35/
MO DA YR

8B. In what month and year did you (reconcile/get married to/start living with) (NAME FROM Q.8A)?

ENTER MONTH AND YEAR --
MONTH YEAR 36-39/

8C. Have you stopped living with (NAME FROM Q.8A)?

YES 1 40/

NO(SKIP TO Q.8F)..... 2

8D. SHOW PARTICIPANT HAND CARD G. How did this (marriage/relationship) end?
Choose one of the responses on Card G.

- SEPARATION 1 41/
- DIVORCE 2
- DEATH OF SPOUSE OR PARTNER 3

8I. QUESTION DELETED.

57-80/R

8J. QUESTION DELETED.

BEGIN DECK 25
10-36/R

8K. QUESTION DELETED.

37-49/R

8L. QUESTION DELETED.

50-74/R

8M. QUESTION DELETED.

75-76/R

8N. QUESTION DELETED.

BEGIN DECK 26
10-34/R
35-61/R

80. QUESTION DELETED.

62-74/R
75/R

8P. QUESTION DELETED.

BEGIN DECK 27
10-34/R

9. IS THERE A FOURTH RELATIONSHIP SINCE THE DATE OF LAST INTERVIEW?

IS NUMBER OF TIMES RECORDED IN Q.3A, EQUAL TO 4 OR MORE?

YES (GO TO NEW QUESTIONNAIRE) 1

35/

NO 2

10. NOW YOU WILL VERIFY BIOLOGICAL CHILDREN USING CHILDREN'S RECORD FORM: THIS FORM INCLUDES R'S BIOLOGICAL CHILDREN AS OF DATE OF LAST INTERVIEW.

ARE CHILDREN LISTED ON CHILDREN'S RECORD FORM?

YES (ASK Q.10A) 1 36/

NO (ASK Q.10B) 2

10A. I'd like to read information about your (child/children) from our last interview to check our records. As of (DATE OF LAST INTERVIEW), our records show that you have had (NUMBER OF CHILDREN).

NEXT, READ EACH CHILD'S FULL NAME, SEX, AND BIRTHDATE AND MOTHER'S NAME.
Is that correct?

YES, CHILDREN ARE CORRECT.
IF INFORMATION IS CORRECT(GO TO Q.11) 1 37/

NO.(IF INFORMATION IS INCOMPLETE,
MAKE CORRECTIONS FOR EACH CHILD
ON CHILDREN'S RECORD FORM.
CORRECT FULL NAME, SEX, DOB,
MOTHER'S MAIDEN NAME. THEN GO TO Q.11) 2

10B. Our records show that you had not had any children of your own as of (DATE OF LAST INTERVIEW).
Is that correct?

YES, IF INFORMATION IS CORRECT(GO TO Q.12) 1 38/

NOMISSING(IF CHILDREN MISSING, ADD TO CHILDREN'S
RECORD FORM. RECORD BEGINNING
AT LINE 01 ON CHILDREN'S
RECORD FORM. THEN GO TO Q.11) 2

11. NOW YOU WILL UPDATE EACH CHILD'S AGE. ASK THIS QUESTION FOR EACH CHILD LISTED ON CHILDREN'S RECORD FORM FOR WHOM THERE IS NO DEATH DATE: What is (READ NAME OF 1ST CHILD/NAME OF 2ND CHILD, SO FORTH)'s current age? UPDATE AGE ON CHILDREN'S RECORD FORM.

NOW YOU WILL ASK IF ANY OF THE CHILDREN HAVE DIED: Have any of your children died since (DATE OF LAST INTERVIEW)? FOR EACH CHILD THAT DIED, RECORD CHILD ID# IN QUESTIONNAIRE AND ASK QUESTIONS 11A THROUGH 11C. IF NO CHILDREN HAVE DIED, SKIP TO Q.12.

11A. FOR EACH DECEASED CHILD ASK: When did (NAME OF CHILD) die? RECORD DAY, MONTH, AND YEAR ON CHILDREN'S RECORD FORM.

11B. What was the cause of death? RECORD BELOW.

BEGIN DECK 28

11C. Where is (CHILD)'s death registered? In what city and state? RECORD BELOW.

CHILD ID: <input type="text"/> <input type="text"/> <input type="text"/> 39-40/	CHILD ID: <input type="text"/> <input type="text"/> <input type="text"/> 60-61/	CHILD ID: <input type="text"/> <input type="text"/> <input type="text"/> 10-11/
CAUSE: _____ 41/	CAUSE: _____ 62/	CAUSE: _____ 12/
REGISTRATION: _____ CITY 42-57/	REGISTRATION: _____ CITY 63-78/	REGISTRATION: _____ CITY 13-28/
STATE 58-59/	STATE 79-80/	STATE 29-30/

12. HAS R BEEN MARRIED OR HAD A PARTNER FOR 3 MONTHS OR MORE SINCE (DATE OF LAST INTERVIEW)? VERIFY WITH R.

YES (ASK Q.12A) 1 31/

NO (SKIP TO SECTION F, PAGE F-1) 2

12A. Has/Have (your wife/any of your partners) become pregnant by you since (DATE OF LAST INTERVIEW)? This includes pregnancies that began before (DATE OF LAST INTERVIEW) and ended after (DATE OF LAST INTERVIEW).

YES (ASK Q.12B) 1 32/

NO (SKIP TO Q.25, PAGE E-35) 2

12B. How many pregnancies (has your wife/have your partners) had with you since (DATE OF LAST INTERVIEW)?

ENTER NUMBER OF PREGNANCIES: 33-34/

FIRST PREGNANCY

13. When did the first pregnancy begin? What month and year?

ENTER MONTH AND YEAR

|_|_| -- |_|_|
MONTH YEAR

35-38/

13A. HAS R HAD MORE THAN ONE RELATIONSHIP SINCE DATE OF LAST INTERVIEW? IS "YES" CODED AT Q.3, PAGE E-5?)

YES (ASK Q.13B) 1

39/

NO (SKIP TO Q.13C) 2

13B. Which (spouse/partner) had this pregnancy?

RECORD NAME:

(LAST) (MAIDEN)

(FIRST) (MIDDLE)

40-64/

RECORD ID # FROM INFORMATION SHEET.

65-66/

13C. How many months did it take (NAME OF SPOUSE/PARTNER) to become pregnant (this time)?

RECORD MONTHS	<input type="text"/>	<input type="text"/>	AND/OR	<input type="text"/>	<input type="text"/>	67-68/
AND/OR YEARS	MOS			YRS		
WASN'T TRYING	.....		00			69-70/
OR						
DON'T KNOW	.....		98			

13D. Were either you or (NAME OF SPOUSE/PARTNER) using birth control at the time she became pregnant?

YES	..... (ASK Q.13E)	1	71/
NO	..... (SKIP TO Q.14)	2	

13E. SHOW PARTICIPANT HAND CARD H. Please look at this card and tell me all the numbers of the types of birth control you and (NAME FROM Q.13B) were using when she became pregnant. CODE ALL THAT APPLY.

1. PILL	.....	01	72-73/
2. DOUCHE	.....	02	74-75/
3. FOAM	.....	03	76-77/
4. JELLY, CREAM, SUPPOSITORY	.....	04	78-79/
BEGIN DECK 29			
5. IUD	.....	05	10-11/
6. CONDOM, RUBBER	.....	06	12-13/
7. DIAPHRAGM	.....	07	14-15/
8. DIAPHRAGM AND JELLY	.....	08	16-17/
9. SPONGE	.....	09	18-19/
10. RHYTHM - CALENDAR	.....	10	20-21/
11. RHYTHM - TEMPERATURE	.....	11	22-23/
12. WITHDRAWAL	.....	12	24-25/
13. OTHER (SPECIFY) _____			
		13	26-27/
DON'T KNOW	.....	98	28-29/

14. Did that pregnancy result in a live birth; or in a miscarriage, stillbirth, or abortion, [or is (NAME) still pregnant]?

LIVE BIRTH	.....	1	30/
MISCARRIAGE	..... (SKIP TO Q.16)	2	
STILLBIRTH	..... (SKIP TO Q.16)	3	
ABORTION	..... (SKIP TO Q.16)	4	
STILL PREGNANT	..... (SKIP TO Q.25, PAGE E-35)	5	

14A. What is the first and last name of the child as it appears on the birth certificate?
RECORD ON SUPPLEMENTARY CHILDREN'S RECORD FORM.

RECORD ID FROM SUPPLEMENTARY CHILDREN'S RECORD FORM 31-32/

14B. When was (CHILD) born? ENTER BIRTHDATE ON SUPPLEMENTARY CHILDREN'S RECORD FORM.

14C. Was (CHILD) male or female? RECORD ON SUPPLEMENTARY CHILDREN'S RECORD FORM.

14D. How much did (CHILD) weigh at birth?

ENTER POUNDS: 33-34/

AND

OUNCES: 35-36/

OR
DON'T KNOW 98

14E. Was (CHILD) a twin?

YES 1 37/

NO 2

14F. Was (CHILD) premature, full term, or overdue?

PREMATURE 1 38/

FULL TERM 2

OVERDUE 3

DON'T KNOW 8

14G. How old was (NAME OF MOTHER) when (CHILD) was born?

RECORD AGE: 39-40/

DON'T KNOW 98

14H. What is the name and address of the hospital where this child was born? RECORD BELOW

41/

 NAME OF HOSPITAL

 STREET ADDRESS

 (CITY) _____ (STATE)

RECORD NAME AND ADDRESS ON MEDICAL CONSENT FORM

14I. What is the name and address of the doctor or medical facility who has (CHILD)'s current medical records? RECORD BELOW.

42/

 DOCTOR'S NAME OR FACILITY NAME

 STREET ADDRESS

 (CITY) _____ (STATE)

RECORD NAME AND ADDRESS ON MEDICAL CONSENT FORM

14J. Is this child still living? IF NO, SKIP TO Q.14K. IF YES, ASK: What is child's current age?
RECORD AGE ON SUPPLEMENT CHILDREN'S FORM. SKIP TO Q.15.

14K. When did (CHILD) die?

RECORD DAY, MONTH, AND YEAR ON SUPPLEMENTARY CHILDREN'S RECORD FORM.

14L. What was the cause of death? RECORD BELOW.

43/

14M. Where is (CHILD'S) death registered? In what city and state?

 (CITY) _____ (STATE)

44-59/
60-61/

15. IS THERE A SECOND PREGNANCY SINCE THE DATE OF LAST INTERVIEW? IS NUMBER OF PREGNANCIES IN Q.12B ON PAGE E-20 EQUAL TO 2 OR MORE?

YES (SKIP TO Q.17) 1 62/
NO (SKIP TO Q.25, PAGE E-35) 2

16. When did that pregnancy end?

RECORD DATE: 63-68/
MO DA YR

16A. How many weeks had (NAME FROM Q.13B) been pregnant when that happened?

ENTER NUMBER OF WEEKS: 69-70/
DONT KNOW 98

16B. IF CODE "2" OR "3" IN Q.14, MISCARRIAGE OR STILLBIRTH, ASK Q.16B-C. OTHERS GO TO Q.16D. Did a doctor tell you why this (miscarriage/stillbirth) might have occurred?

YES (ASK Q.16C) 1 71/
NO (SKIP TO Q.16D) 2

16C. What did the doctor say caused the (miscarriage/stillbirth)? RECORD VERBATIM.

72/

16D. IS THERE A SECOND PREGNANCY SINCE DATE OF LAST INTERVIEW? IS NUMBER OF PREGNANCIES IN Q.12B ON PAGE E-20 EQUAL TO 2 OR MORE?

YES (GO TO Q.17) 1 73/
NO (SKIP TO Q.25, PAGE E-35) . 2

SECOND PREGNANCY

17. When did the next pregnancy begin? What month and year?

ENTER MONTH AND YEAR -
MONTH YEAR

74-77/

17A. HAS R HAD MORE THAN ONE RELATIONSHIP SINCE DATE OF LAST INTERVIEW?
(SEE ITEM 7, INFORMATION SHEET.)

YES (ASK Q.17B) 1

78/

NO (SKIP TO Q.17C) 2

BEGIN DECK 30

17B. Which (spouse/partner) had this pregnancy?

RECORD NAME: _____
(LAST)

10-34/

(FIRST) (MIDDLE)

RECORD ID # FROM INFORMATION SHEET.

35-36/

17C. How many months did it take (NAME OF SPOUSE/PARTNER) to become pregnant (this time)?

RECORD MONTHS AND/OR
AND/OR YEARS MOS YRS

37-38/

WASN'T TRYING 00

39-40/

OR

DON'T KNOW 98

17D. Were either you or (NAME OF SPOUSE/PARTNER) using birth control at the time she became pregnant?

YES (ASK Q.17E) 1

41/

NO (SKIP TO Q.18, PAGE E-27) 2

17E. SHOW PARTICIPANT HAND CARD H. Please look at card H again and tell me all the numbers of the types of birth control you and (NAME FROM Q.17B) were using when she became pregnant. CODE ALL THAT APPLY.

1. PILL	01	42-43/
2. DOUCHE	02	44-45/
3. FOAM	03	46-47/
4. JELLY, CREAM, SUPPOSITORY	04	48-49/
5. IUD	05	50-51/
6. CONDOM, RUBBER	06	52-53/
7. DIAPHRAGM	07	54-55/
8. DIAPHRAGM AND JELLY	08	56-57/
9. SPONGE	09	58-59/
10. RHYTHM - CALENDAR	10	60-61/
11. RHYTHM - TEMPERATURE	11	62-63/
12. WITHDRAWAL	12	64-65/
13. OTHER (SPECIFY) _____		
_____	13	66-67/
DON'T KNOW	98	68-69/

18. Did that pregnancy result in a live birth; or in a miscarriage, stillbirth, or abortion, [or is (NAME) still pregnant]?

LIVE BIRTH 1 70/

MISCARRIAGE.....(SKIP TO Q.20)	2
STILLBIRTH.....(SKIP TO Q.20)	3

ABORTION.....(SKIP TO Q.20) 4
 STILL PREGNANT.....(SKIP TO Q.25, PAGE 35) 5

18A. What is the first and last name of the child as it appears on the birth certificate?
 RECORD ON SUPPLEMENTARY CHILDREN'S RECORD FORM.

RECORD ID FROM SUPPLEMENTARY CHILDREN'S RECORD FORM 71-72/

18B. When was (CHILD) born? ENTER BIRTHDATE ON SUPPLEMENTARY CHILDREN'S RECORD FORM.

18C. Was (CHILD) male or female? RECORD ON SUPPLEMENTARY CHILDREN'S RECORD FORM.

18D. How much did (CHILD) weigh at birth?

ENTER POUNDS: 73-74/

AND

OUNCES: 75-76/

OR

DON'T KNOW 98

18E. Was (CHILD) a twin?

YES 1 77/

NO 2

18F. Was (CHILD) premature, full term, or overdue?

PREMATURE 1 78/

FULL TERM 2

OVERDUE 3

DON'T KNOW 8

18G. How old was (NAME OF MOTHER) when (CHILD) was born?

RECORD AGE: 79-80/

Don't know 98

18H. What is the name and address of the hospital where this child was born? RECORD BELOW

NAME OF HOSPITAL

STREET ADDRESS

(CITY)

(STATE)

RECORD NAME AND ADDRESS ON MEDICAL CONSENT FORM

18I. What is the name and address of the doctor or medical facility who has (CHILD)'s current medical records?
RECORD BELOW.

DOCTOR'S NAME OR FACILITY NAME

STREET ADDRESS

(CITY) (STATE)

RECORD NAME AND ADDRESS ON MEDICAL CONSENT FORM.

18J. Is this child still living? IF NO, SKIP TO Q.18K. IF YES, ASK: What is child's current age? RECORD AGE ON SUPPLEMENT CHILDREN'S FORM. SKIP TO Q.19.

18K. When did (CHILD) die? RECORD DAY, MONTH, AND YEAR ON SUPPLEMENTARY CHILDREN'S RECORD FORM.

18L. What was the cause of death? RECORD BELOW. BEGIN DECK 31

10/

18M. Where is (CHILD'S) death registered? In what city and state?

(CITY) (STATE)
11-26/ 27-28/

19. IS THERE A THIRD PREGNANCY SINCE THE DATE OF LAST INTERVIEW? IS NUMBER OF PREGNANCIES IN Q.12B ON PAGE E-20 EQUAL TO 3 OR MORE?

YES (SKIP TO Q.21) 1 29/

NO (SKIP TO Q.25, PAGE E-35) 2

20. When did that pregnancy end?

RECORD DATE: 30-35/
MO DA YR

20A. How many weeks had (NAME FROM Q.17B, PAGE E-26) been pregnant when that happened?

ENTER NUMBER OF WEEKS: 36-37/
DON'T KNOW 98

20B. IF CODE "2" OR "3" IN Q.18, MISCARRIAGE OR STILLBIRTH, ASK Q.20B-C; OTHERS GO TO Q.20D.
Did a doctor tell why this (miscarriage/stillbirth) might have occurred?

YES (ASK Q.20C) 1 38/

NO (SKIP TO Q.20D) 2

20C. What did the doctor say caused the (miscarriage/stillbirth)? RECORD VERBATIM.

39/

20D. IS THERE A THIRD PREGNANCY SINCE DATE OF LAST INTERVIEW? IS NUMBER OF
PREGNANCIES IN Q.12B ON PAGE E-20 EQUAL TO 2 OR MORE?

YES (GO TO Q.21) 1 40/

NO (SKIP TO Q.25, PAGE E-35) . 2

21E. SHOW PARTICIPANT HAND CARD H. Please look at card H again and tell me all the numbers of the types of birth control you and (NAME FROM Q.21B) were using when she became pregnant. CODE ALL THAT APPLY.

	BEGIN DECK 32	
1. PILL	01	10-11/
2. DOUCHE	02	12-13/
3. FOAM	03	14-15/
4. JELLY, CREAM, SUPPOSITORY	04	16-17/
5. IUD	05	18-19/
6. CONDOM, RUBBER	06	20-21/
7. DIAPHRAGM	07	22-23/
8. DIAPHRAGM AND JELLY	08	24-25/
9. SPONGE	09	26-27/
10. RHYTHM - CALENDAR	10	28-29/
11. RHYTHM - TEMPERATURE	11	30-31/
12. WITHDRAWAL	12	32-33/
13. OTHER (SPECIFY) _____		
_____	13	34-35/
DONT KNOW	98	36-37/

22. Did that pregnancy result in a live birth; or in a miscarriage, stillbirth, or abortion, [or is (NAME) still pregnant]?

LIVE BIRTH 1 38/

MISCARRIAGE.....(SKIP TO Q.24) 2
 STILLBIRTH.....(SKIP TO Q.24) 3

ABORTION.....(SKIP TO Q.24) 4
 STILL PREGNANT.....(SKIP TO Q.25, PAGE E-35) 5

22A. What is the first and last name of the child as it appears on the birth certificate?
 RECORD ON SUPPLEMENTARY CHILDREN'S RECORD FORM.

RECORD ID FROM SUPPLEMENTARY CHILDREN'S RECORD FORM:

39-40/

22B. When was (CHILD) born? ENTER BIRTHDATE ON SUPPLEMENTARY CHILDREN'S RECORD FORM.

22C. Was (CHILD) male or female? RECORD ON SUPPLEMENTARY CHILDREN'S RECORD FORM.

22D. How much did (CHILD) weigh at birth?

ENTER POUNDS: 41-42/
 AND
 OUNCES: 43-44/
 OR
 DON'T KNOW 98

22E. Was (CHILD) a twin?

YES 1 45/
 NO 2

22F. Was (CHILD) premature, full term, or overdue?

PREMATURE 1 46/
 FULL TERM 2
 OVERDUE 3
 DON'T KNOW 8

22G. How old was (NAME OF MOTHER) when (CHILD) was born?

RECORD AGE: 47-48/
 DON'T KNOW 98

22H. What is the name and address of the hospital where this child was born? RECORD BELOW

NAME OF HOSPITAL

STREET ADDRESS

(CITY)

(STATE)

RECORD NAME AND ADDRESS ON MEDICAL CONSENT FORM

22I. What is the name and address of the doctor or medical facility who has (CHILD)'s current medical records? RECORD BELOW.

DOCTOR'S NAME OR FACILITY NAME

STREET ADDRESS

(CITY) (STATE)

RECORD NAME AND ADDRESS ON MEDICAL CONSENT FORM

22J. Is this child still living? IF NO, SKIP TO Q.22K. IF YES, ASK: What is child's current age? RECORD AGE ON SUPPLEMENT CHILDREN'S FORM. SKIP TO Q.23.

22K. When did (CHILD) die? RECORD DAY, MONTH, AND YEAR ON SUPPLEMENTARY CHILDREN'S RECORD FORM.

22L. What was the cause of death? RECORD BELOW.

49/

22M. Where is (CHILD'S) death registered? In what city and state?

(CITY) (STATE)

23. IS THERE A FOURTH PREGNANCY SINCE THE DATE OF LAST INTERVIEW? IS NUMBER OF PREGNANCIES IN Q.12B EQUAL TO 4 OR MORE?

YES (GO TO NEW QUESTIONNAIRE) 1 68/

NO (SKIP TO Q.25, PAGE E-35) 2

24. When did that pregnancy end?

RECORD DATE: [] [] []
MO DA YR 69-74/

24A. How many weeks had (NAME FRgnant when that happened)?

ENTER NUMBER OF WEEKS: [] [] 75-76/
DON'T KNOW 98

24B. IF CODE "2" OR "3" IN Q.22, MISCARRIAGE OR STILLBIRTH, ASK Q.24B AND Q.24C. OTHERS GO TO Q.24D. Did a doctor tell why this (miscarriage/stillbirth) might have occurred?

YES (ASK Q.24C) 1 77/

NO (SKIP TO Q.24D) 2

24C. What did the doctor say caused the (miscarriage/stillbirth)? RECORD VERBATIM.

**43. CODE "PERIOD 3" AND ASK PARTICIPANT TO READ SELF ADMINISTERED FORM 1.
READ INSTRUCTIONS BELOW.**

There are many reasons that some couples find it difficult or impossible to conceive a child. Please read this form and circle the number on Side A for each reason which applied to you for this period. Side B provides reasons appropriate for your spouse. Circle as many responses as appropriate for you and your spouse.

Now please fill out Side A for yourself and Side B for your spouse on this form.

44. IS THERE A FOURTH PERIOD OF INFERTILITY SINCE DATE OF LAST INTERVIEW? (IS Q.26 CODED "FOUR" OR MORE?)

YES (GO TO NEW QUESTIONNAIRE) 1

NO (INSTRUCT R TO PUT SELF-
ADMINISTERED FORM 1
IN ENVELOPE AND SKIP
TO SECTION F, PAGE F-1) 2

SECTION F: CHILD AND FAMILY HEALTH
FOR THIS SECTION YOU WILL NEED:
- HAND CARD I
- INTERVAL SUPPLEMENTAL RECORDING BOOK (I.S.R.B.)

1. Now I would like to ask you some questions about birth defects in your family. By birth defects I mean a physical abnormality present (though not necessarily noticed) at the time of birth. Birth defects range in severity from unusual birthmarks to a missing or mishapen limb. Birth defects can affect any part of the body, including bones, body organs such as kidneys or the heart, reproductive and respiratory systems, blood, and the skin.

INTERVIEWER: HAS RESPONDENT HAD ANY BIOLOGICAL CHILDREN?

YES 1 29/
NO... (SKIP TO INSTRUCTION 12
BOX ABOVE Q.22, PAGE F-14) 2

1A. ARE CHILDREN RECORDED ON CHILDREN'S RECORD FORM?

YES (ASK Q.1B) 1 30/
NO (SKIP TO Q.2B) 2

1B. FOR EACH CHILD LISTED ON CHILDREN'S RECORD FORM ASK: Our records indicate that (READ CHILD'S NAME)(had/did not have) a birth defect at the time you were last interviewed. Is this information correct?

YES, IF INFORMATION IS CORRECT... (GO TO Q.2, PAGE F-2) ... 1 31/
NO, IF INFORMATION IS INCORRECT, UPDATE
CHILDREN'S RECORD FORM, THEN GO TO Q.2, PAGE F-2 2
MISSING 8

2. CHILDREN'S RECORD FORM HAS INFORMATION FOR CHILDREN PREVIOUSLY REPORTED. THESE ARE CHILDREN BORN TO PARTICIPANT AS OF DATE OF LAST INTERVIEW.

FOR EACH CHILD ON RECORD FORM (EXCEPT CHILDREN WHO DIED BEFORE DATE OF LAST INTERVIEW), ASK:

- 2A-1. Has any new defect, impairment or cancer been identified in (READ CHILD'S NAME) since our last interview, that is, since (READ DATE OF LAST INTERVIEW)? RECORD ON CHILDREN'S RECORD FORM.
- 2A-2. IF DEFECTS, IMPAIRMENTS, OR CANCER EXISTS PREVIOUSLY ASK: Has any change occurred in the condition for previously existing defects, impairments, or cancer for (CHILD) since (DATE OF LAST INTERVIEW)? RECORD ON CHILDREN'S RECORD FORM.

IF NO NEW DEFECT, IMPAIRMENT, OR CANCER, AND NO CHANGE IN CONDITION FOR CHILD, REASK Q.2 AND Q.2A FOR EACH CHILD.

- 2B. SUPPLEMENTARY CHILDREN'S RECORD FORM HAS INFORMATION FOR CHILDREN BORN TO PARTICIPANT SINCE THE DATE OF LAST INTERVIEW.

FOR EACH CHILD ON SUPPLEMENTARY CR FORM, ASK:

Has a defect, impairment or cancer been identified in (READ CHILD'S NAME)?

RECORD ON SUPPLEMENTARY CHILDREN'S RECORD FORM.

3. ASK QUESTIONS 4-20 FOR EACH CHILD WITH CANCER, DEFECT, OR IMPAIRMENT OR ANY CHANGE IN PREVIOUS CONDITION(S), INCLUDING ALL WHO MAY HAVE DIED AFTER DATE OF LAST INTERVIEW.

IF NONE OF THE CHILDREN HAVE CANCER, A BIRTH DEFECT, OR IMPAIRMENT, SKIP TO INSTRUCTION BOX ABOVE Q.22.

B-77

May 15, 1992

16:03 pm

Field Version 1.1

	1ST CHILD	2ND CHILD																																
CHILD'S NAME:																																		
CHILD'S ID#	<input type="checkbox"/> <input type="checkbox"/> 32-33/	<input type="checkbox"/> <input type="checkbox"/> 49-50/																																
MOTHER'S ID#	<input type="checkbox"/> <input type="checkbox"/> 34-35/	<input type="checkbox"/> <input type="checkbox"/> 51-52/																																
4. Was (READ CHILD'S NAME) (ever/since/last interview) diagnosed as having cancer?	YES 1 36/ NO (GO TO Q.5) 2	YES 1 53/ NO (GO TO Q.5) 2																																
5. Was (CHILD) (ever/since last interview) diagnosed as having a ... (READ EACH CATEGORY).	<table border="0"> <tr> <td></td> <td>YES</td> <td>NO</td> <td></td> </tr> <tr> <td>Learning Disability</td> <td>1</td> <td>2</td> <td>37/</td> </tr> <tr> <td>Physical or Motor Impairment</td> <td>1</td> <td>2</td> <td>38/</td> </tr> <tr> <td>Mental Impairment</td> <td>1</td> <td>2</td> <td>39/</td> </tr> </table>		YES	NO		Learning Disability	1	2	37/	Physical or Motor Impairment	1	2	38/	Mental Impairment	1	2	39/	<table border="0"> <tr> <td></td> <td>YES</td> <td>NO</td> <td></td> </tr> <tr> <td>Learning Disability</td> <td>1</td> <td>2</td> <td>54/</td> </tr> <tr> <td>Physical or Motor Impairment</td> <td>1</td> <td>2</td> <td>55/</td> </tr> <tr> <td>Mental Impairment</td> <td>1</td> <td>2</td> <td>56/</td> </tr> </table>		YES	NO		Learning Disability	1	2	54/	Physical or Motor Impairment	1	2	55/	Mental Impairment	1	2	56/
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Learning Disability	1	2	54/																															
Physical or Motor Impairment	1	2	55/																															
Mental Impairment	1	2	56/																															
6. INTERVIEWER: HAS ANY CANCER, DEFECT OR IMPAIRMENT BEEN IDENTIFIED IN CHILD? CHECK CHILDREN'S RECORD FORM OR SUPPLEMENTAL FORM. IF YES, ASK Q.7. IF NO, ASK Q.6A.	<p style="text-align: right;">40-44/R</p> YES (GO TO Q.7) 1 45/ NO (ASK Q.6A) 2	<p style="text-align: right;">57-61/R</p> YES (GO TO Q.7) 1 62/ NO (ASK Q.6A) 2																																
6A. INTERVIEWER: IS THERE ANOTHER CHILD?	YES (Q.4 AND 5 FOR NEXT CHILD) 1 46/ NO (SKIP TO BOX ABOVE Q.22) 2	YES (Q.4 AND 5 FOR NEXT CHILD) 1 63/ NO (SKIP TO BOX ABOVE Q.22) 2																																
7. What kind of birth defect or impairment (does/did) (CHILD) have? Any others?	_____ _____ _____ 47/	_____ _____ _____ 64/																																
8. Did you or someone else discuss (CHILD'S) birth defect or impairment with a doctor?	YES (GO TO Q.9) 1 48/ NO (SKIP TO Q.11) 2	YES (GO TO Q.9) 1 65/ NO (SKIP TO Q.11) 2																																

3RD CHILD	4TH CHILD	5TH CHILD	6TH CHILD																																																																
<input type="checkbox"/> <input type="checkbox"/> 66-67/	<input type="checkbox"/> <input type="checkbox"/> 14-15/	<input type="checkbox"/> <input type="checkbox"/> 31-32/	<input type="checkbox"/> <input type="checkbox"/> 48-49/																																																																
<input type="checkbox"/> <input type="checkbox"/> 68-69/	<input type="checkbox"/> <input type="checkbox"/> 16-17/	<input type="checkbox"/> <input type="checkbox"/> 33-34/	<input type="checkbox"/> <input type="checkbox"/> 50-51/																																																																
YES 1 70/ NO....(GO TO Q.5) . 2	YES 1 18/ NO....(GO TO Q.5) . 2	YES 1 35/ NO....(GO TO Q.5) .. 2	YES 1 52/ NO....(GO TO Q.5) . 2																																																																
<table border="0"> <tr> <td></td> <td>YES</td> <td>NO</td> <td></td> </tr> <tr> <td>Learning Disability ...</td> <td>1</td> <td>2</td> <td>71/</td> </tr> <tr> <td>Physical or Motor Impairment ..</td> <td>1</td> <td>2</td> <td>72/</td> </tr> <tr> <td>Mental Impairment. .</td> <td>1</td> <td>2</td> <td>73/</td> </tr> </table>		YES	NO		Learning Disability ...	1	2	71/	Physical or Motor Impairment ..	1	2	72/	Mental Impairment. .	1	2	73/	<table border="0"> <tr> <td></td> <td>YES</td> <td>NO</td> <td></td> </tr> <tr> <td>Learning Disability ...</td> <td>1</td> <td>2</td> <td>19/</td> </tr> <tr> <td>Physical or Motor Impairment ..</td> <td>1</td> <td>2</td> <td>20/</td> </tr> <tr> <td>Mental Impairment. .</td> <td>1</td> <td>2</td> <td>21/</td> </tr> </table>		YES	NO		Learning Disability ...	1	2	19/	Physical or Motor Impairment ..	1	2	20/	Mental Impairment. .	1	2	21/	<table border="0"> <tr> <td></td> <td>YES</td> <td>NO</td> <td></td> </tr> <tr> <td>Learning Disability ...</td> <td>1</td> <td>2</td> <td>36/</td> </tr> <tr> <td>Physical or Motor Impairment ..</td> <td>1</td> <td>2</td> <td>37/</td> </tr> <tr> <td>Mental Impairment. .</td> <td>1</td> <td>2</td> <td>38/</td> </tr> </table>		YES	NO		Learning Disability ...	1	2	36/	Physical or Motor Impairment ..	1	2	37/	Mental Impairment. .	1	2	38/	<table border="0"> <tr> <td></td> <td>YES</td> <td>NO</td> <td></td> </tr> <tr> <td>Learning Disability ...</td> <td>1</td> <td>2</td> <td>53/</td> </tr> <tr> <td>Physical or Motor Impairment ..</td> <td>1</td> <td>2</td> <td>54/</td> </tr> <tr> <td>Mental Impairment. .</td> <td>1</td> <td>2</td> <td>55/</td> </tr> </table>		YES	NO		Learning Disability ...	1	2	53/	Physical or Motor Impairment ..	1	2	54/	Mental Impairment. .	1	2	55/
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Mental Impairment. .	1	2	55/																																																																
<p>BEGIN DECK 35</p> <p>YES . (GO TO Q.7) ... 1 10/ NO .. (ASK Q.6A) 2</p>	<p>YES . (GO TO Q.7) ... 1 27/ NO .. (ASK Q.6A) 2</p>	<p>YES .. (GO TO Q.7) .. 1 44/ NO ... (ASK Q.6A) ... 2</p>	<p>YES . (GO TO Q.7) ... 1 61/ NO .. (ASK Q.6A) 2</p>																																																																
<p>YES . (Q.4 AND 5 FOR NEXT CHILD) .. 1 11/ NO .. (SKIP TO BOX ABOVE Q.22) .. 2</p>	<p>YES . (Q.4 AND 5 FOR NEXT CHILD) .. 1 28/ NO .. (SKIP TO BOX ABOVE Q.22) .. 2</p>	<p>YES .. (Q.4 AND 5 FOR NEXT CHILD) . 1 45/ NO ... (SKIP TO BOX ABOVE Q.22) . 2</p>	<p>YES . (Q.4 AND 5 FOR NEXT CHILD) .. 1 62/ NO .. (SKIP TO BOX ABOVE Q.22) .. 2</p>																																																																
_____	_____	_____	_____																																																																
_____	_____	_____	_____																																																																
12/	29/	46/	63/																																																																
YES . (GO TO Q.9) ... 1 13/ NO .. (SKIP TO Q.11) . 2	YES .. (GO TO Q.9) . 1 30/ NO ... (SKIP TO Q.11) 2	YES .. (GO TO Q.9) .. 1 47/ NO ... (SKIP TO Q.11) 2	YES . (GO TO Q.9) ... 1 64/ NO .. (SKIP TO Q.11) . 2																																																																

	1ST CHILD	2ND CHILD
CHILD'S NAME:		
CHILD'S ID#	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
MOTHER'S ID#	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<p>9. COMPLETE HEALTH CARE PROVIDER FORM FOR EACH CANCER, DISABILITY AND DEFECT.</p> <p>IF NECESSARY, COMPLETE A MEDICAL AUTHORIZATION FORM</p>	<p>COMPLETE HEALTH CARE PROVIDER FORM FOR EACH CANCER, DISABILITY AND DEFECT.</p> <p>65/R</p> <p>IF NECESSARY, COMPLETE A MEDICAL AUTHORIZATION FORM</p>	<p>COMPLETE HEALTH CARE PROVIDER FORM FOR EACH CANCER, DISABILITY AND DEFECT.</p> <p>71/R</p> <p>IF NECESSARY, COMPLETE A MEDICAL AUTHORIZATION FORM</p>
<p>10. Did the doctor say that (CHILD) need (s/ed) any testing, medication, treatment, surgery, or special equipment because of the birth defect or impairment? By special equipment I mean a wheelchair, walker, artificial limb, body brace(s), or crutches.</p>	<p>66/</p> <p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p>	<p>72/</p> <p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p>
<p>11. Did (CHILD) ever receive any testing, medication, treatment, surgery or special equipment because of the birth defect or impairment?</p>	<p>67/</p> <p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p>	<p>73/</p> <p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p>
<p>12. At any time, did (CHILD'S) birth defect or impairment interfere in any way with (CHILD'S) physical or social development? For example, getting a job or making friends?</p>	<p>68/</p> <p>YES... (GO TO Q.13) 1</p> <p>NO... (ASK Q.12A) 2</p> <p>DON'T KNOW 8</p>	<p>74/</p> <p>YES... (GO TO Q.13) 1</p> <p>NO... (ASK Q.12A) 2</p> <p>DON'T KNOW 8</p>
<p>12A. INTERVIEWER: WAS THERE A "YES" CODED AT Q.10 OR Q.11?</p>	<p>69/</p> <p>YES... (SKIP TO Q.13) 1</p> <p>NO... (ASK Q.12B) 2</p>	<p>75/</p> <p>YES... (SKIP TO Q.13) 1</p> <p>NO... (ASK Q.12B) 2</p>
<p>12B. INTERVIEWER: IS THERE ANOTHER CHILD?</p>	<p>70/</p> <p>YES... (GO BACK TO Q.4 FOR NEXT CHILD) 1</p> <p>NO... (SKIP TO BOX ABOVE Q.22) 2</p>	<p>76/</p> <p>YES... (GO BACK TO Q.4 FOR NEXT CHILD) 1</p> <p>NO... (SKIP TO BOX ABOVE Q.22) 2</p>

3RD CHILD	4TH CHILD	5TH CHILD	6TH CHILD
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
COMPLETE HEALTH CARE PROVIDER FORM FOR EACH CANCER, DISABILITY AND DEFECT. IF NECESSARY, COMPLETE A MEDICAL AUTHORIZATION FORM	COMPLETE HEALTH CARE PROVIDER FORM FOR EACH CANCER, DISABILITY AND DEFECT. IF NECESSARY, COMPLETE A MEDICAL AUTHORIZATION FORM	COMPLETE HEALTH CARE PROVIDER FORM FOR EACH CANCER, DISABILITY AND DEFECT. IF NECESSARY, COMPLETE A MEDICAL AUTHORIZATION FORM	COMPLETE HEALTH CARE PROVIDER FORM FOR EACH CANCER, DISABILITY AND DEFECT. IF NECESSARY, COMPLETE A MEDICAL AUTHORIZATION FORM
78/ YES 1 NO 2 DONT KNOW 8	14/ YES 1 NO 2 DONT KNOW 8	20/ YES 1 NO 2 DONT KNOW 8	26/ YES 1 NO 2 DONT KNOW 8
79/ YES 1 NO 2 DONT KNOW 8	15/ YES 1 NO 2 DONT KNOW 8	21/ YES 1 NO 2 DONT KNOW 8	27/ YES 1 NO 2 DONT KNOW 8
BEGIN DECK 36 10/ YES... (GO TO Q.13) 1 NO... (ASK Q.12A) . 2 DONT KNOW 8 YES... (SKIP TO Q.13) 11/ NO... (ASK Q.12B) . 2 YES... (GO BACK TO Q.4 FOR NEXT CHILD) 12/ NO... (SKIP TO BOX ABOVE Q.22) 2	16/ YES... (GO TO Q.13) . 1 NO... (ASK Q.12A) .. 2 DONT KNOW 8 YES... (SKIP TO Q.13) 17/ NO... (ASK Q.12B) .. 2 YES... (GO BACK TO Q.4 FOR NEXT CHILD) 18/ NO... (SKIP TO BOX ABOVE Q.22) . 2	22/ YES... (GO TO Q.13) . 1 NO... (ASK Q.12A) .. 2 DONT KNOW 8 YES... (SKIP TO Q.13) 23/ NO... (ASK Q.12B) .. 2 YES... (GO BACK TO Q.4 FOR NEXT CHILD) 24/ NO... (SKIP TO BOX ABOVE Q.22) . 2	28/ YES... (GO TO Q.13) . 1 NO... (ASK Q.12A) .. 2 DONT KNOW 8 YES... (SKIP TO Q.13) 29/ NO... (ASK Q.12B) .. 2 YES... (GO BACK TO Q.4 FOR NEXT CHILD) 30/ NO... (SKIP TO BOX ABOVE Q.22) . 2

	1ST CHILD	2ND CHILD
CHILD'S NAME:		
CHILD'S ID#	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
MOTHER'S ID#	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
13. Did (CHILD'S) doctor say that any of the birth defect(s) or impairments (was/were) life-threatening if left untreated? By untreated I mean if (CHILD) did not receive surgery, medication, a special diet, or some other medical intervention.	31/ YES..... (ASK Q.13A) 1 NO.....(ASK Q.13A) 2 DON'T KNOW..... (ASK Q.13A) 8	37/ YES..... (ASK Q.13A) 1 NO.....(ASK Q.13A) 2 DON'T KNOW.....(ASK Q.13A) 8
13A. INTERVIEWER: IS CHILD UNDER TWO YEARS OLD OR DID CHILD DIE BEFORE HE OR SHE WAS TWO YEARS OLD?	32/ YES..... SKIP TO Q.21, PAGE F-12 1 NO..... 2	38/ YES..... SKIP TO Q.21, PAGE F-12 1 NO..... 2
14. Did (CHILD) ever need help with eating, dressing, bathing, or using the toilet because of a birth defect or impairment? Help includes someone actually helping rather than just standing by to assist if needed.	33/ YES 1 NO 2	39/ YES 1 NO 2
15. Because of a birth defect or impairment, did (CHILD) ever use or need any mechanical or need any mechanical or special aids such as a wheelchair, walker, body braces, artificial limbs, or crutches to carry out everyday activities?	34/ YES 1 NO 2	40/ YES 1 NO 2
16. Was (CHILD) ever unable to take part at all in ordinary play with other children because of a birth defect or impairment?	35/ YES.....(SKIP TO Q.17) 1 NO..... (ASK Q.16A) 2	41/ YES.....(SKIP TO Q.17) 1 NO.....(ASK Q.16A) 2
16A. Was (CHILD) ever limited in the kind or amount of play he/she could do because of his/her birth defect or impairment?	36/ YES 1 NO 2	42/ YES 1 NO 2

3RD CHILD	4TH CHILD	5TH CHILD	6TH CHILD
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
YES... (ASK Q.13A) . 43/ 1 NO... (ASK Q.13A) . 2 DONT KNOW. (ASK Q.13A) . 8 YES. SKIP TO Q.21, PAGE F-12 44/ 1 NO 2	YES... (ASK Q.13A) .. 49/ 1 NO... (ASK Q.13A) .. 2 DONT KNOW. (ASK Q.13A) . 8 YES. SKIP TO Q.21, PAGE F-12 50/ 1 NO 2	YES... (ASK Q.13A) .. 55/ 1 NO... (ASK Q.13A) .. 2 DONT KNOW. (ASK Q.13A) . 8 YES. SKIP TO Q.21, PAGE F-12 56/ 1 NO 2	YES... (ASK Q.13A) ... 61/ 1 NO... (ASK Q.13A) ... 2 DONT KNOW. (ASK Q.13A) .. 8 YES. SKIP TO Q.21, PAGE F-12 62/ 1 NO 2
YES 45/ 1 NO 2	YES 51/ 1 NO 2	YES 57/ 1 NO 2	YES 63/ 1 NO 2
YES 46/ 1 NO 2	YES 52/ 1 NO 2	YES 58/ 1 NO 2	YES 64/ 1 NO 2
YES... (SKIP TO Q.17) 47/ 1 NO... (ASK Q.16A) . 2 YES 48/ 1 NO 2	YES... (SKIP TO Q.17) 53/ 1 NO... (ASK Q.16A) .. 2 YES 54/ 1 NO 2	YES... (SKIP TO Q.17) 59/ 1 NO... (ASK Q.16A) .. 2 YES 60/ 1 NO 2	YES... (SKIP TO Q.17) . 65/ 1 NO... (ASK Q.16A) ... 2 YES 66/ 1 NO 2

	1ST CHILD	2ND CHILD
CHILD'S NAME:		
CHILD'S ID#	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
MOTHER'S ID#	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
17. Did (CHILD'S) birth defect or impairment ever keep (him/her) from going to school?	67/ YES.....(SKIP TO Q.18) 1 NO..... (ASK Q.17A) 2	75/ YES.....(SKIP TO Q.18) 1 NO..... (ASK Q.17A) 2
17A. Did (CHILD) ever have to go to a certain type of school, or be in a special class because of (his/her) birth defect or impairment?	68/ YES.....(SKIP TO Q.18) 1 NO..... (ASK Q.17B) 2	76/ YES.....(SKIP TO Q.18) 1 NO..... (ASK Q.17B) 2
17B. Was (CHILD) ever limited in school attendance or in being able to learn because of (his/her) birth defect or impairment?	69/ YES 1 NO 2	77/ YES 1 NO 2
18. Because of (his/her) birth defect or impairment did (CHILD) ever need a lot more help than other children (his/her) age in going outside, getting to school, going to the store, and other everyday activities like that?	70/ YES 1 NO 2	78/ YES 1 NO 2
19. Because of a birth defect or impairment, did (CHILD) ever need the help of another person for everyday activities such as taking care of the house or yard, doing the laundry, or preparing meals?	71/ YES 1 NO 2	79/ YES 1 NO 2 BEGIN DECK 37
20. Will/Would (CHILD'S) impairment (keep/have kept) (him/her) from working on a job for pay?	72/ YES.....(SKIP TO Q.21) 1 NO.....(ASK Q.20A) 2	10/ YES.....(SKIP TO Q.21) 1 NO.....(ASK Q.20A) 2
20A. Will/Would (CHILD) (be/have been) limited in the kind of work (he/she) could (do/have done) because of (his/her) birth defect?	73/ YES.....(SKIP TO Q.21) 1 NO.....(ASK Q.20B) 2	11/ YES.....(SKIP TO Q.21) 1 NO.....(ASK Q.20B) 2
20B. Will/Would (CHILD) (be/have been) limited in the amount of work (he/she) could (do/have done) because of (his/her) birth defect?	74/ YES 1 NO 2	12/ YES 1 NO 2

3RD CHILD	4TH CHILD	5TH CHILD	6TH CHILD
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
YES... (SKIP TO Q.18) ^{13/} 1 NO... (ASK Q.17A) .. 2 YES... (SKIP TO Q.18) ^{14/} 1 NO... (ASK Q.17B) .. 2 YES ^{15/} 1 NO 2	YES... (SKIP TO Q.18) ^{21/} 1 NO... (ASK Q.17A) .. 2 YES... (SKIP TO Q.18) ^{22/} 1 NO... (ASK Q.17B) .. 2 YES ^{23/} 1 NO 2	YES... (SKIP TO Q.18) ^{29/} 1 NO... (ASK Q.17A) .. 2 YES... (SKIP TO Q.18) ^{30/} 1 NO... (ASK Q.17B) .. 2 YES ^{31/} 1 NO 2	YES... (SKIP TO Q.18) . 1 NO... (ASK Q.17A) ... 2 YES... (SKIP TO Q.18) . 1 NO... (ASK Q.17B) ... 2 YES ^{39/} 1 NO 2
YES ^{16/} 1 NO 2	YES ^{24/} 1 NO 2	YES ^{32/} 1 NO 2	YES ^{40/} 1 NO 2
YES ^{17/} 1 NO 2	YES ^{25/} 1 NO 2	YES ^{33/} 1 NO 2	YES ^{41/} 1 NO 2
YES... (SKIP TO Q.21) ^{18/} 1 NO... (ASK Q.20A) .. 2 YES... (SKIP TO Q.21) ^{19/} 1 NO... (ASK Q.20B) .. 2 YES ^{20/} 1 NO 2	YES... (SKIP TO Q.21) ^{26/} 1 NO... (ASK Q.20A) .. 2 YES... (SKIP TO Q.21) ^{27/} 1 NO... (ASK Q.20B) .. 2 YES ^{28/} 1 NO 2	YES... (SKIP TO Q.21) ^{34/} 1 NO... (ASK Q.20A) .. 2 YES... (SKIP TO Q.21) ^{35/} 1 NO... (ASK Q.20B) .. 2 YES ^{36/} 1 NO 2	YES... (SKIP TO Q.21) 1 NO... (ASK Q.20A) .. 2 YES... (SKIP TO Q.21) 1 NO... (ASK Q.20B) .. 2 YES ^{44/} 1 NO 2

	1ST CHILD	2ND CHILD
CHILD'S NAME:		
CHILD'S ID#	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
MOTHER'S ID#	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
21. INTERVIEWER: DOES RESPONDENT HAVE ANOTHER CHILD WITH CONDITIONS?	YES.. (GO BACK TO Q.4 FOR NEXT CHILD) ^{45/} 1 NO..... (SKIP TO BOX ABOVE Q.22) ... 2	YES.. (GO BACK TO Q.4 FOR NEXT CHILD) ^{46/} 1 NO..... (SKIP TO BOX ABOVE Q.22) ... 2



22. Did you ever have a birth defect?

YES (ASK Q.22A) 1 47/
 NO 2

22A. What kind of birth defect was it? Any others?

48/

23. Do you have any biological brothers or sisters? Include any brothers or sisters who may have died before age of 1.

YES (ASK Q.24, PAGE F-14) 1 49/
 NO (SKIP TO Q.25, PAGE F-14) 2
 DON'T KNOW ... (SKIP TO Q.25, PAGE F-14) 8

3RD CHILD	4TH CHILD	5TH CHILD	6TH CHILD
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
YES. . (GO BACK TO Q.4 FOR NEXT CHILD) ^{50/} 1 NO. . . (SKIP TO BOX ABOVE Q.22) 2	YES. . (GO BACK TO Q.4 FOR NEXT CHILD) ^{51/} 1 NO. (SKIP TO BOX ABOVE Q.22) . . . 2	YES. . (GO BACK TO Q.4 FOR NEXT CHILD) ^{52/} 1 NO. . . (SKIP TO BOX ABOVE Q.22) . . . 2	YES. . (NEW QUEX) . . ^{53/} 1 NO. . . (SKIP TO BOX ABOVE Q.22) . . . 2

24. Did any of your biological brothers or sisters ever have a birth defect?
- YES (ASK Q.24A) 1 54/
 - NO (SKIP TO Q.25) 2
 - DON'T KNOW ... (SKIP TO Q.25) 8

- 24A. Who had a defect, your brothers, sisters, or both?
- BROTHERS 1 55/
 - SISTERS 2
 - BOTH 3

FOR EACH SIBLING WITH A BIRTH DEFECT, ASK: What kind of birth defect did your (brother/sister) have? RECORD DEFECT. Was this sibling a half (brother/sister) or a full (brother/sister)? RECORD BELOW.

SIBLING 1 56/ DEFECT: _____ _____ 57/ HALF (BROTHER/SISTER) 1 FULL (BROTHER/SISTER) 2	SIBLING 2 58/ DEFECT: _____ _____ 59/ HALF (BROTHER/SISTER) 1 FULL (BROTHER/SISTER) 2
SIBLING 3 60/ DEFECT: _____ _____ 61/ HALF (BROTHER/SISTER) 1 FULL (BROTHER/SISTER) 2	SIBLING 4 62/ DEFECT: _____ _____ 63/ HALF (BROTHER/SISTER) 1 FULL (BROTHER/SISTER) 2

25. Now I would like to ask you some questions about your biological parents. Did either your biological mother or biological father ever have a birth defect?
- YES (GO TO Q.26) 1 64/
 - NO (SKIP TO Q.28, PAGE F-15) 2
 - DON'T KNOW ... (SKIP TO Q.28, PAGE F-15) 8

26. Which parent had a birth defect?
- MOTHER ONLY 1 65/
 - FATHER ONLY 2
 - BOTH PARENTS 3

27. What kind of birth defect did your (PARENT) have?
- Mother: _____ 66/ Father: _____ 67/
- _____

I.S.R.B. ON PAGE 5.

28. Now there are some questions about death in your family. Has anyone near to you died in the last 12 months?

YES 1 68/

NO (SKIP TO SECTION G) 2

28A. SHOW PARTICIPANT HAND CARD I. What was the person's relationship to you? Please choose as many as apply from the card. CODE ALL THAT APPLY.

A. CHILD 01 69-70/

B. PARENT 02 71-72/

C. SPOUSE/PARTNER 03 73-74/

D. BROTHER OR SISTER 04 75-76/

E. OTHER NEAR RELATIVE OF YOU OR YOUR SPOUSE/PARTNER 05 77-78/

F. FRIEND 06 79-80/

G. OTHER (SPECIFY) _____ BEGIN DECK 38

_____ 07 10-11/

28B. What (was the date/were the dates) of the death(s)? What month and year?
(ENTER DATES OF DEATH IN SAME ORDER AS CIRCLED CODES.)

ENTER MONTH AND YEAR [] [] - [] [] 12-15/

ENTER MONTH AND YEAR [] [] - [] [] 16-19/

ENTER MONTH AND YEAR [] [] - [] [] 20-23/



4. Think about the [first/next] time you had acne on your face, chest or back between (DATE OF LAST INTERVIEW) and now. When did it start and until when did it last? (PROBE FOR ALL PERIODS OF TIME.)

FIRST	SECOND	THIRD
[] [] - [] [] 28-31/ MONTH YEAR	[] [] - [] [] 36-39/ MONTH YEAR	[] [] - [] [] 44-47/ MONTH YEAR
TO	TO	TO
[] [] - [] [] 32-35/ MONTH YEAR	[] [] - [] [] 40-43/ MONTH YEAR	[] [] - [] [] 48-51/ MONTH YEAR

4A. ASK Q.4A FOR EACH TIME IN Q.4. SHOW RESPONDENT HAND CARD J. Where was the acne located [the (first/next) time]?
CIRCLE "YES" OR "NO."

FIRST TIME	SECOND TIME	THIRD TIME
YES NO	YES NO	YES NO

TEMPLES	1 . 2	52/	1 . . 2	61/	1 . . 2	70/
EYES OR EYELIDS	1 . . 2	53/	1 . . 2	62/	1 . . 2	71/
EARS	1 . . 2	54/	1 . . 2	63/	1 . . 2	72/
CHEEKS	1 . . 2	55/	1 . . 2	64/	1 . . 2	73/
NOSE	1 . . 2	56/	1 . . 2	65/	1 . . 2	74/
FOREHEAD	1 . . 2	57/	1 . . 2	66/	1 . . 2	75/
JAW, CHIN	1 . . 2	58/	1 . . 2	67/	1 . . 2	76/
OTHER	1 . . 2	58/	1 . . 2	67/	1 . . 2	76/
CHEST	1 . . 2	59/	1 . . 2	68/	1 . . 2	77/
BACK	1 . . 2	60/	1 . . 2	69/	1 . . 2	78/

5. IF TEMPLES, EYES, EYELIDS, OR EARS NOT CIRCLED IN Q.4A, SKIP TO Q.9, PAGE G-5.
OTHERWISE ASK: Between (DATE OF LAST INTERVIEW) and now, did you ever consult a doctor or
medical facility about the acne on your (temples/eyes or eyelids/ears)?

YES 1 79/
NO (SKIP TO Q.9, PAGE G-5) 2

6. What month and year did you first consult a doctor about the acne on your (temples/eyes or eyelids/ears)?

 |_| - |_|
 MONTH YEAR

BEGIN DECK 39
10-13/

6A. What is the full name of the doctor who made the diagnosis or the name of the medical facility where the diagnosis was made?

COMPLETE MEDICAL AUTHORIZATION FORM, IF NECESSARY.

PHYSICIAN'S LAST NAME

FIRST NAME

OR

FACILITY NAME

INSTRUCTIONS FOR MEDICAL AUTHORIZATION FORMS:

YOU MUST COMPLETE AN AUTHORIZATION FORM FOR EACH PHYSICIAN OR FACILITY NAMED BY THE PARTICIPANT.

IF THE PARTICIPANT SEES THE SAME PROVIDER (PHYSICIAN OR FACILITY) FOR SEVERAL CONDITIONS, YOU COMPLETE ONE AUTHORIZATION FORM FOR THE SAME PROVIDER FORM.

LIST EACH INDIVIDUAL CONDITION ON THE SAME PROVIDER FORM.

6B. What is the address of that (doctor/medical facility)?

STREET ADDRESS

14/

CITY (STATE)

7. What month and year did you last consult a doctor about the acne on your (temples/eyes or eyelids/ears)?

 | | - | |
MONTH YEAR

15-18/

8A. What was the name of the doctor or medical facility you consulted at that time?
IF THE NAME OF THE PROVIDER IS THE SAME AS IN Q.6A,
WRITE: "SAME PROVIDER AS IN Q.6A."

PHYSICIANS LAST NAME

FIRST NAME

OR

FACILITY NAME

8B. What is the address of that (doctor/medical facility)?

STREET ADDRESS

CITY (STATE)

9. WAS R INTERVIEWED IN 1985/1986 OR 1987/1988? SEE INFORMATION SHEET.

YES (SKIP TO Q.11, PAGE G-6) 1
NO 2

10. SHOW RESPONDENT HAND CARD K. What is your blood type?

A 1 19/
B 2
O 3
AB 4
DON'T KNOW 8

10A. Is that positive or negative?

POSITIVE 1 20/
NEGATIVE 2

11. ASK ALL RESPONDENTS. SHOW RESPONDENT HAND CARD L. During the last year, how often, on average, would you say you use aspirin?

More than 4 aspirin a day	1	21/
4 aspirin a day (2 doses a day)	2	
2 aspirin a day (1 dose a day)	3	
6-8 aspirin a week (1 dose, 3-4 days/week)	4	
4 aspirin a week or less	5	
NONE	6	

12. In the summer, once you have already been in the sun several times, what reaction will your skin have the next time you go out in the sun for two or more hours on a bright day? Would you say you get . . .

A painful burn?	1	22/
A burn?	2	
Some redness only?	3	
Or no reaction?	4	

13. SHOW RESPONDENT HAND CARD N. After repeated sun exposures, for example, a two week vacation outdoors, will your skin become . . .

Only freckled or no suntan at all?	1	23/
Only mildly tanned due to a tendency to peel?	2	
Moderately tanned?	3	
Very brown and deeply tanned?	4	

WAS R INTERVIEWED IN 1985/1986 OR 1987/1988? SEE INFORMATION SHEET.

- YES (SKIP TO Q.15, BELOW) 1
- NO 2

14. **HAND R SELF-ADMINISTERED FORM 2.** We would like you to tell us all the places you've lived since you were born. Please list all the places you've lived for more than 12 months starting with the first place since birth. Please take your time. It will probably take you 10 minutes or so to fill out this form. Please begin.

15. Since (DATE OF LAST INTERVIEW)/(During any period in your life), did a doctor (ever) tell you that you had a peptic or stomach ulcer?

- Yes (GO TO Q.16) 1 24/
- No (SKIP TO Q.30, PAGE G-11) 2

16. During what month and year did a doctor first tell you that you had a peptic or stomach ulcer?

-
 MONTH YEAR

25-28/

17. What is the full name of the doctor who made the diagnosis or the name of the medical facility where the diagnosis was made? COMPLETE MEDICAL AUTHORIZATION FORM.

PHYSICIAN'S LAST NAME

FIRST NAME

OR

FACILITY NAME

A. What is the address of that (doctor/medical facility)?

STREET ADDRESS

 CITY (STATE)

21. During what month and year did a doctor first tell you that you had a bleeding ulcer?

____ - ____
MONTH YEAR

35-38/

22. What is the full name of the doctor who made the diagnosis or the medical facility where the diagnosis was made?

IF NAME OF THE PROVIDER IS THE SAME AS IN Q.17,
WRITE: "SAME PROVIDER AS IN Q.17."

PHYSICIAN'S LAST NAME

FIRST NAME

OR

FACILITY NAME

23. What is the address of that (doctor/medical facility)?

STREET ADDRESS

CITY (STATE)

24. What month and year did you last consult a doctor for your bleeding ulcer?

____ - ____
MONTH YEAR

39-42/

A. Was this the same doctor that had originally diagnosed the stomach ulcer for the first time?

YES (SKIP TO Q.25, NEXT PAGE) 1

NO 2

B. What is the full name of the doctor or the name of the medical facility you last consulted for you bleeding ulcer?

COMPLETE MEDICAL AUTHORIZATION FORM.

PHYSICIAN'S LAST NAME

FIRST NAME

OR

FACILITY NAME

C. What is the address of that doctor/medical facility)?

STREET ADDRESS

CITY (STATE)

25. What is the treatment you are currently taking for the bleeding ulcer?

26. During what month(s) and year(s) did you have a bleeding ulcer? Any other times?

FROM

____ - ____ |43-46/
MONTH YEAR

TO

____ - ____ |47-50/
MONTH YEAR

FROM

____ - ____ |51-54/
MONTH YEAR

TO

____ - ____ |55-58/
MONTH YEAR

FROM

____ - ____ |59-62/
MONTH YEAR

TO

____ - ____ |63-66/
MONTH YEAR

27. FOR PARTICIPANTS INTERVIEWED IN 1985/1986 OR 1987/1988 READ "SINCE DATE OF LAST INTERVIEW. Since (DATE OF LAST INTERVIEW) have you been/(Were you ever during any period in your life) hospitalized for your peptic or stomach ulcer?

- YES 1 67/
- NO 2

28. Since (DATE OF LAST INTERVIEW) did you have/(Have you ever during any period in your life had) surgery for your peptic or stomach ulcer?

- YES 1 68/
- NO 2

29. Are you currently taking any prescribed medicines for your peptic or stomach ulcer?

- YES 1 69/
- NO (SKIP TO Q.30, BELOW) 2

A. What are the names of the medicines you are taking?
(PROBE: WHAT OTHERS?)

- 1) _____
- 2) _____
- 3) _____

30. SHOW RESPONDENT HAND CARD O. Please indicate which of the following members of your biological family have ever had a peptic or stomach ulcer?

- 1. Mother 01 70-71/
- 2. Father 02 72-73/
- 3. Full Brother 03 74-75/
- 4. Half Brother 04 76-77/
- 5. Full Sister 05 78-79/
- BEGIN DECK 40
- 6. Half Sister 06 10-11/
- 7. NONE 07 12-13/
- 8. DON'T KNOW 98 14-15/

31. Do you have or have you recently had sharp upper stomach pain?
- YES 1 16/
NO (SKIP TO Q.34, BELOW) 2
32. Was this pain relieved by food, milk, or antacids?
- YES 1 17/
NO 2
33. Has this stomach pain awakened you from sleep?
- YES 1 18/
NO 2
34. Have you vomited blood recently?
- YES 1 19/
NO 2
35. Have you recently experienced dark tar colored stools or bowel movements?
- YES 1 20/
NO 2

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C	D	E	F	G
<p>Do you have (CONDITION) now?</p>	<p>Are you currently taking any prescribed medicines for your (CONDITION)?</p>	<p>What are the names of medicines you are taking? Any others?</p>	<p>When did you last consult a doctor for (CONDITION) between (DATE OF LAST INTERVIEW) and now?</p>	<p>What is the full name and address of the doctor or medical facility you last consulted? IF DIFFERENT DOCTOR FROM B, COMPLETE MEDICAL AUTHORIZATION FORM.</p>
<p>YES 1 NO 2 34/</p>	<p>YES 1 NO. (SKIP TO F FOR THIS CONDITION) 2 35/</p>	<p>1) _____ 36-38/ 2) _____ 39-41/ 3) _____ 42-44/</p>	<p>_____|_____|_____|_____| MONTH YEAR 45-48/</p>	<p>_____ PHYSICIAN'S LAST NAME 49/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____|_____|_____|_____| CITY STATE INTERVIEWER: BEFORE ASKING ABOUT THYROID PROBLEMS, SKIP TO Q.IS25 IN I.S.R.B. PAGE 7.</p>
<p>YES 1 NO 2 50/</p>	<p>YES 1 NO. (SKIP TO F FOR THIS CONDITION) 2 51/</p>	<p>1) _____ 52-54/ 2) _____ 55-57/ 3) _____ 58-60/</p>	<p>_____|_____|_____|_____| MONTH YEAR/</p>	<p>_____ PHYSICIAN'S LAST NAME 65/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____|_____|_____|_____| CITY STATE</p>

		A	B																
Since (DATE OF LAST INTERVIEW) has a doctor told you for the first time that you had . . . ?		Between (DATE OF LAST INTERVIEW) and now, in what month and year <u>did</u> a doctor first tell you that you had (CONDITION)?	What is the full name and address of the doctor who first made the <u>diagnosis</u> or the medical facility where the <u>diagnosis</u> was first made? REVIEW MEDICAL AUTHORIZATION FORMS. IF FORM NOT COMPLETED FOR THIS DOCTOR, COMPLETE FORM NOW.																
38. Anemia?	YES 1 NO. . (SKIP TO Q.39 BELOW) . . . 2 66/	<table border="1"> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td colspan="2">MONTH</td> <td colspan="2">YEAR</td> </tr> <tr> <td colspan="4">67-70/</td> </tr> </table>									MONTH		YEAR		67-70/				PHYSICIAN'S LAST NAME _____ 71/ FIRST NAME _____ OR _____ FACILITY NAME _____ STREET ADDRESS _____ CITY _____ STATE _____
MONTH		YEAR																	
67-70/																			
39. A heart condition? (SPECIFY) _____ _____ _____ 73/	YES 1 NO. . (SKIP TO Q.40, PAGE G-18) 2 72/	<table border="1"> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td colspan="2">MONTH</td> <td colspan="2">YEAR</td> </tr> <tr> <td colspan="4">74-77/</td> </tr> </table>									MONTH		YEAR		74-77/				PHYSICIAN'S LAST NAME _____ 78/ FIRST NAME _____ OR _____ FACILITY NAME _____ STREET ADDRESS _____ CITY _____ STATE _____
MONTH		YEAR																	
74-77/																			

B-106

C	D	E	F	G
<p>Do you have (CONDITION) now?</p>	<p>Are you currently taking any prescribed medicines for your (CONDITION)?</p>	<p>What are the names of medicines you are taking? Any others?</p>	<p>When did you last consult a doctor for (CONDITION) between (DATE OF LAST INTERVIEW) and now?</p>	<p>What is the full name and address of the doctor or medical facility you last consulted? IF DIFFERENT DOCTOR FROM B, COMPLETE MEDICAL AUTHORIZATION FORM.</p>
<p>YES 1 NO 2 10/</p>	<p>YES 1 NO. (SKIP TO F FOR THIS CONDITION) 2 11/</p>	<p>1) _____ 12-14/ 2) _____ 15-17/ 3) _____ 18-20/</p>	<p>____|____|____|____| MONTH YEAR 21-24/</p>	<p>_____ PHYSICIAN'S LAST NAME 25/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____|_____|_____|_____| CITY STATE</p>
<p>YES 1 NO 2 26/</p>	<p>YES 1 NO. (SKIP TO F FOR THIS CONDITION) 2 27/</p>	<p>1) _____ 28-30/ 2) _____ 31-33/ 3) _____ 34-36/</p>	<p>____|____|____|____| MONTH YEAR 37-40/</p>	<p>_____ PHYSICIAN'S LAST NAME 41/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____|_____|_____|_____| CITY STATE</p>

		A	B																
Since (DATE OF LAST INTERVIEW) has a doctor told you for the first time that you had...?		Between (DATE OF LAST INTERVIEW) and now, in what month and year <u>did</u> a doctor first tell you that you had (CONDITION)?	What is the full name and address of the doctor who first made the diagnosis or the medical facility where the diagnosis was first made? IF AUTHORIZATION FORM NOT COMPLETED FOR THIS DOCTOR, COMPLETE FORM.																
40. An enlarged liver?	YES 1 NO.. (SKIP TO Q.41 BELOW) ... 2 42/	<table border="1"> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td colspan="2">MONTH</td> <td colspan="2">YEAR</td> </tr> <tr> <td colspan="4">43-46/</td> </tr> </table>									MONTH		YEAR		43-46/				_____ PHYSICIAN'S LAST NAME 47/ _____ FIRST NAME _____ OR _____ FACILITY NAME _____ STREET ADDRESS _____ CITY STATE
MONTH		YEAR																	
43-46/																			
41. Jaundice? (SPECIFY) _____ _____ _____	YES 1 NO.. (SKIP TO Q.42 PAGE G-20) 2 48/	<table border="1"> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td colspan="2">MONTH</td> <td colspan="2">YEAR</td> </tr> <tr> <td colspan="4">49-52/</td> </tr> </table>									MONTH		YEAR		49-52/				_____ PHYSICIAN'S LAST NAME 53/ _____ FIRST NAME _____ OR _____ FACILITY NAME _____ STREET ADDRESS _____ CITY STATE
MONTH		YEAR																	
49-52/																			

B-108

May 15, 1992

16:10 pm

Field Version 1.1

C	D	E	F	G
<p>Do you have (CONDITION) now?</p>	<p>Are you currently taking any prescribed medicines for your (CONDITION)?</p>	<p>What are the names of medicines you are taking? Any others?</p>	<p>When did you last consult a doctor for (CONDITION) between (DATE OF LAST INTERVIEW) and now?</p>	<p>What is the full name and address of the doctor or medical facility you last consulted? IF DIFFERENT DOCTOR FROM B, COMPLETE MEDICAL AUTHORIZATION FORM.</p>
<p>YES 1 NO 2 54/</p>	<p>YES 1 NO. (SKIP TO F FOR THIS CONDITION) 2 55/</p>	<p>1) _____ 56-58/ 2) _____ 59-61/ 3) _____ 62-64/</p>	<p>____|____|____|____| MONTH YEAR 65-68/ BEGIN DECK 42</p>	<p>_____ PHYSICIAN'S LAST NAME 69/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____|_____|_____|_____| CITY STATE</p>
<p>YES 1 NO 2 70/</p>	<p>YES 1 NO. (SKIP TO F FOR THIS CONDITION) 2 71/</p>	<p>1) _____ 72-74/ 2) _____ 75-77/ 3) _____ 78-80/</p>	<p>____|____|____|____| MONTH YEAR 10-13/</p>	<p>_____ PHYSICIAN'S LAST NAME 14/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____|_____|_____|_____| CITY STATE</p>

B-109

May 15, 1992

18:07 pm

Field Version 1.1

		A	B															
Since (DATE OF LAST INTERVIEW) has a doctor told you for the first time that you had...?		Between (DATE OF LAST INTERVIEW) and now, in what month and year <u>did a doctor first tell you that you had (CONDITION)?</u>	What is the full name and address of the doctor who first made the <u>diagnosis</u> or the <u>medical facility where the diagnosis was first made?</u> IF AUTHORIZATION FORM NOT COMPLETED FOR THIS DOCTOR, COMPLETE FORM.															
42. Hepatitis?	YES 1 NO... (SKIP TO Q.43 BELOW) ... 2 15/	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td colspan="2">MONTH</td><td colspan="3">YEAR</td> </tr> <tr> <td colspan="5">16-19/</td> </tr> </table>						MONTH		YEAR			16-19/					PHYSICIAN'S LAST NAME 20/ _____ FIRST NAME _____ OR _____ FACILITY NAME _____ STREET ADDRESS _____ CITY STATE _____
MONTH		YEAR																
16-19/																		
43. Cirrhosis of the liver? (*SIR-O-SIS*)	YES 1 NO... (SKIP TO Q.44, PAGE G-22) 2 21/	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td colspan="2">MONTH</td><td colspan="3">YEAR</td> </tr> <tr> <td colspan="5">22-25/</td> </tr> </table>						MONTH		YEAR			22-25/					PHYSICIAN'S LAST NAME 26/ _____ FIRST NAME _____ OR _____ FACILITY NAME _____ STREET ADDRESS _____ CITY STATE _____
MONTH		YEAR																
22-25/																		

B-110

C	D	E	F	G
<p>Do you have (CONDITION) now?</p>	<p>Are you currently taking any prescribed medicines for your (CONDITION)?</p>	<p>What are the names of medicines you are taking? Any others?</p>	<p>When did you last consult a doctor for (CONDITION) between (DATE OF LAST INTERVIEW) and now?</p>	<p>What is the full name and address of the doctor or medical facility you last consulted? IF DIFFERENT DOCTOR FROM B, COMPLETE MEDICAL AUTHORIZATION FORM.</p>
<p>YES 1 NO 2 27/</p>	<p>YES 1 NO. (SKIP TO F FOR THIS CONDITION) 2 28/</p>	<p>1) _____ 29-31/ 2) _____ 32-34/ 3) _____ 35-37/</p>	<p>_____|_____|_____|_____| MONTH YEAR 38-41/</p>	<p>_____ PHYSICIAN'S LAST NAME 42/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____|_____|_____| CITY STATE</p>
<p>YES 1 NO 2 43/</p>	<p>YES 1 NO. (SKIP TO F FOR THIS CONDITION) 2 44/</p>	<p>1) _____ 45-47/ 2) _____ 48-50/ 3) _____ 51-53/</p>	<p>_____|_____|_____|_____| MONTH YEAR 54-57/</p>	<p>_____ PHYSICIAN'S LAST NAME 58/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____|_____|_____| CITY STATE</p>

B-111

May 15, 1992

18:08 pm

Field Version 1.1

		A	B																		
Since (DATE OF LAST INTERVIEW) has a doctor told you for the first time that you had...?		Between (DATE OF LAST INTERVIEW) and now, in what month and year <u>did a doctor first tell you that you had (CONDITION)?</u>	What is the full name and address of the doctor who first made the diagnosis or the medical facility where the diagnosis was first made? IF AUTHORIZATION FORM NOT COMPLETED FOR THIS DOCTOR, COMPLETE FORM.																		
44. Intestinal parasites?	YES 1 NO. . (SKIP TO Q.45 BELOW) ... 2 59/	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td colspan="3">MONTH</td> <td colspan="3">YEAR</td> </tr> <tr> <td colspan="6">60-63/</td> </tr> </table>							MONTH			YEAR			60-63/						PHYSICIAN'S LAST NAME 64/ FIRST NAME OR FACILITY NAME STREET ADDRESS CITY STATE
MONTH			YEAR																		
60-63/																					
45. Gall bladder problems?	YES 1 NO. . (SKIP TO Q.46, PAGE G-24) 2 65/	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td colspan="3">MONTH</td> <td colspan="3">YEAR</td> </tr> <tr> <td colspan="6">66-69/</td> </tr> </table>							MONTH			YEAR			66-69/						PHYSICIAN'S LAST NAME 70/ FIRST NAME OR FACILITY NAME STREET ADDRESS CITY STATE
MONTH			YEAR																		
66-69/																					

B-112

C	D	E	F	G
<p>Do you have (CONDITION) now?</p>	<p>Are you currently taking any prescribed medicines for your (CONDITION)?</p>	<p>What are the names of medicines you are taking? Any others?</p>	<p>When did you last consult a doctor for (CONDITION) between (DATE OF LAST INTERVIEW) and now?</p>	<p>What is the full name and address of the doctor or medical facility you last consulted? IF DIFFERENT DOCTOR FROM B, COMPLETE MEDICAL AUTHORIZATION FORM.</p>
<p>YES 1 NO 2 71/</p>	<p>YES 1 NO. (SKIP TO F FOR THIS CONDITION) 2 72/</p>	<p>1) _____ 73-75/ 2) _____ 76-78/ BEGIN DECK 43 3) _____ 10-12/</p>	<p>_____|_____|_____|_____| MONTH YEAR 13-16/</p>	<p>_____ PHYSICIAN'S LAST NAME 17/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____|_____|_____| CITY STATE</p>
<p>YES 1 NO 2 18/</p>	<p>YES 1 NO. (SKIP TO F FOR THIS CONDITION) 2 19/</p>	<p>1) _____ 20-22/ 2) _____ 23-25/ 3) _____ 26-28/</p>	<p>_____|_____|_____|_____| MONTH YEAR 29-32/</p>	<p>_____ PHYSICIAN'S LAST NAME 33/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____|_____|_____| CITY STATE</p>

B-113

		A	B												
Since (DATE OF LAST INTERVIEW) has a doctor told you for the first time that you had...?		Between (DATE OF LAST INTERVIEW) and now, in what month and year <u>did a doctor first tell you that you had (CONDITION)?</u>	What is the full name and address of the doctor <u>who first made the diagnosis</u> or the medical facility <u>where the diagnosis was first made?</u> IF AUTHORIZATION FORM NOT COMPLETED FOR THIS DOCTOR, COMPLETE FORM.												
46. Any other liver condition? (SPECIFY) _____ _____ _____ 35/	YES 1 NO. (SKIP TO Q.47 BELOW) ... 2 34/	<table border="1"> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td colspan="2">MONTH</td> <td colspan="2">YEAR</td> </tr> <tr> <td colspan="4">36-39/</td> </tr> </table>					MONTH		YEAR		36-39/				PHYSICIAN'S LAST NAME _____ 40/ FIRST NAME _____ OR FACILITY NAME _____ STREET ADDRESS _____ CITY _____ STATE _____
MONTH		YEAR													
36-39/															
47. Pneumonia?	YES 1 NO. (SKIP TO Q.48 PAGE G-26) 2 41/	<table border="1"> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td colspan="2">MONTH</td> <td colspan="2">YEAR</td> </tr> <tr> <td colspan="4">42-45/</td> </tr> </table>					MONTH		YEAR		42-45/				PHYSICIAN'S LAST NAME _____ 46/ FIRST NAME _____ OR FACILITY NAME _____ STREET ADDRESS _____ CITY _____ STATE _____
MONTH		YEAR													
42-45/															

B-114

		A	B									
Since (DATE OF LAST INTERVIEW) has a doctor told you for the first time that you had...?		Between (DATE OF LAST INTERVIEW) and now, in what month and year did a doctor first tell you that you had (CONDITION)?	What is the full name and address of the doctor who first made the diagnosis or the medical facility where the diagnosis was first made? IF AUTHORIZATION FORM NOT COMPLETED FOR THIS DOCTOR, COMPLETE FORM.									
48. A respiratory condition other than pneumonia? (SPECIFY) _____ _____ _____ 11/	YES 1 NO. . (SKIP TO Q.49 BELOW) ... 2 10/	<table style="width: 100%; border: none;"> <tr> <td style="border: none;"> _ _ </td> <td style="border: none;">-</td> <td style="border: none;"> _ _ </td> </tr> <tr> <td style="border: none;">MONTH</td> <td style="border: none;"></td> <td style="border: none;">YEAR</td> </tr> <tr> <td colspan="3" style="border: none; text-align: center;">12-15/</td> </tr> </table>	_ _	-	_ _	MONTH		YEAR	12-15/			_____ PHYSICIAN'S LAST NAME 16/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____ CITY STATE
_ _	-	_ _										
MONTH		YEAR										
12-15/												
49. Any other major condition? (SPECIFY) _____ _____ _____ 18/	YES 1 NO. . (SKIP TO Q.50, PAGE G-28) 2 17/	<table style="width: 100%; border: none;"> <tr> <td style="border: none;"> _ _ </td> <td style="border: none;">-</td> <td style="border: none;"> _ _ </td> </tr> <tr> <td style="border: none;">MONTH</td> <td style="border: none;"></td> <td style="border: none;">YEAR</td> </tr> <tr> <td colspan="3" style="border: none; text-align: center;">19-22/</td> </tr> </table>	_ _	-	_ _	MONTH		YEAR	19-22/			_____ PHYSICIAN'S LAST NAME 23/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____ CITY STATE
_ _	-	_ _										
MONTH		YEAR										
19-22/												

C	D	E	F	G
<p>Do you have (CONDITION) now?</p>	<p>Are you currently taking any prescribed medicines for your (CONDITION)?</p>	<p>What are the names of medicines you are taking? Any others?</p>	<p>When did you last consult a doctor for (CONDITION) between (DATE OF LAST INTERVIEW) and now?</p>	<p>What is the full name and address of the doctor or medical facility you last consulted? IF DIFFERENT DOCTOR FROM B, COMPLETE MEDICAL AUTHORIZATION FORM.</p>
<p>YES 1 NO 2 24/</p>	<p>YES 1 NO. (SKIP TO F FOR THIS CONDITION) 2 25/</p>	<p>1) _____ 26-28/ 2) _____ 29-31/ 3) _____ 32-34/</p>	<p>____|____|____|____| MONTH YEAR 35-38/</p>	<p>_____ PHYSICIAN'S LAST NAME 39/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____|_____|_____|_____| CITY STATE</p>
<p>YES 1 NO 2 40/</p>	<p>YES 1 NO. (SKIP TO F FOR THIS CONDITION) 2 41/</p>	<p>1) _____ 42-44/ 2) _____ 45-47/ 3) _____ 48-50/</p>	<p>____|____|____|____| MONTH YEAR 51-54/</p>	<p>_____ PHYSICIAN'S LAST NAME 55/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____|_____|_____|_____| CITY STATE</p>

C	D	E	F	G																								
Do you have emotional disorder now?	Are you currently taking any prescribed medicines for your (CONDITION)?	What are the names of medicines you are taking? Any others?	When did you last consult a doctor for (CONDITION) between (DATE OF LAST INTERVIEW) and now?	What is the full name and address of the doctor or medical facility you last consulted? IF DIFFERENT DOCTOR FROM B, COMPLETE MEDICAL AUTHORIZATION FORM.																								
YES 1 NO 2 63/	YES 1 NO. (SKIP TO F FOR THIS CONDITION) 2 64/	1) _____ _____ 2) _____ _____ 3) _____ _____	<table border="0"> <tr> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">MONTH</td> <td colspan="4" style="text-align: center;">YEAR</td> </tr> <tr> <td colspan="6" style="text-align: center;">65-68/</td> </tr> </table>							MONTH		YEAR				65-68/						_____ PHYSICIAN'S LAST NAME _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS <table border="0" style="width: 100%;"> <tr> <td style="border: 1px solid black; width: 60%; height: 15px;"></td> <td style="border: 1px solid black; width: 20%; height: 15px;"></td> <td style="border: 1px solid black; width: 20%; height: 15px;"></td> </tr> <tr> <td>CITY</td> <td>STATE</td> <td></td> </tr> </table>				CITY	STATE	
MONTH		YEAR																										
65-68/																												
CITY	STATE																											

BEFORE ASKING Q.51, SKIP TO Q.1650 in I.S.F.B. on PAGE 12.

51. At any time since (DATE OF LAST INTERVIEW) has a doctor told you that you had cancer?

YES 1 69/
NO (SKIP TO Q.55, PAGE G-³⁷~~30~~) 2

52. Did the doctor tell you that this was a skin cancer or a systemic (body) cancer?

SKIN CANCER ONLY 1 70/
SYSTEMIC CANCER ONLY (SKIP TO Q.54, PAGE G-34) .. 2
BOTH SKIN AND SYSTEMIC CANCER 3

SKIN CANCER ONLY

53. SHOW RESPONDENT HAND CARD J. Please look at this chart and tell me where each of your skin cancers (is/was) located.

INDICATE THE ANATOMICAL CODE FOR EACH SITE BEING REPORTED.

SITE NUMBER

1	2	3
□□	□□	□□
71-72/	73-74/	75-76/

SITE CODE

- | | |
|---|--|
| <p>CODES: (01) Scalp or Forehead
(02) Eye Lid
(03) Ear
(04) Nose
(05) Head or Neck, Not
 Otherwise Specified
(06) Cheek, chin or jaw
(07) Neck or Supraclavicular
(08) Vermilion
(09) Trunk, Front
(10) Trunk, Back
(11) Trunk, Not Otherwise
 Specified
(12) Arm
(13) Hand</p> | <p>(14) Arm or Hand, Not Otherwise
 Specified
(15) Genitals
(16) Leg
(17) Foot
(18) Leg or Foot, Not Otherwise
 Specified
(19) Skin, Not Otherwise Specified
(20) Upperlip, Not Otherwise
 Specified
(21) Lowerlip, Not Otherwise
 Specified
(22) Lip, Not Otherwise Specified</p> |
|---|--|

SITE 1	SITE 2	SITE 3
<p>53C.1 What is the full name and address of the doctor or the medical facility where the <u>first</u> diagnosis was made? COMPLETE MEDICAL AUTHORIZATION FORM IF NECESSARY.</p> <p>_____ PHYSICIAN'S LAST NAME 33/</p> <p>_____ FIRST NAME</p> <p style="text-align:center">OR</p> <p>_____ FACILITY NAME</p> <p>_____ STREET ADDRESS</p> <p>_____ CITY STATE</p>	<p>53C.1 What is the full name and address of the doctor or the medical facility where the <u>first</u> diagnosis was made? COMPLETE MEDICAL AUTHORIZATION FORM IF NECESSARY.</p> <p>_____ PHYSICIAN'S LAST NAME 34/</p> <p>_____ FIRST NAME</p> <p style="text-align:center">OR</p> <p>_____ FACILITY NAME</p> <p>_____ STREET ADDRESS</p> <p>_____ CITY STATE</p>	<p>53C.1 What is the full name and address of the doctor or the medical facility where the <u>first</u> diagnosis was made? COMPLETE MEDICAL AUTHORIZATION FORM IF NECESSARY.</p> <p>_____ PHYSICIAN'S LAST NAME 35/</p> <p>_____ FIRST NAME</p> <p style="text-align:center">OR</p> <p>_____ FACILITY NAME</p> <p>_____ STREET ADDRESS</p> <p>_____ CITY STATE</p>
<p>53C.2 What is the full name and address of the doctor or medical facility you <u>last</u> consulted? COMPLETE AUTHORIZATION FORM IF NECESSARY. IF SAME AS IN C.1, WRITE "SAME AS IN C.1"</p> <p>_____ PHYSICIAN'S LAST NAME</p> <p>_____ FIRST NAME</p> <p style="text-align:center">OR</p> <p>_____ FACILITY NAME</p> <p>_____ STREET ADDRESS</p> <p>_____ CITY STATE</p>	<p>53C.2 What is the full name and address of the doctor or medical facility you <u>last</u> consulted? COMPLETE AUTHORIZATION FORM IF NECESSARY. IF SAME AS IN C.1, WRITE "SAME AS IN C.1"</p> <p>_____ PHYSICIAN'S LAST NAME</p> <p>_____ FIRST NAME</p> <p style="text-align:center">OR</p> <p>_____ FACILITY NAME</p> <p>_____ STREET ADDRESS</p> <p>_____ CITY STATE</p>	<p>53C.2 What is the full name and address of the doctor or medical facility you <u>last</u> consulted? COMPLETE AUTHORIZATION FORM IF NECESSARY. IF SAME AS IN C.1, WRITE "SAME AS IN C.1"</p> <p>_____ PHYSICIAN'S LAST NAME</p> <p>_____ FIRST NAME</p> <p style="text-align:center">OR</p> <p>_____ FACILITY NAME</p> <p>_____ STREET ADDRESS</p> <p>_____ CITY STATE</p>

SYSTEMIC (BODY) CANCER ONLY

BEGIN DECK 47

QUESTION 54 BODY PART 1	QUESTION 54 BODY PART 2	QUESTION 54 BODY PART 3																														
<p>54A. In what part of your body (is/was) cancer located? RECORD VERBATIM 26-41/ _____ _____ _____</p>	<p>54A. In what part of your body (is/was) cancer located? RECORD VERBATIM 51-66/ _____ _____ _____</p>	<p>54A. In what part of your body (is/was) cancer located? RECORD VERBATIM 10-25/ _____ _____ _____</p>																														
<p>54B. What kind of cancer was it? 42/ _____ _____ _____</p>	<p>54B. What kind of cancer was it? 67/ _____ _____ _____</p>	<p>54B. What kind of cancer was it? 26/ _____ _____ _____</p>																														
<p>54C.1 In what month and year was cancer of the (BODY PART) first diagnosed? <table border="0" style="margin-left: auto; margin-right: auto;"> <tr> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="text-align: center;">--</td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> <tr> <td style="text-align: center;">MONTH</td> <td></td> <td></td> <td style="text-align: center;">YEAR</td> <td></td> </tr> </table> 43-46/</p>			--			MONTH			YEAR		<p>54C.1 In what month and year was cancer of the (BODY PART) first diagnosed? <table border="0" style="margin-left: auto; margin-right: auto;"> <tr> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="text-align: center;">--</td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> <tr> <td style="text-align: center;">MONTH</td> <td></td> <td></td> <td style="text-align: center;">YEAR</td> <td></td> </tr> </table> 68-71/</p>			--			MONTH			YEAR		<p>54C.1 In what month and year was cancer of the (BODY PART) first diagnosed? <table border="0" style="margin-left: auto; margin-right: auto;"> <tr> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="text-align: center;">--</td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> <tr> <td style="text-align: center;">MONTH</td> <td></td> <td></td> <td style="text-align: center;">YEAR</td> <td></td> </tr> </table> 27-30/</p>			--			MONTH			YEAR	
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35/R

QUESTION 54 BODY PART 1	QUESTION 54 BODY PART 2	QUESTION 54 BODY PART 3
<p>54D.1 What is the full name and address of the doctor or the medical facility where the diagnosis was <u>first</u> made? COMPLETE MEDICAL AUTHORIZATION FORM IF NECESSARY.</p> <p>_____ PHYSICIAN'S LAST NAME</p> <p>_____ FIRST NAME</p> <p>OR</p> <p>_____ FACILITY NAME</p> <p>_____ STREET ADDRESS</p> <p>_____ _____ _____ _____ CITY STATE</p>	<p>54D.1 What is the full name and address of the doctor or the medical facility where the diagnosis was <u>first</u> made? COMPLETE MEDICAL AUTHORIZATION FORM IF NECESSARY.</p> <p>_____ PHYSICIAN'S LAST NAME</p> <p>_____ FIRST NAME</p> <p>OR</p> <p>_____ FACILITY NAME</p> <p>_____ STREET ADDRESS</p> <p>_____ _____ _____ _____ CITY STATE</p>	<p>54D.1 What is the full name and address of the doctor or the medical facility where the diagnosis was <u>first</u> made? COMPLETE MEDICAL AUTHORIZATION FORM IF NECESSARY.</p> <p>_____ PHYSICIAN'S LAST NAME</p> <p>_____ FIRST NAME</p> <p>OR</p> <p>_____ FACILITY NAME</p> <p>_____ STREET ADDRESS</p> <p>_____ _____ _____ _____ CITY STATE</p>
<p>54D.2 What is the full name and address of the doctor or medical facility you <u>last consulted</u>? COMPLETE MEDICAL AUTHORIZATION FORM IF NECESSARY. IF SAME AS IN D.1, WRITE "SAME AS IN D.1"</p> <p>_____ PHYSICIAN'S LAST NAME</p> <p>_____ FIRST NAME</p> <p>OR</p> <p>_____ FACILITY NAME</p> <p>_____ STREET ADDRESS</p> <p>_____|_____|_____|_____| CITY STATE</p>	<p>54D.2 What is the full name and address of the doctor or medical facility you <u>last consulted</u>? COMPLETE MEDICAL AUTHORIZATION FORM IF NECESSARY. IF SAME AS IN D.1, WRITE "SAME AS IN D.1"</p> <p>_____ PHYSICIAN'S LAST NAME</p> <p>_____ FIRST NAME</p> <p>OR</p> <p>_____ FACILITY NAME</p> <p>_____ STREET ADDRESS</p> <p>_____|_____|_____|_____| CITY STATE</p>	<p>54D.2 What is the full name and address of the doctor or medical facility you <u>last consulted</u>? COMPLETE MEDICAL AUTHORIZATION FORM IF NECESSARY. IF SAME AS IN D.1, WRITE "SAME AS IN D.1"</p> <p>_____ PHYSICIAN'S LAST NAME</p> <p>_____ FIRST NAME</p> <p>OR</p> <p>_____ FACILITY NAME</p> <p>_____ STREET ADDRESS</p> <p>_____|_____|_____|_____| CITY STATE</p>

55. At any time since (DATE OF LAST INTERVIEW) has a doctor told you that you had leukemia?

YES (ASK Q.55A THROUGH Q.55F) 1 32/

NO (GO TO Q.56, PAGE G-39) 2

55A. Thinking about the period between (DATE OF LAST INTERVIEW) and now, in what month and year was your leukemia diagnosed?

 |_|_| - |_|_|
 MONTH YEAR

33-36/

55B. What is the name and address of the doctor or the medical facility where the diagnosis was made?
COMPLETE MEDICAL AUTHORIZATION FORM IF NECESSARY.

PHYSICIAN'S LAST NAME

37/

FIRST NAME

OR

FACILITY NAME

STREET ADDRESS

CITY

 |_|_|
 STATE

55C. What treatments or medicines have you taken for leukemia since (DATE OF LAST INTERVIEW)?

1) _____

38-40/

2) _____

41-43/

3) _____

44-46/

55D. For the period between (DATE OF LAST INTERVIEW) and now, during what month and year did you first receive (EACH TREATMENT OR MEDICINE IN C)?

MONTH YR.

TREATMENT 1 |_|_| - |_|_|

47-50/

TREATMENT 2 |_|_| - |_|_|

51-54/

TREATMENT 3 |_|_| - |_|_|

55-58/

55E. What is the name and address of the doctor or medical facility you last consulted about your leukemia?
COMPLETE MEDICAL AUTHORIZATION FORM IF NECESSARY.

PHYSICIAN'S LAST NAME

FIRST NAME

OR

FACILITY NAME

STREET ADDRESS

CITY STATE

59/

55F. During what month and year did you last consult (NAME IN Q.55E)?

____ - ____
MONTH YEAR

60-63/

56. Since (DATE OF LAST INTERVIEW) have you had . . .	A. FOR EACH YES, ASK A AND B. SHOW PARTICIPANT HAND CARD J. On what part of your body did you have (CONDITION)? Any other part?	B. Did you discuss (CONDITION) with a doctor since (DATE OF LAST INTERVIEW)?	C. ASK C THROUGH G FOR EACH "YES" AT B. What was the diagnosis?	D. What is the name and address of the doctor or medical facility? COMPLETE MEDICAL AUTHORIZATION FORM IF NECESSARY.
56.1 Patches of your skin change color YES 1 NO. . . (SKIP TO Q.56.2 BELOW) . 2 64/	<input type="checkbox"/> <input type="checkbox"/> SITE CODE 65-66/ <input type="checkbox"/> <input type="checkbox"/> SITE CODE 67-68/ <input type="checkbox"/> <input type="checkbox"/> SITE CODE 69-70/	YES 1 NO. . . (SKIP TO Q.56.2 BELOW) . . . 2 71/	_____ _____ _____ 72/	_____ PHYSICIAN'S LAST NAME/FACILITY 73/ _____ FIRST NAME _____ ADDRESS _____ | | | CITY STATE
56.2 Easier bruising of the skin than usual? YES 1 NO. . . (SKIP TO Q.56.3, PAGE G-43) . . . 2 74/	<input type="checkbox"/> <input type="checkbox"/> SITE CODE 75-76/ <input type="checkbox"/> <input type="checkbox"/> SITE CODE 77-78/ <input type="checkbox"/> <input type="checkbox"/> SITE CODE 79-80/	BEGIN DECK 49 YES 1 NO. . . (SKIP TO Q.56.3, PAGE G-41) 2 10/	_____ _____ _____ 11/	_____ PHYSICIAN'S LAST NAME/FACILITY 12/ _____ FIRST NAME _____ ADDRESS _____ | | | CITY STATE

CODES FOR Q.56

- | | |
|--|---|
| (01) Scalp or Forehead | (12) Arm |
| (02) Eye Lid | (13) Hand |
| (03) Ear | (14) Arm or Hand, Not Otherwise Specified |
| (04) Nose | (15) Genitals |
| (05) Head or Neck, Not Otherwise Specified | (16) Leg |
| (06) Cheek, chin or jaw | (17) Foot |
| (07) Neck or Supraclavicular | (18) Leg or Foot, Not Otherwise Specified |
| (08) Vermilion | (19) Skin, Not Otherwise Specified |
| (09) Trunk, Front | (20) Upperlip, Not Otherwise Specified |
| (10) Trunk, Back | (21) Lowerlip, Not Otherwise Specified |
| (11) Trunk, Not Otherwise Specified | (22) Lip, Not Otherwise Specified |

E.	F.	G.
<p>56. ASK E THROUGH G FOR EACH "YES" AT B. During what month and year was that?</p> <p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR </p> <p>13-16/</p>	<p>What is the name and address of the doctor or medical facility you last consulted about (CONDITION)? IF DIFFERENT DOCTOR IN D, COMPLETE AUTHORIZATION FORM.</p> <p> _____ PHYSICIAN'S LAST NAME </p> <p>17/</p> <p> _____ FIRST NAME OR _____ FACILITY NAME </p> <p> _____ STREET ADDRESS </p> <p> _____ <input type="text"/> <input type="text"/> <input type="text"/> CITY STATE </p>	<p>During what month and year did you last consult (NAME FROM F)?</p> <p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR </p> <p>18-21/</p> <p>(SKIP BACK TO Q.56.2, PAGE G-39)</p>
<p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR </p> <p>22-25/</p>	<p> _____ PHYSICIAN'S LAST NAME </p> <p>26/</p> <p> _____ FIRST NAME OR _____ FACILITY NAME </p> <p> _____ STREET ADDRESS </p> <p> _____ <input type="text"/> <input type="text"/> <input type="text"/> CITY STATE </p>	<p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR </p> <p>27-30/</p> <p>(GO TO Q.56.3, PAGE G-41)</p>

E.	F.	G.
<p>56. ASK E THROUGH G FOR EACH "YES" AT B. During what month and year was that?</p> <p> _ _ _ _ MONTH YEAR</p> <p>41-44/</p>	<p>What is the name and address of the doctor or medical facility you last consulted about (CONDITION)? IF DIFFERENT DOCTOR IN D, COMPLETE AUTHORIZATION FORM.</p> <p>_____ PHYSICIAN'S LAST NAME</p> <p>45/</p> <p>_____ FIRST NAME</p> <p>OR</p> <p>_____ FACILITY NAME</p> <p>_____ STREET ADDRESS</p> <p>_____ _ _ _ _ CITY STATE</p>	<p>During what month and year did you last consult (NAME FROM F)?</p> <p> _ _ _ _ MONTH YEAR</p> <p>46-49/</p>

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56. Aside from injury, since (DATE OF LAST INTERVIEW) have you had . . .	A. ASK A THROUGH C FOR EACH YES IN Q.56.4 OR Q.56.5. Thinking about the period between (DATE OF LAST INTERVIEW) and now, when did you first notice (CONDITION)?	B. Which limbs or muscles were affected?	C. Do you still have (CONDITION)?
<p>56.4 Persistent numbness of any of your limbs?</p> <p>YES 1</p> <p>NO. . . (SKIP TO Q.56.5, BELOW) . . 2 50/</p>	<p> | | | | | | | | MONTH YEAR 51-54/</p>	<p>_____</p> <p>_____</p> <p>_____ 55-56/</p>	<p>YES 1</p> <p>NO 2 57/</p>
<p>56.5 Persistent tingling sensations in any of your limbs?</p> <p>YES 1</p> <p>NO. . (SKIP TO Q.57.1, PAGE G-46) 2 58/</p>	<p> | | | | | | | | MONTH YEAR 59-62/</p>	<p>_____</p> <p>_____</p> <p>_____ 63-64/</p>	<p>YES 1</p> <p>NO 2 65/</p>

<p>H.</p> <p>ASK H THROUGH J FOR EACH YES IN Q.56.4E OR Q.56.5E. During what month and year was that?</p>	<p>I.</p> <p>What is the name and address of the doctor or medical facility you last consulted about (CONDITION)? IF DIFFERENT DOCTOR IN G, COMPLETE AUTHORIZATION FORM.</p>	<p>J.</p> <p>During what month and year did you last consult (NAME FROM I)?</p>
<p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR 17-20/ </p>	<p> _____ PHYSICIAN'S LAST NAME 21/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____ <input type="text"/> <input type="text"/> <input type="text"/> CITY STATE </p>	<p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR 22-25/ (SKIP BACK TO Q.56.5, PAGE G-43) </p>
<p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR 14-17/ </p>	<p> _____ PHYSICIAN'S LAST NAME 18/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____ <input type="text"/> <input type="text"/> <input type="text"/> CITY STATE </p>	<p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR 31-34/ </p>

<p>H.</p> <p>57. During what month and year was that?</p>	<p>I.</p> <p>What is the name and address of the doctor or medical facility you last consulted about (CONDITION)? IF DIFFERENT DOCTOR IN G, COMPLETE AUTHORIZATION FORM.</p>	<p>J.</p> <p>During what month and year did you last consult (NAME FROM I)?</p> <p>BEGIN DECK 51</p>
<p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR </p> <p>73-76/</p>	<p> _____ PHYSICIAN'S LAST NAME </p> <p>77/</p> <p> _____ FIRST NAME </p> <p>OR</p> <p> _____ FACILITY NAME </p> <p> _____ STREET ADDRESS </p> <p> _____ CITY STATE </p>	<p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR </p> <p>10-13/</p> <p>GO TO Q.57.2, PAGE G-46</p>
<p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR </p> <p>14-17/</p>	<p> _____ PHYSICIAN'S LAST NAME </p> <p>18/</p> <p> _____ FIRST NAME </p> <p>OR</p> <p> _____ FACILITY NAME </p> <p> _____ STREET ADDRESS </p> <p> _____ CITY STATE </p>	<p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR </p> <p>19-22/</p>

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58. Aside from injury, since (DATE OF LAST INTERVIEW) have you had . . .	A. ASK A THROUGH C FOR EACH YES IN Q.58. Thinking about the period between (DATE OF LAST INTERVIEW) and now, when did you first notice (CONDITION)?	B. Which limbs or muscles were affected?	C. Do you still have (CONDITION)?
58.1 A reduction in grip strength YES 1 NO . . . (SKIP TO Q.IS51, IN I.S.R.B. PAGE 13) . 2 23/	MONTH YEAR 24-27/	_____ _____ _____ 28-29/	YES 1 NO 2 30/

<p>H.</p> <p>58. During what month and year was that?</p>	<p>I.</p> <p>What is the name and address of the doctor or medical facility you last consulted about (CONDITION)? IF DIFFERENT DOCTOR IN G, COMPLETE AUTHORIZATION FORM.</p>	<p>J.</p> <p>During what month and year did you last consult (NAME FROM I)?</p>
<p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR </p> <p style="text-align: right;">42-45/</p>	<p> _____ PHYSICIAN'S LAST NAME </p> <p style="text-align: right;">46/</p> <p> _____ FIRST NAME </p> <p style="text-align: center;">OR</p> <p> _____ FACILITY NAME </p> <p> _____ STREET ADDRESS </p> <p> _____ <input type="text"/> <input type="text"/> <input type="text"/> CITY STATE </p>	<p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR </p> <p style="text-align: right;">47-50/</p>

INTERVIEWER: BEFORE ASKING QUESTION 59 ON NEXT PAGE, SKIP TO Q.IS51, in I.S.R.B. on Page 13.

SECTION H: HEALTH HABITS

FOR THIS SECTION YOU WILL NEED:

- Hand Card R
- Hand Card S
- Hand Card T
- Hand Card U
- Hand Card V
- Hand Card W
- Hand Card X
- Hand Card Y
- Hand Card Z
- Hand Card AA
- Hand Card BB
- Hand Card CC
- Hand Card DD
- Hand Card EE
- Hand Card FF

1A. WAS R INTERVIEWED IN 1985/1986 OR 1987/1988?

- YES (SKIP TO Q.62, PAGE H-23) 1
- NO 2

1B. THESE QUESTIONS ARE ASKED TO NEW PARTICIPANTS OR THOSE COMPLIANT ONLY AT BASELINE. The next set of questions refers to smoking habits.

Have you ever smoked at least as many as 5 packs of cigarettes, that is, 100 cigarettes, during your entire life?

- YES 1 53/
- NO (SKIP TO Q.22, PAGE H-9) 2

2. Do you now smoke cigarettes?

- YES 1 54/
- NO (SKIP TO Q.11, PAGE H-5) 2

CURRENT CIGARETTE SMOKER SECTION

3. On average, how many cigarettes do you smoke a day?

IF R ANSWERS BY GIVING NUMBER OF PACKS OF CIGARETTES, RECORD VERBATIM IN MARGIN.
THEN MULTIPLY THE NUMBER OF PACKS BY 20 AND ENTER THE NUMBER OF CIGARETTES
SMOKED.

ENTER NUMBER OF CIGARETTES: PER DAY 55-56/

(IF NOT EVERY DAY:) # PER MONTH 57-58/

OR

(IF NOT EVERY DAY:) # PER YEAR 59-60/

4. SHOW PARTICIPANT HAND CARD R. For how many years have you been smoking (NUMBER IN Q.3)
cigarettes (per day/per month/per year)?

- Less than 2 years 01 61-62/
- 2-5 years 02
- 6-10 years 03
- 11-15 years 04
- 16-20 years 05
- 21-25 years 06
- 26-30 years 07
- 31-35 years 08
- 36-40 years 09
- More than 40 years 10

5. What brand of cigarettes do you usually smoke? (IF MORE THAN ONE BRAND OR NO REGULAR
BRAND MENTIONED ASK: Which one do you smoke the most?)

ENTER BRAND _____ OFFICE USE 63-65/

NO REGULAR BRAND (SKIP TO Q.8, PAGE H-3) 996

6. For how long now have you been smoking this particular brand?

ENTER DAYS:	<input type="text"/>	<input type="text"/>	66-67/
OR WEEKS:	<input type="text"/>	<input type="text"/>	68-69/
OR MONTHS:	<input type="text"/>	<input type="text"/>	70-71/
OR YEARS:	<input type="text"/>	<input type="text"/>	72-73/

7. What type of cigarettes are they? Are they . . . (READ EACH PAIR TOGETHER)

	CODE ONE NUMBER	
A. Filter tip or	1	74/
Non-filter tip?	2	
	CODE ONE NUMBER	
B. Regular size	1	75/
King size or	2	
100 Millimeter?	3	

8. SHOW PARTICIPANT HAND CARD S. Now I am going to show you a diagram of different size cigarettes. Please look at the picture of the (KIND OF CIGARETTE NAMED IN Q.7A AND Q.7B). Now, considering your style of smoking--for example, how long you usually leave the cigarette in an ashtray or just hold it in your hand--tell me the number which indicates how much of the cigarette you actually smoke.

SECTION 1	1	76/
SECTION 2	2	
SECTION 3	3	
SECTION 4	4	

9. During the period when you were smoking the most heavily on a regular basis, about how many cigarettes did you usually smoke in a day? (CONVERT PACKS TO NUMBER OF CIGARETTES BY MULTIPLYING NUMBER OF PACKS BY 20)

ENTER NUMBER OF CIGARETTES: PER DAY 77-78/

(IF NOT EVERY DAY:) # PER MONTH 79-80/

OR

BEGIN DECK 52

(IF NOT EVERY DAY:) # PER YEAR 10-11/

A. When was that?

FROM

-
MONTH YEAR 12-15/

TO

-
MONTH YEAR 16-19/

10. SHOW PARTICIPANT HAND CARD T. When you smoke cigarettes, how deeply do you usually inhale?
Would you say:

- As deeply into the chest as possible 1 20/
- Only partly into the chest 2
- As far back as the throat 3
- Well back into the mouth, or 4
- Just puff and don't really draw it in at all 5
- DON'T KNOW 8

SKIP TO Q.22, PAGE H-9

FORMER CIGARETTE SMOKER SECTION

11. How long has it been since you smoked cigarettes fairly regularly (RECORD NUMBER)?

ENTER DAYS: 21-22/

OR WEEKS: 23-24/

OR MONTHS: 25-26/

OR YEARS: 27-28/

NEVER SMOKED REGULARLY (SKIP TO Q.22, PAGE H-9) 1 29/

12. On the average, about how many cigarettes a day were you smoking at that time?

IF R ANSWERS BY GIVING NUMBER OF PACKS OF CIGARETTES, RECORD VERBATIM IN MARGIN.
THEN MULTIPLY THE NUMBER OF PACKS BY 20 AND ENTER THE NUMBER OF CIGARETTES
SMOKED.

ENTER NUMBER OF CIGARETTES: PER DAY 30-31/

(IF NOT EVERY DAY:) # PER MONTH 32-33/

OR

(IF NOT EVERY DAY:) # PER YEAR 34-35/

13. SHOW PARTICIPANT HAND CARD R. How long had you been smoking (NUMBER IN Q.12) cigarettes (per day/per month/per year)?

- Less than 2 years 01 36-37/
- 2-5 years 02
- 6-10 years 03
- 11-15 years 04
- 16-20 years 05
- 21-25 years 06
- 26-30 years 07
- 31-35 years 08
- 36-40 years 09
- More than 40 years 10

14. You mentioned that you have not smoked regularly for (TIME IN Q.11). Did you ever stay off cigarettes for a longer period of time?

- YES 1 38/
- NO (SKIP TO Q.16, BELOW) 2

15. How long did you stay off cigarettes at that time? (PROBE: About how long did you stay off?)

- ENTER DAYS: 39-40/
- OR WEEKS: 41-42/
- OR MONTHS: 43-44/
- OR YEARS: 45-46/

16. What brand of cigarettes did you usually smoke? (IF MORE THAN ONE BRAND OR NO REGULAR BRAND MENTIONED ASK: Which one did you smoke the most?)

- ENTER BRAND _____ OFFICE USE 47-49/
- NO REGULAR BRAND. (SKIP TO Q.19, PAGE H-7) 996

17. For how long did you smoke this particular brand?

ENTER DAYS:	<input type="text"/>	<input type="text"/>	50-51/
OR WEEKS:	<input type="text"/>	<input type="text"/>	52-53/
OR MONTHS:	<input type="text"/>	<input type="text"/>	54-55/
OR YEARS:	<input type="text"/>	<input type="text"/>	56-57/

18. What type of cigarettes were they? Were they . . . (READ EACH PAIR TOGETHER)

	CODE ONE NUMBER	
A. Filter tip or	1	58/
Non-filter tip?	2	
	CODE ONE NUMBER	
B. Regular size	1	59/
King size or	2	
100 Millimeter?	3	

19. SHOW PARTICIPANT HAND CARD S. Now I am going to show you a diagram of different size cigarettes. Please look at the picture of the (KIND OF CIGARETTE IN Q.18A AND Q.18B). Now, considering your style of smoking--for example, how long you usually leave the cigarette in an ashtray or just hold it in your hand--tell me the number which indicates how much of the cigarette you actually smoked.

Section 1	1	60/
Section 2	2	
Section 3	3	
Section 4	4	

20. During the period when you were smoking the most heavily on a regular basis, about how many cigarettes did you usually smoke in a day?

ENTER NUMBER OF CIGARETTES: PER DAY 61-62/

(IF NOT EVERY DAY:) # PER MONTH 63-64/

OR

(IF NOT EVERY DAY:) # PER YEAR 65-66/

A. When was that?

FROM

-
MONTH YEAR 67-70/

TO

-
MONTH YEAR 71-74/

21. SHOW PARTICIPANT HAND CARD T. When you smoked cigarettes, how deeply did you usually inhale? Would you say:

- As deeply into the chest as possible 1 75/
- Only partly into the chest 2
- As far back as the throat 3
- Well back into the mouth, or 4
- Just puff and don't really draw it in at all 5
- DON'T KNOW 8

CURRENT PIPE SMOKER SECTION

22. During your entire life, have you smoked at least as many as 50 pipefuls of tobacco?

- YES 1 76/
- NO (SKIP TO Q.35, PAGE H-14) 2

23. Do you now smoke a pipe?

- YES 1 77/
- NO (SKIP TO Q.28, PAGE H-11) 2

24. About how many average sized pipefuls of tobacco do you usually smoke in a day?

ENTER NUMBER OF PIPEFULS OF TOBACCO: PER DAY 78-79/

BEGIN DECK 53

(IF NOT EVERY DAY:) # PER MONTH 10-11/

OR

(IF NOT EVERY DAY:) # PER YEAR 12-13/

25. SHOW PARTICIPANT HAND CARD R. For how many years have you been smoking (NUMBER IN Q.24) pipefuls (per day/per month/per year)?

- Less than 2 years 01 14-15/
- 2-5 years 02
- 6-10 years 03
- 11-15 years 04
- 16-20 years 05
- 21-25 years 06
- 26-30 years 07
- 31-35 years 08
- 36-40 years 09
- More than 40 years 10

26. During the period when you were smoking the most heavily, about how many pipefuls of tobacco did you usually smoke in a day?

ENTER NUMBER PER DAY 16-17/

(IF NOT EVERY DAY:) # PER MONTH 18-19/

OR

(IF NOT EVERY DAY:) # PER YEAR 20-21/

A. When was that?

FROM

--
MONTH YEAR 22-25/

TO

--
MONTH YEAR 26-29/

27. SHOW PARTICIPANT HAND CARD T. When you smoke a pipe, how deeply do you usually inhale? Would you say:

- As deeply into the chest as possible 1 30/
- Only partly into the chest 2
- As far back as the throat 3
- Well back into the mouth, or 4
- Just puff and don't really draw it in at all 5
- DON'T KNOW 8

SKIP TO Q.35, PAGE H-14

FORMER PIPE SMOKER SECTION

28. How long has it been since you smoked a pipe fairly regularly? (RECORD NUMBER)

ENTER DAYS: 31-32/

OR WEEKS: 33-34/

OR MONTHS: 35-36/

OR YEARS: 37-38/

NEVER SMOKED REGULARLY (SKIP TO Q.35, PAGE H-14) 1 39/

29. On the average, about how many pipefuls of tobacco a day were you smoking at that time?

ENTER NUMBER OF PIPEFULS OF TOBACCO: PER DAY 40-41/

(IF NOT EVERY DAY:) # PER MONTH 42-43/

OR

(IF NOT EVERY DAY:) # PER YEAR 44-45/

30. SHOW PARTICIPANT HAND CARD R. For how long did you smoke (NUMBER IN Q.29) pipefuls of tobacco (per day/per week/per month)?

- Less than 2 years 01 46-47/
- 2-5 years 02
- 6-10 years 03
- 11-15 years 04
- 16-20 years 05
- 21-25 years 06
- 26-30 years 07
- 31-35 years 08
- 36-40 years 09
- More than 40 years 10

31. You mentioned that you have not smoked regularly for (TIME RECORDED IN Q.28). Did you ever not smoke a pipe for a longer period of time?

- YES 1 48/
NO (SKIP TO Q.33, BELOW) 2

32. How long did you not smoke a pipe at that time?

- ENTER DAYS: 49-50/
OR WEEKS: 51-52/
OR MONTHS: 53-54/
OR YEARS: 55-56/

33. During the period when you were smoking the most heavily on a regular basis, about how many pipefuls of tobacco did you usually smoke in a day?

- ENTER NUMBER PER DAY 57-58/
(IF NOT EVERY DAY:) # PER MONTH 59-60/
OR
(IF NOT EVERY DAY:) # PER YEAR 61-62/

A. When was that?

FROM

--
MONTH YEAR 63-66/

TO

--
MONTH YEAR 67-70/

34. SHOW PARTICIPANT HAND CARD T. When you smoked a pipe, how deeply did you usually inhale?
Would you say:

- As deeply into the chest as possible 1 71/
- Only partly into the chest 2
- As far back as the throat 3
- Well back into the mouth, or 4
- Just puff and don't really draw it in at all 5
- DON'T KNOW 8

CURRENT CIGAR SMOKER SECTION

35. During your entire life have you smoked at least as many as 50 cigars?

- YES 1 72/
- NO (SKIP TO Q.51, PAGE H-19) 2

36. Do you now smoke cigars?

- YES 1 73/
- NO (SKIP TO Q.42, PAGE H-17) 2

37. On average, about how many cigars a day do you now smoke?

- ENTER NUMBER OF CIGARS: PER DAY 74-75/
- (IF NOT EVERY DAY:) # PER MONTH 76-77/
- OR
- (IF NOT EVERY DAY:) # PER YEAR 78-79/

38. SHOW PARTICIPANT HAND CARD R. For how many years have you been smoking (NUMBER RECORDED IN Q.37) cigars (per day/per month/per year)?

- Less than 2 years 01 BEGIN DECK 54
10-11/
- 2-5 years 02
- 6-10 years 03
- 11-15 years 04
- 16-20 years 05
- 21-25 years 06
- 26-30 years 07
- 31-35 years 08
- 36-40 years 09
- More than 40 years 10

39. During the period when you were smoking the most heavily on a regular basis, about how many cigars did you usually smoke in a day.

ENTER NUMBER PER DAY 12-13/

(IF NOT EVERY DAY:) # PER MONTH 14-15/

OR

(IF NOT EVERY DAY:) # PER YEAR 16-17/

A. When was that?

FROM

-
MONTH YEAR 18-21/

TO

-
MONTH YEAR 22-25/

40. SHOW PARTICIPANT HAND CARD T. When you smoke cigars, how deeply do you usually inhale? Would you say:

- As deeply into the chest as possible 1 26/
- Only partly into the chest 2
- As far back as the throat 3
- Well back into the mouth, or 4
- Just puff and don't really draw it in at all 5
- DON'T KNOW 8

41. What type of cigars do you usually smoke?

ONLY CODE ONE TYPE

- Filter tip or 1 27/
- Non-filter tip? 2

A. SHOW PARTICIPANT HAND CARD U. Now I am going to show you a diagram of different size cigars. Please look at the picture of the (KIND OF CIGAR IN Q.41). Now considering your style of smoking--for example, how long you usually leave the cigar in an ashtray or just hold it in your hand--tell me the number which indicates how much of the cigar you actually smoke.

- SECTION 1 1 28/
- SECTION 2 2
- SECTION 3 3
- SECTION 4 4

SKIP TO Q.51, PAGE H-19

FORMER CIGAR SMOKER SECTION

42. How long has it been since you smoked cigars fairly regularly?

ENTER DAYS: 29-30/

OR WEEKS: 31-32/

OR MONTHS: 33-34/

OR YEARS: 35-36/

NEVER SMOKED REGULARLY (SKIP TO Q.51, PAGE H-19) 1 37/

43. On the average, about how many cigars a day were you smoking at that time?

ENTER NUMBER OF CIGARS: PER DAY 38-39/

(IF NOT EVERY DAY:) # PER MONTH 40-41/

OR

(IF NOT EVERY DAY:) # PER YEAR 42-43/

44. SHOW PARTICIPANT HAND CARD R. For how long did you smoke (NUMBER PER DAY IN Q.43) cigars per day?

Less than 2 years 01 44-45/

2-5 years 02

6-10 years 03

11-15 years 04

16-20 years 05

21-25 years 06

26-30 years 07

31-35 years 08

36-40 years 09

More than 40 years 10

45. You mentioned that you have not smoked regularly for (TIME RECORDED IN Q.42). Did you ever stay off cigars for a longer period of time?

- YES 1 46/
- NO (SKIP TO Q.47, BELOW) 2

46. How long did you stay off cigars at that time?

- ENTER DAYS: 47-48/
- OR WEEKS: 49-50/
- OR MONTHS: 51-52/
- OR YEARS: 53-54/

47. What type of cigars did you usually smoke just before you stopped smoking cigars regularly?

ONLY CODE ONE TYPE

- Filter tip or 1 55/
- Non-filter tip? 2

48. SHOW PARTICIPANT HAND CARD U. Now I am going to show you a diagram of different size cigars. Please look at the picture of the (KIND OF CIGAR IN Q.47). Now, considering your style of smoking--for example, how long you usually leave the cigar in an ashtray or just hold it in your hand--tell me the number which indicates how much of the cigar you actually smoke.

- SECTION 1 1 56/
- SECTION 2 2
- SECTION 3 3
- SECTION 4 4

49. During the period when you were smoking the most on a regular basis, about how many cigars did you usually smoke in a day?

ENTER NUMBER PER DAY 57-58/

(IF NOT EVERY DAY:) # PER MONTH 59-60/

OR

(IF NOT EVERY DAY:) # PER YEAR 61-62/

A. When was that?

FROM

--
MONTH YEAR 63-66/

TO

--
MONTH YEAR 67-70/

50. SHOW PARTICIPANT HAND CARD T. When you smoked a cigar, how deeply did you usually inhale? Would you say:

- As deeply into the chest as possible 1 71/
- Only partly into the chest 2
- As far back as the throat 3
- Well back into the mouth, or 4
- Just puff and don't really draw it in at all 5
- DON'T KNOW 8

51. IS PARTICIPANT CURRENTLY LIVING WITH A SPOUSE OR PARTNER? CHECK INFORMATION SHEET.

IS ANY "NO" CODED IN SECTION E: Q.2, PAGE E-3 , Q.6C, PAGE E-10, OR Q.8C, PAGE E-14?

- YES 1 72/
- NO (SKIP TO Q.53, PAGE H-20) 2

52. Does your (spouse/partner) smoke regularly any of the following?

	YES	NO	DON'T KNOW	
Cigarettes	1	2	8	73/
Cigars	1	2	8	74/
Pipe	1	2	8	75/

53. Approximately how much smoke is there in the air in your home?

A lot	1	76/
A little	2	
NONE	3	(SKIP TO Q.56, PAGE H-21)

54. SHOW PARTICIPANT HAND CARD V. Approximately how many hours a week are you exposed to this smoke in your home?

10 hours or less	1	77/
11 to 15 hours	2	
16 to 20 hours	3	
21 to 25 hours	4	
26 or more hours	5	

55. SHOW PARTICIPANT HAND CARD W. For how many years have you been exposed to smoke in this way? (CHECK ONLY ONE)

Less than 1 year	01	78-79/
1 to 4 years	02	
5 to 10 years	03	
11 to 15 years	04	
16 to 20 years	05	
21 to 30 years	06	
More than 30 years	07	
DON'T KNOW	98	

56. DOES R WORK? (IS "YES" CODED AT SECTION B, Q.4, PAGE B-5 OR "CURRENT JOB" CODED AT SECTION C, Q.1F PAGE C-2)?

- | | | |
|-----|---------------------------------------|---------------|
| | | BEGIN DECK 55 |
| YES | 1 | 10/ |
| NO | (SKIP TO Q.62, PAGE H-23) | 2 |

A. Approximately how much smoke is there in the air in the transportation you take to and from work (For example, your car, the train, the bus, etc.)?

- | | | |
|----------|---------------------------------------|-----|
| A lot | 1 | 11/ |
| A little | 2 | |
| NONE | (SKIP TO Q.59, PAGE H-22) | 3 |

57. SHOW PARTICIPANT HAND CARD V. Approximately how many hours a week are you exposed to this smoke?

- | | | |
|------------------|---------|-----|
| 10 hours or less | 1 | 12/ |
| 11 to 15 hours | 2 | |
| 16 to 20 hours | 3 | |
| 21 to 25 hours | 4 | |
| 26 or more hours | 5 | |

58. SHOW PARTICIPANT HAND CARD W. For how many years have you been exposed to this smoke?

- | | | |
|--------------------|----------|--------|
| Less than 1 year | 01 | 13-14/ |
| 1 to 4 years | 02 | |
| 5 to 10 years | 03 | |
| 11 to 15 years | 04 | |
| 16 to 20 years | 05 | |
| 21 to 30 years | 06 | |
| More than 30 years | 07 | |
| DON'T KNOW | 98 | |

59. Approximately how much smoke is there in the air where you work?

- | | | |
|--|---|-----|
| A lot | 1 | 15/ |
| A little | 2 | |
| NONE (SKIP TO Q.62, PAGE H-23) | 3 | |

60. SHOW PARTICIPANT HAND CARD V. Approximately how many hours a week are you exposed to this smoke?

- | | | |
|------------------------|---|-----|
| 10 hours or less | 1 | 16/ |
| 11 to 15 hours | 2 | |
| 16 to 20 hours | 3 | |
| 21 to 25 hours | 4 | |
| 26 or more hours | 5 | |

61. For how many years have you been exposed to this smoke at work?

- | | | |
|--------------------------|----|--------|
| Less than 1 year | 01 | 17-18/ |
| 1 to 4 years | 02 | |
| 5 to 10 years | 03 | |
| 11 to 15 years | 04 | |
| 16 to 20 years | 05 | |
| 21 to 30 years | 06 | |
| More than 30 years | 07 | |

62. SHOW PARTICIPANT HAND CARD X. There are some questions that are asked in survey research that are difficult to ask directly because many people think they are too personal. While it is understandable that people feel this way, there is a real need for the information for the population as a whole. We now have a way that makes it possible for people to give information, without telling anyone about their own situation. Let me show you how this works; we will use the next question I have here as an example.

CONTINUE WITH CARD X. As you see, there are two questions on the card. One deals with the "real" question that the research is concerned with, the other is completely unrelated. Both questions can be answered "yes" or "no." One of the two questions is selected by chance and you answer it. (I'll show you how that works in a minute). I do not know which question you are answering. When all the questionnaires have been tallied, the researchers can tell how many people have smoked marijuana, but they have no way of knowing whether it was you or any other person in particular who has smoked marijuana.

HAND R COIN

It is very simple, as you will see. You will flip the coin. The question you will answer is selected by chance. In no way can a truthful answer prove harmful to you. There is no identifying information that can link you to your answers.

Please take the coin that you have been handed and flip it now. Don't tell me which side came up. If the coin shows heads, please answer only question 1. If the coin shows tails, please answer only question 2. I won't look to see if the coin comes up heads or tails; and you don't tell me which question you are answering. Just tell me if your answer is "yes" or "no."

YES	1	19/
NO	2	
DON'T KNOW	8	

A. SHOW PARTICIPANT HAND CARD Y. Now let's do that again, using the next question. CONTINUE WITH CARD Y. Flip the coin again. If the coin turns up heads, please answer only question number 1. If the coin comes up tails, please answer only question number 2. Don't tell me the question. Is your answer "yes" or "no"?

YES	1	20/
NO	2	
DON'T KNOW	8	

IF PARTICIPANT INTERVIEWED IN CYCLES '85-'86 AND/OR '87-'88, GO TO Q.63, PAGE H-24. OTHERWISE, SKIP TO Q.64, PAGE H-43.

SMOKING INTERVAL QUESTIONS

63. THIS SECTION FOR PARTICIPANTS INTERVIEWED IN CYCLES '85,-'86 AND/OR CYCLE '87-'88.

IF PARTICIPANT NEW TO STUDY OR ONLY COMPLAINT AT BASELINE, DO NOT ASK THIS SECTION.

63a. The next set of questions refers to smoking habits.

63-1. Have you ever smoked at least as many as 5 packs of cigarettes, that is, 100 cigarettes, during your entire life?

- YES 1 53/
- NO (SKIP TO Q.63-14, PAGE H-30) 2

63-2. Do you now smoke cigarettes?

- YES 1 54/
- NO (SKIP TO Q.63-8, PAGE H-27) 2

CURRENT CIGARETTE SMOKER SECTION

63-3. On average, how many cigarettes do you smoke a day?

IF R ANSWERS BY GIVING NUMBER OF PACKS OF CIGARETTES, RECORD VERBATIM IN MARGIN. THEN MULTIPLY THE NUMBER OF PACKS BY 20 AND ENTER THE NUMBER OF CIGARETTES SMOKED.

ENTER NUMBER OF CIGARETTES: PER DAY 55-56/

(IF NOT EVERY DAY:) # PER MONTH 57-58/

OR

(IF NOT EVERY DAY:) # PER YEAR 59-60/

63-4. SHOW PARTICIPANT HAND CARD R. For how many years have you been smoking (NUMBER IN Q.63-3) cigarettes (per day/per month/per year)?

Less than 2 years	01	61-62/
2-5 years	02	
6-10 years	03	
11-15 years	04	
16-20 years	05	
21-25 years	06	
26-30 years	07	
31-35 years	08	
36-40 years	09	
More than 40 years	10	63-73/R

63-5. What type of cigarettes are they? Are they ... (READ EACH PAIR TOGETHER)

	CODE ONE NUMBER	
A. Filter tip or	1	74/
Non-filter tip?	2	
	CODE ONE NUMBER	
B. Regular size	1	75/
King size or	2	
100 Millimeter?	3	76/R

63-6. During the period when you were smoking the most heavily on a regular basis, about how many cigarettes did you usually smoke in a day?

ENTER NUMBER PER DAY 77-78/

(IF NOT EVERY DAY:) # PER MONTH 79-80/

OR

BEGIN DECK 52

(IF NOT EVERY DAY:) # PER YEAR 10-11/

A. When was that?

FROM

-
MONTH YEAR

12-15/

TO

-
MONTH YEAR

16-19/

63-7. SHOW PARTICIPANT HAND CARD T. When you smoke cigarettes, how deeply do you usually inhale? Would you say:

- As deeply into the chest as possible 1 20/
- Only partly into the chest 2
- As far back as the throat 3
- Well back into the mouth, or 4
- Just puff and don't really draw it in at all 5
- DON'T KNOW 8

(SKIP TO Q.63-14, PAGE H-30)

FORMER CIGARETTE SMOKER SECTION

63-8. How long has it been since you smoked cigarettes fairly regularly? (RECORD NUMBER)

ENTER DAYS: 21-22/OR WEEKS: 23-24/OR MONTHS: 25-26/OR YEARS: 27-28/

NEVER SMOKED REGULARLY (SKIP TO Q.63-14, PAGE H-30) 1 29/

63-9. On the average, about how many cigarettes a day were you smoking at that time?

IF R ANSWERS BY GIVING NUMBER OF PACKS OF CIGARETTES, RECORD VERBATIM IN MARGIN. THEN MULTIPLY THE NUMBER OF PACKS BY 20 AND ENTER THE NUMBER OF CIGARETTES SMOKED.

ENTER NUMBER OF CIGARETTES: PER DAY 30-31/(IF NOT EVERY DAY:) # PER MONTH 32-33/

OR

(IF NOT EVERY DAY:) # PER YEAR 34-35/

63-10. SHOW PARTICIPANT HAND CARD R. How long had you been smoking (NUMBER IN Q.63-9) cigarettes (per day/per week/per month)?

Less than 2 years	01	36-37/
2-5 years	02	
6-10 years	03	
11-15 years	04	
16-20 years	05	
21-25 years	06	
26-30 years	07	
31-35 years	08	
36-40 years	09	
More than 40 years	10	38-57/R

63-11. What type of cigarettes were they? Were they ... (READ EACH PAIR TOGETHER)

	CODE ONE NUMBER	
A. Filter tip or	1	58/
Non-filter tip?	2	
	CODE ONE NUMBER	
B. Regular size	1	59/
King size or	2	
100 Millimeter?	3	60/R

63-12. During the period when you were smoking the most heavily on a regular basis, about how many cigarettes did you usually smoke in a day?

ENTER NUMBER PER DAY 61-62/

(IF NOT EVERY DAY:) # PER MONTH 63-64/

OR

(IF NOT EVERY DAY:) # PER YEAR 65-66/

A. When was that?

FROM

-
MONTH YEAR 67-70/

TO

-
MONTH YEAR 71-74/

63-13. SHOW PARTICIPANT HAND CARD T. When you smoked cigarettes, how deeply did you usually inhale? Would you say:

- As deeply into the chest as possible 1 75/
- Only partly into the chest 2
- As far back as the throat 3
- Well back into the mouth, or 4
- Just puff and don't really draw it in at all 5
- DON'T KNOW 8

CURRENT PIPE SMOKER SECTION

63-14. During your entire life, have you smoked at least as many as 50 pipefuls of tobacco?

- YES 1 76/
- NO (SKIP TO Q.63-25, PAGE H-35) 2

63-15. Do you now smoke a pipe?

- YES 1 77/
- NO (SKIP TO Q.63-20, PAGE H-32) 2

63-16. About how many average sized pipefuls of tobacco do you usually smoke in a day?

ENTER NUMBER OF PIPEFULS OF TOBACCO: PER DAY 78-79/

BEGIN DECK 53

(IF NOT EVERY DAY:) # PER MONTH 10-11/

OR

(IF NOT EVERY DAY:) # PER YEAR 12-13/

63-17. SHOW PARTICIPANT HAND CARD R. For how many years have you been smoking (NUMBER IN Q.63-16) pipefuls (per day/per month/per year)?

- Less than 2 years 01 14-15/
- 2-5 years 02
- 6-10 years 03
- 11-15 years 04
- 16-20 years 05
- 21-25 years 06
- 26-30 years 07
- 31-35 years 08
- 36-40 years 09
- More than 40 years 10

63-18. During the period when you were smoking the most heavily, about how many pipefuls of tobacco did you usually smoke in a day?

ENTER NUMBER PER DAY 16-17/

(IF NOT EVERY DAY:) # PER MONTH 18-19/

OR

(IF NOT EVERY DAY:) # PER YEAR 20-21/

A. When was that?

FROM

--
MONTH YEAR 22-25/

TO

--
MONTH YEAR 26-29/

63-19. SHOW PARTICIPANT HAND CARD T. When you smoke a pipe, how deeply do you usually inhale?
Would you say:

- As deeply into the chest as possible 1 30/
- Only partly into the chest 2
- As far back as the throat 3
- Well back into the mouth, or 4
- Just puff and don't really draw it in at all 5
- DON'T KNOW 8

SKIP TO Q.63-25, PAGE H-35

FORMER PIPE SMOKER SECTION

63-20. How long has it been since you smoked a pipe fairly regularly? (RECORD NUMBER)

ENTER DAYS: 31-32/

OR WEEKS: 33-34/

OR MONTHS: 35-36/

OR YEARS: 37-38/

NEVER SMOKED REGULARLY (SKIP TO Q.63-25, PAGE H-35) 1 39/

63-21. On the average, about how many pipefuls of tobacco a day were you smoking at that time?

ENTER NUMBER OF PIPEFULS OF TOBACCO: PER DAY 40-41/

(IF NOT EVERY DAY:) # PER MONTH 42-43/

OR

(IF NOT EVERY DAY:) # PER YEAR 44-45/

63-22. SHOW PARTICIPANT HAND CARD R. For how long did you smoke (NUMBER IN Q.63-21) pipefuls of tobacco (per day/per week/per month)?

- Less than 2 years 01 46-47/
- 2-5 years 02
- 6-10 years 03
- 11-15 years 04
- 16-20 years 05
- 21-25 years 06
- 26-30 years 07
- 31-35 years 08
- 36-40 years 09
- More than 40 years 10 48-56/R

63-23. During the period when you were smoking the most heavily on a regular basis, about how many pipefuls of tobacco did you usually smoke in a day?

ENTER NUMBER PER DAY 57-58/

(IF NOT EVERY DAY:) # PER MONTH 59-60/

OR

(IF NOT EVERY DAY:) # PER YEAR 61-62/

A. When was that?

FROM

-
MONTH YEAR 63-66/

TO

-
MONTH YEAR 67-70/

63-24. SHOW PARTICIPANT HAND CARD T. When you smoked a pipe, how deeply did you usually inhale?
Would you say:

- As deeply into the chest as possible 1 71/
- Only partly into the chest 2
- As far back as the throat 3
- Well back into the mouth, or 4
- Just puff and don't really draw it in at all 5
- DON'T KNOW 8

CURRENT CIGAR SMOKER SECTION

63-25. During your entire life have you smoked at least as many as 50 cigars?

- Yes 1 72/
- No (SKIP TO Q.63-38, PAGE H-40) 2

63-26. Do you now smoke cigars?

- Yes 1 73/
- No (SKIP TO Q.63-32, PAGE H-38) 2

63-27. On average, about how many cigars a day do you now smoke?

ENTER NUMBER OF CIGARS: PER DAY 74-75/

(IF NOT EVERY DAY:) # PER MONTH 76-77/

OR

(IF NOT EVERY DAY:) # PER YEAR 78-79/

63-28. SHOW PARTICIPANT HAND CARD R. For how many years have you been smoking (# in Q.63-27) cigars (per day/per month/per year)?

- Less than 2 years 01 10-11/
- 2-5 years 02
- 6-10 years 03
- 11-15 years 04
- 16-20 years 05
- 21-25 years 06
- 26-30 years 07
- 31-35 years 08
- 36-40 years 09
- More than 40 years 10

63-29. During the period when you were smoking the most heavily on a regular basis, about how many cigars did you usually smoke in a day?

- ENTER NUMBER PER DAY 12-13/
- (IF NOT EVERY DAY:) # PER MONTH 14-15/
- OR
- (IF NOT EVERY DAY:) # PER YEAR 16-17/

A. When was that?

- FROM
-
- MONTH YEAR 18-21/
- TO
-
- MONTH YEAR 22-25/

63-30. SHOW PARTICIPANT HAND CARD T. When you smoke cigars, how deeply do you usually inhale?
Would you say:

- As deeply into the chest as possible 1 26/
- Only partly into the chest 2
- As far back as the throat 3
- Well back into the mouth, or 4
- Just puff and don't really draw it in at all 5
- DON'T KNOW 8

63-31. What type of cigars do you usually smoke?

- Filter tip or 1 27/
- Non-filter tip? 2

SKIP TO Q. 63-38, PAGE H-40

FORMER CIGAR SMOKER SECTION

63-32. How long has it been since you smoked cigars fairly regularly? 28/R

ENTER DAYS: 29-30/

OR WEEKS: 31-32/

OR MONTHS: 33-34/

OR YEARS: 35-36/

NEVER SMOKED REGULARLY (SKIP TO Q.63-38, PAGE H-40) 1 37/

63-33. On the average, about how many cigars a day were you smoking at that time?

ENTER NUMBER OF CIGARS: PER DAY 38-39/

(IF NOT EVERY DAY:) # PER MONTH 40-41/

OR

(IF NOT EVERY DAY:) # PER YEAR 42-43/

63-34. SHOW PARTICIPANT HAND CARD R. For how long did you smoke (NUMBER PER DAY IN Q.63-33) cigars per day?

Less than 2 years	01	44-45/
2-5 years	02	
6-10 years	03	
11-15 years	04	
16-20 years	05	
21-25 years	06	
26-30 years	07	
31-35 years	08	
36-40 years	09	
More than 40 years	10	46-54/R

63-35. What type of cigars did you usually smoke just before you stopped smoking cigars regularly?

	CODE ONE NUMBER	
Filter tip or	1	55/
Non-filter tip?	2	56/R

63-36. During the period when you were smoking the most on a regular basis, about how many cigars did you usually smoke in a day?

ENTER NUMBER PER DAY 57-58/

(IF NOT EVERY DAY:) # PER MONTH 59-60/

OR

(IF NOT EVERY DAY:) # PER YEAR 61-62/

A. When was that?

FROM

-
 MONTH YEAR 63-66/

TO

-
 MONTH YEAR 67-70/

63-37. SHOW PARTICIPANT HAND CARD T. When you smoked a cigar, how deeply did you usually inhale?
Would you say:

- As deeply into the chest as possible 1 71/
- Only partly into the chest 2
- As far back as the throat 3
- Well back into the mouth, or 4
- Just puff and don't really draw it in at all 5
- DON'T KNOW 8

63-38. DOES R CURRENTLY HAVE A SPOUSE OR PARTNER? IS ANY "NO" CODED IN SECTION E: Q.2, PAGE E-3; Q.6C, PAGE E-10; OR Q.8C, PAGE E-14.

- YES 1 72/
- NO (SKIP TO Q.63-40, BELOW) 2

63-39. Does your (spouse/partner) smoke regularly any of the following? Does she smoke ... ?

	YES	NO	DON'T KNOW	
Cigarettes	1	2	8	73/
Cigars	1	2	8	74/
Pipe	1	2	8	75/

63-40. Approximately how much smoke is there in the air in your home?

- A lot 1 76/
- A little 2
- NONE (SKIP TO Q.63-42, PAGE H-41) 3

63-41. SHOW PARTICIPANT HAND CARD V. Approximately how many hours a week are you exposed to this smoke in your home?

- 10 hours or less 1 77/
- 11 to 15 hours 2
- 16 to 20 hours 3
- 21 to 25 hours 4
- 26 or more hours 5

63-42. DOES R WORK? IS "YES" CODED AT SECTION B, Q.4, PAGE B-5 OR "CURRENT JOB" CODED AT SECTION C. Q.1F, PAGE C-2?

- YES 1 BEGIN DECK 55 10/
- NO (SKIP TO Q.64, PAGE H-43) 2

A. Approximately how much smoke is there in the air in the transportation you take to and from work for example, your car, the train, the bus, etc.?

- A lot 1 11/
- A little 2
- NONE (SKIP TO Q.63-44, BELOW) 3

63-43. SHOW PARTICIPANT HAND CARD V. Approximately how many hours a week are you exposed to this smoke?

- 10 hours or less 1 12/
- 11 to 15 hours 2
- 16 to 20 hours 3
- 21 to 25 hours 4
- 26 or more hours 5 13-14/R

63-44. Approximately how much smoke is there in the air where you work?

- A lot 1 15/
- A little 2
- NONE (SKIP TO Q.64, PAGE H-43) 3

63-45. SHOW PARTICIPANT HAND CARD V. Approximately how many hours a week are you exposed to this smoke?

- 10 hours or less 1 16/
- 11 to 15 hours 2
- 16 to 20 hours 3
- 21 to 25 hours 4
- 26 or more hours 5

64. ASK ALL RESPONDENTS. Have you been arrested for a felony since (DATE OF LAST INTERVIEW)?

- YES 1 21/
- NO (SKIP TO Q.65, PAGE H-44) 2

64A. Have you ever been convicted of a felony since (DATE OF LAST INTERVIEW)?

- YES 1 22/
- NO (SKIP TO Q.65, PAGE H-44) 2

64B. How many felonies have you been convicted of?

ENTER NUMBER: 23-24/

64C. What month and year were you convicted of (this/your first) felony?

-
MONTH YEAR 25-28/

64D. On what charge wre you convicted?

_____ 29-30/

64E. HAS R EVER BEEN CONVICTED OF A SECOND FELONY? IS # IN Q.64B EQUAL TO 2 OR MORE?

- YES 1 31/
- NO (SKIP TO Q.65, PAGE H-44) 2

64F. What month and year were you convicted of this second felony?

MONTH YEAR 32-35/

64G. On what charge were you convicted?

_____ 36-37/

64H. HAS R EVER BEEN CONVICTED OF A THIRD FELONY? IS # IN Q.64B EQUAL TO 3 OR MORE?

- YES (GO TO NEW QUEX) 1 38/
- NO 2

65. Next, I'd like some information about drinking alcoholic beverages. Have you had any alcoholic beverages, including beer, wine, or liquor, since (DATE OF LAST INTERVIEW)?

- YES 1 39/
- NO (SKIP TO LIFETIME DRINKING HISTORY SECTION, PAGE H-52) ... 2

66. Since (DATE OF LAST INTERVIEW) have you had a drink of beer?

- YES 1 40/
- NO (SKIP TO Q.72, PAGE H-46) 2

67. SHOW PARTICIPANT HAND CARD Z. How long has it been since your last drink of beer?

- Today 01 41-42/
- 1-7 days ago 02
- 8-14 days ago 03
- 15-30 days ago 04
- 1 month ago 05
- 2-3 months ago 06
- 4-6 months ago 07
- 7-12 months ago 08
- More than 1 year ago 09

68. As you think back over the period of time between (DATE OF LAST INTERVIEW) and now, about how many cans or bottles of beer would you drink on a typical day when you drank beer?

ENTER NUMBER OF CANS OR BOTTLES: 43-44/

69. SHOW PARTICIPANT HAND CARD AA. Again, thinking back over the period of time between (DATE OF LAST INTERVIEW) and now, about how regularly did you drink beer? PROBE IF NECESSARY: It's sometimes hard to remember. Just give me your best guess.

- Most often than once a day 01 45-46/
- Every day 02
- 5 or 6 days a week 03
- 3 or 4 days a week 04
- 1 or 2 days a week 05
- Less often than once a week 06
- DON'T KNOW 98

70. SHOW PARTICIPANT HAND CARD BB. How large were the cans or bottles that you usually drank?

- Standard 12 oz. cans or bottles 1 47/
- 16 oz. (half quart) cans or bottles 2
- 32 oz. (full quart) cans or bottles 3
- Less than 12 oz. cans or bottles 4
- More than 32 oz. cans or bottles 5
- Don't drink cans or bottles of beer 6

71. SHOW PARTICIPANT HAND CARD CC. During the last 12 months that you drank since (DATE OF LAST INTERVIEW), how often did you have 8 or more cans of beer in a single day, that means 3 quarts or more?

- Every day or nearly every day 01 48-49/
- 3-4 times a week 02
- Once or twice a week 03
- 1-3 times a month 04
- 7-11 times a year 05
- 3-6 times a year 06
- Once or twice a year 07
- Never 08

72. Since (DATE OF LAST INTERVIEW) have you had a drink of wine?

- Yes 1 50/
- No (SKIP TO Q.77, PAGE H-47) 2

73. SHOW PARTICIPANT HAND CARD Z. How long has it been since your last drink of wine?

- Today 01 51-52/
- 1-7 days ago 02
- 8-14 days ago 03
- 15-30 days ago 04
- 1 month ago 05
- 2-3 months ago 06
- 4-6 months ago 07
- 7-12 months ago 08
- More than 1 year ago 09

74. As you think back over the period of time between (DATE OF LAST INTERVIEW) and now, about how many glasses/bottles of wine would you drink on a typical day when you drank wine?

- 3 or more bottles 1 53/
- 2 bottles 2
- About 1 bottle (7 - 8 wine glasses) 3
- 5 - 6 wine glasses (3 water glasses) 4
- 3 - 4 wine glasses (2 water glasses) 5
- 1 - 2 wine glasses (1 water glass) 6 54/R

75. SHOW PARTICIPANT HAND CARD AA. Again, thinking back over the period of time between (DATE OF LAST INTERVIEW) and now, about how regularly did you drink wine? PROBE IF NECESSARY: It's sometimes hard to remember. Just give me your best guess.

- More often than once a day 1 55/
- Every day 2
- 5 or 6 days a week 3
- 3 or 4 days a week 4
- 1 or 2 days a week 5
- Less often than once a week 6
- IF CANNOT DECIDE: DON'T KNOW 8

76. SHOW PARTICIPANT HAND CARD CC. During the last 12 months that you drank since (DATE OF LAST INTERVIEW), how often did you have 8 or more glasses of wine in a single day (more than a fifth)?

- Every day or nearly every day 01 56-57/
- 3-4 times a week 02
- Once or twice a week 03
- 1-3 times a month 04
- 7-11 times a year 05
- 3-6 times a year 06
- Once or twice a year 07
- Never 08

77. Since (DATE OF LAST INTERVIEW) have you had a drink containing liquor, such as whiskey, vodka, gin, brandy, etc.?

- YES 1 58/
- NO (SKIP TO Q.83, PAGE H-49) 2

78. SHOW PARTICIPANT HAND CARD Z. How long has it been since your last drink of hard liquor?

- Today 01 59-60/
- 1-7 days ago 02
- 8-14 days ago 03
- 15-30 days ago 04
- 1 month ago 05
- 2-3 months ago 06
- 4-6 months ago 07
- 7-12 months ago 08
- More than 1 year ago 09

79. As you think back over the period of time between (DATE OF LAST INTERVIEW) and now, about how many drinks of hard liquor would you drink on a typical day in which you drank hard liquor? 1 BOTTLE = 17 DRINKS

ENTER NUMBER OF DRINKS: 61-62/

80. SHOW PARTICIPANT HAND CARD AA. Again, thinking back over the period of time between (DATE OF LAST INTERVIEW) and now, about how regularly did you drink hard liquor? PROBE IF NECESSARY: It's sometimes hard to remember. Just give me your best guess.

- More often than once a day 1 63/
- Every day 2
- 5 or 6 days a week 3
- 3 or 4 days a week 4
- 1 or 2 days a week 5
- Less often than once a week 6
- DON'T KNOW 8

81. SHOW PARTICIPANT HAND CARD DD. About how many ounces of hard liquor are there in the drinks that you usually drink?

- One ounce (one shot) 1 64/
- 1.5 ounces (one jigger) 2
- 2 ounces (2 shots) 3
- 3 ounces (2 jiggers or 3 shots) 4
- 4 ounces (4 shots) 5
- 5 or more ounces (3 or more jiggers) 6
- Don't know 8

82. SHOW PARTICIPANT HAND CARD CC. During the last 12 months that you drank since (DATE OF LAST INTERVIEW), how often did you have 8 or more drinks of hard liquor in a single day, that is a half pint or more?

- Every day or nearly every day 01 65-66/
- 3-4 times a week 02
- Once or twice a week 03
- 1-3 times a month 04
- 7-11 times a year 05
- 3-6 times a year 06
- Once or twice a year 07
- Never 08

83. Have you had a drink of beer, wine or hard liquor in the last 12 months?

- Yes 1 67/
- NO (SKIP TO LIFETIME DRINKING HISTORY SECTION, PAGE H-52) ... 2

84. SHOW PARTICIPANT HAND CARD EE. About how often during the past 12 months did you drink enough to feel high -- (that is, happier or more carefree than usual, maybe a little flushed or dizzy,) but not drunk, for more than 24 hours in a row, that is, for more than one full day?

- 5 or more times 01 68-69/
- 4 times 02
- 3 times 03
- 2 times 04
- Once 05
- Never in the past year, but
sometime before that 06
- Never in my life 07

85. Now I would like to ask you some questions about experiences that many people have had with drinking. During the past year . . .

	YES	NO	
A. Have you felt aggressive or angry while drinking?	1	2	70/
B. Have you gotten into a heated argument while drinking?	1	2	71/
C. Have you gotten into a fight while drinking?	1	2	72/
D. Have you deliberately tried to cut down or quit drinking, but didn't manage to do so?	1	2	73/
E. Were you afraid you might be an alcoholic or that you might become one?	1	2	74/
F. Once you started drinking, was it difficult for you to stop before you became completely intoxicated?	1	2	75/
G. Have you awakened the next day not being able to remember things you had done while drinking?	1	2	76/
H. Have you often taken a drink the first thing when you got up in the morning?	1	2	77/
I. Have your hands shaken a lot the morning after drinking?	1	2	78/
J. Have you sometimes gotten drunk when drinking by yourself? . . .	1	2	79/
K. Have you sometimes kept on drinking after promising yourself not to?	1	2	80/

86. HAS R WORKED THE PAST YEAR?

- YES 1 10/
- NO (SKIP TO Q.87, BELOW) 2

During the past year:

- | | YES | NO | |
|--|-----|----|-----|
| A. Have you stayed away from work because of a hangover? | 1 | 2 | 11/ |
| B. Have you gotten drunk when on the job? | 1 | 2 | 12/ |
| C. Have you lost a job, or nearly lost one, because of drinking? | 1 | 2 | 13/ |
| D. Has drinking led to your quitting a job? | 1 | 2 | 14/ |
| E. Has drinking hurt your chances for promotion or raises or a better job? | 1 | 2 | 15/ |

87. When you were growing up, do you think your father drank occasionally, drank frequently, had a drinking problem, or didn't he drink?

- Drank occasionally 1 16/
- Drank frequently 2
- Had a drinking problem 3
- Didn't drink 4
- DON'T KNOW 8

88. When you were growing up, do you think your mother drank occasionally, drank frequently, had a drinking problem, or didn't she drink?

- Drank occasionally 1 17/
- Drank frequently 2
- Had a drinking problem 3
- Didn't drink 4
- DON'T KNOW 8

LIFETIME DRINKING HISTORY SECTION

USE THESE DIRECTIONS TO COMPLETE THE ANSWER SHEET FOR LIFETIME DRINKING HISTORY. IF PARTICIPANT WAS LAST INTERVIEWED IN 1987/1988, USE DATE OF LAST INTERVIEW. OTHERWISE, ASK ABOUT TIME SINCE BEGAN DRINKING REGULARLY.

Now I am going to ask you questions about your drinking history. I'd like to start with [the year that you first began drinking regularly (i.e., at least once a month / the period since (DATE OF LAST INTERVIEW)), and work forward to the present. Please give me information as accurately as you can about what type of beverage you were drinking, how much and how often.

(FIRST) STAGE

Question A H 1.1 To begin I'm going to ask you about your drinking pattern [during the first year that you began to have at least one drink per month/since (DATE OF LAST INTERVIEW)]. [How old were you when you began regular drinking . . . approximately how old? / How old were you at the time of the last interview?] RECORD THE AGE ON THE ANSWER SHEET

TYPE

Question A H 1.2 [During the first year that you began to have at least one drink per month / Since (DATE OF LAST INTERVIEW)], what types of beverages would you usually consume in an average month? About what percentage of your drinking would be . . . ? RECORD THE RELATIVE PERCENTAGES OF BEER, HARD LIQUOR OR WINE. THIS SECTION SHOULD ADD UP TO 100%

QUANTITY

Question A H 1.3 When you drank about how much did you usually drink?

- One drink (approximately) = 12 oz Beer
- One drink (approximately) = 1.5 oz Liquor (40 % Alcohol)
- One drink (approximately) = 5 oz Wine
- One drink (approximately) = 3 oz Fortified Wine (e.g., Sherry)
- One drink (approximately) = 17 ml Absolute Alcohol
- One drink (approximately) = 13.6 g Absolute Alcohol

RECORD THE AVERAGE NUMBER OF DRINKS PER OCCASION

Question A H 1.4 What is the most or maximum number of drinks you would have in any one day? RECORD THE MAXIMUM NUMBER OF DRINKS. NOTE, THIS IS THE MAXIMUM NUMBER THAT THE PERSON ACTUALLY WOULD DRINK, NOT AN ESTIMATE OF HIS POTENTIAL CAPACITY.

FREQUENCY

Question A H 1.5 How many days per month would you generally drink (AVERAGE NUMBER OF DRINKS FROM A H 1.3.)? RECORD THE NUMBER OF DAYS UNDER THE FREQUENCY HEADING.

LIFETIME DRINKING HISTORY SECTION

USE THESE DIRECTIONS TO COMPLETE THE ANSWER SHEET FOR LIFETIME DRINKING HISTORY. IF PARTICIPANT WAS LAST INTERVIEWED IN 1987/1988, USE DATE OF LAST INTERVIEW. OTHERWISE, ASK ABOUT TIME SINCE BEGAN DRINKING REGULARLY.

Now I am going to ask you questions about your drinking history. I'd like to start with [the year that you first began drinking regularly (i.e., at least once a month / the period since (DATE OF LAST INTERVIEW)), and work forward to the present. Please give me information as accurately as you can about what type of beverage you were drinking, how much and how often.

(FIRST) STAGE

Question A H 1.1 To begin I'm going to ask you about your drinking pattern [during the first year that you began to have at least one drink per month/since (DATE OF LAST INTERVIEW)]. [How old were you when you began regular drinking . . . approximately how old? / How old were you at the time of the last interview?] RECORD THE AGE ON THE ANSWER SHEET.

TYPE

Question A H 1.2 [During the first year that you began to have at least one drink per month / Since (DATE OF LAST INTERVIEW)], what types of beverages would you usually consume in an average month? About what percentage of your drinking would be . . .? RECORD THE RELATIVE PERCENTAGES OF BEER, HARD LIQUOR OR WINE. THIS SECTION SHOULD ADD UP TO 100%

QUANTITY

Question A H 1.3 When you drank about how much did you usually drink?

One drink (approximately) = 12 oz Beer
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One drink (approximately) = 17 ml Absolute Alcohol
One drink (approximately) = 13.6 g Absolute Alcohol

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FREQUENCY

Question A H 1.5 How many days per month would you generally drink (AVERAGE NUMBER OF DRINKS FROM A H 1.3.)? RECORD THE NUMBER OF DAYS UNDER THE FREQUENCY HEADING.

STYLE

Question A H 1.6 How would you rate your usual style of drinking in an average month? Was it . . .?
(READ APPROPRIATE CATEGORIES. CIRCLE ONE).

- BLANK = ABSTINENT
1 = Occasional (LESS THAN 15 DAYS).
2 = Weekends mainly.
3 = At least 3 days heavy drinking in a period of time (BINGE DRINKING)
4 = Frequent (15 OR MORE DRINKS PER MONTH).

LIFE EVENTS

Question A H 1.7 Did any important event or events occur during this period that altered your usual drinking habits? EXAMPLES ARE: LOSS OF SPOUSE, MEDICAL PROBLEMS, UNEMPLOYMENT, PRISON TERM, HOSPITALIZATION. RECORD THESE EVENTS BY CODING ALL THAT APPLY. IF NO IMPORTANT EVENT OCCURRED THAT INFLUENCED THE PERSON'S DRINKING BEHAVIOR, THEN LEAVE THIS SECTION BLANK

Question A H 1.8 What was your perception of this event? Would you say that it had a positive (+) or negative (-) effect on your life? RECORD "+" OR "-" BEFORE THE LIFE EVENT. IF NO (NEUTRAL) EFFECT, LEAVE BLANK.

CONTEXT

Question A H 1.9a What percentage of the time would you drink alone?
Question A H 1.9b What percentage of the time with at least one other person?
(RECORD THE APPROPRIATE VALUES BESIDE ALONE AND WITH OTHERS. THIS SECTION SHOULD ADD UP TO 100%)

TIME

Question A H 1.10 During what time of the day would you do most of your drinking? Could you give me the percentage of time during the evening, afternoon and morning? (RECORD THE APPROPRIATE VALUES BESIDE MORNING, AFTERNOON AND EVENING. THIS SECTION SHOULD ADD TO 100%)

SUBSEQUENT PHASES

Instruction A: We have just discussed your drinking habits [at the point when you first began to drink regularly/since (DATE OF LAST INTERVIEW)]. Now I want you to think of when your drinking behavior was different in a significant way from this time. This could be the next 6 months or perhaps 2 or 5 years. Can you think of any events in your life that changed and may have altered your drinking habits (increased/decreased) at any time in your life? Events such as attending high school, college, enlisting, Vietnam, deaths in family, change of jobs.

ESTABLISH WHEN THE PERSON'S DRINKING BEHAVIOR FIRST CHANGED IN A SIGNIFICANT WAY FROM THAT RECORDED UNDER FIRST STAGE. SINCE THIS DRINKING HISTORY IS AIMED AT MAJOR TRENDS, SOME JUDGEMENT WILL BE NECESSARY IN DIFFERENTIATING IMPORTANT FROM MINOR CHANGES IN DRINKING PATTERNS. FILL IN THE AGE RANGE WHEN THE BEHAVIOR CHANGED UNDER SECOND STAGE, AND REPEAT THE QUESTIONS FOR TYPE, QUANTITY, FREQUENCY, STYLE, LIFE EVENTS, CONTEXT, AND TIME.

Instruction B: PROBE FURTHER INTO THE PERSON'S HISTORY TO NOTE CHANGES IN DRINKING BEHAVIOR. MAKE SURE THAT ALL THE YEARS ARE COVERED FROM THE YEAR WHEN THE INDIVIDUAL FIRST STARTED DRINKING ON A REGULAR BASIS (AT LEAST ONCE A MONTH) TO HIS PRESENT AGE OR FROM THE DATE OF LAST INTERVIEW TO NOW. AFTER CONDUCTING THE INTERVIEW, CARE SHOULD BE TAKEN TO ENSURE THAT ALL SECTIONS ARE COMPLETE AND THAT THE AGE RANGE RUNS IN A CHRONOLOGICAL SEQUENCE WITH NO OVERLAP OR AGE GAPS.

EXAMPLE: Participant started drinking at 16. He drank very little for 4 years.

At age 20, he drank a lot more, and more liquor than beer. He did this for 10 years.

At age 30, he decreased his drinking to only weekends. He did this type of drinking for 12 years.

At age 42, he quit drinking completely. He is 50 years old.

FIRST STAGE: From age 16 to 20.

SECOND STAGE: From age 20 to 30.

THIRD STAGE: From age 30 to 42.

FOURTH STAGE: From age 42 to present (50 yrs).

STYLE

Question A H 1.6 How would you rate your usual style of drinking in an average month? Was it . . .? (READ APPROPRIATE CATEGORIES. CIRCLE ONE).

- BLANK = ABSTINENT
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-

LIFE EVENTS

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Question A H 1.8 Deleted SEE GREEN CARDS

CONTEXT

Question A H 1.9a What percentage of the time would you drink alone?

Question A H 1.9b What percentage of the time with at least one other person?

(RECORD THE APPROPRIATE VALUES BESIDE ALONE AND WITH OTHERS. THIS SECTION SHOULD ADD UP TO 100%)

TIME

Question A H 1.10 During what time of the day would you do most of your drinking? Could you give me the percentage of time during the evening, afternoon and morning? (RECORD THE APPROPRIATE VALUES BESIDE MORNING, AFTERNOON AND EVENING. THIS SECTION SHOULD ADD TO 100%)

SUBSEQUENT PHASES

Instruction A: We have just discussed your drinking habits [at the point when you first began to drink regularly/since (DATE OF LAST INTERVIEW)]. Now I want you to think of when your drinking behavior was different in a significant way from this time. This could be the next 6 months or perhaps 2 or 5 years. Can you think of any events in your life that changed and may have altered your drinking habits (increased/decreased) at any time in your life? Events such as attending high school, college, enlisting, Vietnam, deaths in family, change of jobs.

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Instruction B: PROBE FURTHER INTO THE PERSON'S HISTORY TO NOTE CHANGES IN DRINKING BEHAVIOR. MAKE SURE THAT ALL THE YEARS ARE COVERED FROM THE YEAR WHEN THE INDIVIDUAL FIRST STARTED DRINKING ON A REGULAR BASIS (AT LEAST ONCE A MONTH) TO HIS PRESENT AGE OR FROM THE DATE OF LAST INTERVIEW TO NOW. AFTER CONDUCTING THE INTERVIEW, CARE SHOULD BE TAKEN TO ENSURE THAT ALL SECTIONS ARE COMPLETE AND THAT THE AGE RANGE RUNS IN A CHRONOLOGICAL SEQUENCE WITH NO OVERLAP OR AGE GAPS.

EXAMPLE: Participant started drinking at 16. He drank very little for 4 years.

At age 20, he drank a lot more, and more liquor than beer. He did this for 10 years.

At age 30, he decreased his drinking to only weekends. He did this type of drinking for 12 years.

At age 42, he quit drinking completely. He is 50 years old.

FIRST STAGE: From age 16 to 20.

SECOND STAGE: From age 20 to 30.

THIRD STAGE: From age 30 to 42.

FOURTH STAGE: From age 42 to present (50 yrs).

**ANSWER SHEET
LIFETIME DRINKING HISTORY**

DECKS 56-59
OF PHASES
18-39/R

Q.AH1.1	Q.AH1.2	Q.AH1.3/Q.AH1.4	Q.AH1.5	Q.AH1.6	Q.AH1.7	Q.AH1.9 a & b	Q.AH1.10
STAGES AGE RANGE	TYPE	QUANTITY	FREQUENCY	STYLE	LIFE EVENTS OR CHANGES	CONTEXT	TIME
Younger to Older	Percentage %	Drinks/Occasion	Days/Month	Circle One	Code All That Apply	Percentage %	Percentage %
BEGIN DECK 57 FROM _____ 10-13/ TO _____ 14-15/	Beer _____ 18-20 Liquor _____ 21-23/ Wine _____ 24-26/ T = 100%	(1.3) Average _____ 27-28/ (1.4) Maximum _____ 29-30/	_____ 31-32/	1. Occasional 2. Weekends 3. Heavy/Binge 4. Frequent 33/	1 Family 7 Financial 2 Work 8 Peer Group 3 School 9 Drug Use 4 Medical 10 Treatment 5 Residence 11 Death 6 Legal-Jail 34-39/ 12 Emotional 40-45/	a. Alone _____ 46-48/ b. With Others _____ 49-51/ T = 100%	Morning _____ 52-54/ Afternoon _____ 55-57/ Evening _____ 58-60/ T = 100%
BEGIN DECK 58 FROM _____ 10-13/ TO _____ 14-15/	Beer _____ 18-20/ Liquor _____ 21-23/ Wine _____ 24-26/ T = 100%	(1.3) Average _____ 27-28/ (1.4) Maximum _____ 29-30/	_____ 31-32/	1. Occasional 2. Weekends 3. Heavy/Binge 4. Frequent 33/	1 Family 7 Financial 2 Work 8 Peer Group 3 School 9 Drug Use 4 Medical 10 Treatment 5 Residence 11 Death 6 Legal-Jail 34-39/ 12 Emotional 40-45/	a. Alone _____ 46-48/ b. With Others _____ 49-51/ T = 100%	Morning _____ 52-54/ Afternoon _____ 55-57/ Evening _____ 58-60/ T = 100%
BEGIN DECK 59 FROM _____ 10-13/ TO _____ 14-15/	Beer _____ 18-20/ Liquor _____ 21-23/ Wine _____ 24-26/ T = 100%	(1.3) Average _____ 27-28/ (1.4) Maximum _____ 29-30/	_____ 31-32/	1. Occasional 2. Weekends 3. Heavy/Binge 4. Frequent 33/	1 Family 7 Financial 2 Work 8 Peer Group 3 School 9 Drug Use 4 Medical 10 Treatment 5 Residence 11 Death 6 Legal-Jail 34-39/ 12 Emotional 40-45/	a. Alone _____ 46-48/ b. With Others _____ 49-51/ T = 100%	Morning _____ 52-54/ Afternoon _____ 55-57/ Evening _____ 58-60/ T = 100%

FIRST STAGE (PHASE)

SECOND

THIRD

B-202

1mo = .1 5mo = .4 9mo = .8
 2mo = .2 6mo = .5 10mo = .8
 3mo = .3 7mo = .6 11mo = .9
 4mo = .3 8mo = .7 12mo = 1.0

1 Drink (approx.) = 12 oz. beer
 1.5 oz. liquor
 5 oz. wine
 3 oz. fortified wine
 13.6 g absolute alcohol

Liquor: 1 mickey (12 oz) = 8 Drinks
 1 bottle (25 oz) = 17 Drinks

Wine: 1 bottle (25 oz) = 5 Drinks

**ANSWER SHEET
LIFETIME DRINKING HISTORY**

DECKS 60-62
OF PHASES

Q.AH1.1	Q.AH1.2	Q.AH1.3/Q.AH1.4	Q.AH1.5	Q.AH1.6	Q.AH1.7		Q.AH1.9 a & b	Q.AH1.10
STAGES AGE RANGE	TYPE	QUANTITY	FREQUENCY	STYLE	LIFE EVENTS OR CHANGES		CONTEXT	TIME
Younger to Older	Percentage %	Drinks/Occasion	Days/Month	Circle One	Code All That Apply		Percentage %	Percentage %
BEGIN DECK 60 FROM _____ 10-13/ TO _____ 14-15/	Beer _____ 18-20 Liquor _____ 21-23/ Wine _____ 24-26/ T = 100%	(1.3) Average _____ 27-28/ (1.4) Maximum _____ 29-30/	_____ 31-32/	1. Occasional 2. Weekends 3. Heavy/Binge 4. Frequent 33/	1 Family 2 Work 3 School 4 Medical 5 Residence 6 Legal-Jail 34-39/	7 Financial 8 Peer Group 9 Drug Use 10 Treatment 11 Death 12 Emotional 40-45/	a. Alone _____ 46-48/ b. With Others _____ 49-51/ T = 100%	Morning _____ 52-54/ Afternoon _____ 55-57/ Evening _____ 58-60/ T = 100%
BEGIN DECK 61 FROM _____ 10-13/ TO _____ 14-15/	Beer _____ 18-20/ Liquor _____ 21-23/ Wine _____ 24-26/ T = 100%	(1.3) Average _____ 27-28/ (1.4) Maximum _____ 29-30/	_____ 31-32/	1. Occasional 2. Weekends 3. Heavy/Binge 4. Frequent 33/	1 Family 2 Work 3 School 4 Medical 5 Residence 6 Legal-Jail 34-39/	7 Financial 8 Peer Group 9 Drug Use 10 Treatment 11 Death 12 Emotional 40-45/	a. Alone _____ 46-48/ b. With Others _____ 49-51/ T = 100%	Morning _____ 52-54/ Afternoon _____ 55-57/ Evening _____ 58-60/ T = 100%
BEGIN DECK 62 FROM _____ 10-13/ TO _____ 14-15/	Beer _____ 18-20/ Liquor _____ 21-23/ Wine _____ 24-26/ T = 100%	(1.3) Average _____ 27-28/ (1.4) Maximum _____ 29-30/	_____ 31-32/	1. Occasional 2. Weekends 3. Heavy/Binge 4. Frequent 33/	1 Family 2 Work 3 School 4 Medical 5 Residence 6 Legal-Jail 34-39/	7 Financial 8 Peer Group 9 Drug Use 10 Treatment 11 Death 12 Emotional 40-45/	a. Alone _____ 46-48/ b. With Others _____ 49-51/ T = 100%	Morning _____ 52-54/ Afternoon _____ 55-57/ Evening _____ 58-60/ T = 100%

FOURTH
B-203
FIFTH
SIXTH

1mo = .1 5mo = .4 9mo = .8
2mo = .2 6mo = .5 10mo = .8
3mo = .3 7mo = .6 11mo = .9
4mo = .3 8mo = .7 12mo = 1.0

1 Drink (approx.) = 12 oz. beer
1.5 oz. liquor
5 oz. wine
3 oz. fortified wine
13.6 g absolute alcohol

Liquor: 1 mickey (12 oz) = 8 Drinks
1 bottle (25 oz) = 17 Drinks
Wine: 1 bottle (25 oz) = 5 Drinks
1 bottle fortified = 8 Drinks

**ANSWER SHEET
LIFETIME DRINKING HISTORY**

DECKS 63-64
OF PHASES

Q.AH1.1	Q.AH1.2	Q.AH1.3/Q.AH1.4	Q.AH1.5	Q.AH1.6	Q.AH1.7	Q.AH1.9 a & b	Q.AH1.10
STAGES AGE RANGE	TYPE	QUANTITY	FREQUENCY	STYLE	LIFE EVENTS OR CHANGES	CONTEXT	TIME
Younger to Older	Percentage %	Drinks/Occasion	Days/Month	Circle One	Code All That Apply	Percentage %	Percentage %
BEGIN DECK 63 FROM _____ 10-13/ TO _____ 14-15/	Beer _____ 18-20/ Liquor _____ 21-23/ Wine _____ 24-26/ T = 100%	(1.3) Average _____ 27-28/ (1.4) Maximum _____ 29-30/	_____ 31-32/	1. Occasional 2. Weekends 3. Heavy/Binge 4. Frequent 33/	1 Family 2 Work 3 School 4 Medical 5 Residence 6 Legal-Jail 34-39/ 7 Financial 8 Peer Group 9 Drug Use 10 Treatment 11 Death 12 Emotional 40-45/	a. Alone _____ 46-48/ b. With Others _____ 49-51/ T = 100%	Morning _____ 52-54/ Afternoon _____ 55-57/ Evening _____ 58-60/ T = 100%
BEGIN DECK 64 FROM _____ 10-13/ TO _____ 14-15/	Beer _____ 18-20/ Liquor _____ 21-23/ Wine _____ 24-26/ T = 100%	(1.3) Average _____ 27-28/ (1.4) Maximum _____ 29-30/	_____ 31-32/	1. Occasional 2. Weekends 3. Heavy/Binge 4. Frequent 33/	1 Family 2 Work 3 School 4 Medical 5 Residence 6 Legal-Jail 34-39/ 7 Financial 8 Peer Group 9 Drug Use 10 Treatment 11 Death 12 Emotional 40-45/	a. Alone _____ 46-48/ b. With Others _____ 49-51/ T = 100%	Morning _____ 52-54/ Afternoon _____ 55-57/ Evening _____ 58-60/ T = 100%

1mo = .1 5mo = .4 9mo = .8
2mo = .2 6mo = .5 10mo = .8
3mo = .3 7mo = .6 11mo = .9
4mo = .3 8mo = .7 12mo = 1.0

1 Drink (approx.) = 12 oz. beer
1.5 oz. liquor
5 oz. wine
3 oz. fortified wine
13.6 g absolute alcohol

Liquor: 1 mickey (12 oz) = 8 Drinks
1 bottle (25 oz) = 17 Drinks

Wine: 1 bottle (25 oz) = 5 Drinks
1 bottle fortified = 8 Drinks

SEVENTH
B-204
EIGHTH

89. IF R INTERVIEWED IN CYCLES '85-'86 AND/OR '87-'88, USE THE PHRASES IN BRACKETS. Now I am going to ask you some questions about using alcohol. [Since (DATE OF LAST INTERVIEW)], Has there ever been a period of two weeks when every day you were drinking 7 or more beers, 7 or more drinks of hard liquor or 7 or more glasses of wine?

- YES (ASK Q.89A) 1 10/
- NO (SKIP TO Q.90) 2

89A. How long has it been since you drank that much or do you still?
CODE MOST RECENT TIME POSSIBLE

- Still or within last 2 weeks 1 11/
- Within last month 2
- Within last 6 months 3
- Within last year 4
- More than 1 year ago 5

90. [As you think back over the period of time between (DATE OF LAST INTERVIEW) and now], Has there ever been a couple of months or more when at least one evening a week, you drank 7 drinks, or 7 bottles of beer or 7 glasses of wine?

- YES (ASK Q.90A) 1 12/
- NO (SKIP TO Q.91, PAGE H-56) 2

90A. How long has it been since you drank 7 or more drinks at least once a week, or do you still?
CODE MOST RECENT TIME POSSIBLE

- Still or within last 2 weeks 1 13/
- Within last month 2
- Within last 6 months 3
- Within last year 4
- More than 1 year ago. (ASK Q.90B) 5

90B. IF MORE THAN 1 YEAR AGO: How old were you then?

AGE

14-15/

91. [Since (DATE OF LAST INTERVIEW)]/Have you ever told a doctor about a problem you had with drinking?
- YES 1 16/
NO 2
92. [Since (DATE OF LAST INTERVIEW)]/Have friends, your doctor, your clergyman, or any other professional ever said you were drinking too much for your own good?
- YES 1 17/
NO 2
93. [Again, thinking back over the period of time between (DATE OF LAST INTERVIEW) and now]/Have you ever wanted to stop drinking but couldn't?
- YES 1 18/
NO 2
94. Some people promise themselves not to drink before 5 o'clock or never to drink alone, in order to control their drinking. [Since (DATE OF LAST INTERVIEW)]/Have you ever done anything like that?
- YES 1 19/
NO 2
95. [Since (DATE OF LAST INTERVIEW)]/Did you ever need a drink just after you had gotten up (that is, before breakfast)?
- YES 1 20/
NO 2
96. [Over the period of time since (DATE OF LAST INTERVIEW) and now]/Have you ever had job or school troubles because of drinking -- like missing too much work or drinking on the job or at school?
- YES 1 21/
NO 2
97. [Since (DATE OF LAST INTERVIEW)]/Did you ever lose a job or get kicked out of school on account of drinking?
- YES 1 22/
NO 2
98. [As you think back over the period of time between (DATE OF LAST INTERVIEW) and now]/Have you ever gotten into trouble driving because of drinking -- like having an accident or being arrested for drunk driving?
- YES 1 23/
NO 2

99. [Since (DATE OF LAST INTERVIEW)]/Have you ever been arrested or held at the police station because of drinking or for disturbing the peace while drinking?

YES 1 24/
NO 2

100. [Since (DATE OF LAST INTERVIEW)]/Have you ever gotten into physical fights while drinking?

YES 1 25/
NO 2

101. [As you think back over the period of time between (DATE OF LAST INTERVIEW) and now]/Have you ever gone on binges or benders, where you kept drinking for a couple of days or more without sobering up?

YES (ASK Q.101A AND Q.101B) 1 26/
NO (SKIP TO Q.102, NEXT PAGE) 2

101A. Did you neglect some of your usual responsibilities then?

YES 1 27/
NO 2

101B. How many times have you gone on binges or benders that lasted at least a couple of days?

28-29/

OF BENDERS

IF R SAYS 96 OR MORE, CODE 96 AND GO TO Q.102, NEXT PAGE. IF R SAYS "DON'T KNOW" ASK Q.101C.

101C. Was it just once or more often than that?

JUST ONCE (RECORD 01 ABOVE)
MORE THAN ONCE (RECORD 95 ABOVE)
STILL DON'T KNOW (RECORD 98 ABOVE)

102. [Since (DATE OF LAST INTERVIEW)]/Have you ever had blackouts while drinking, that is, where you drank enough so that you couldn't remember the next day what you had said or done?
- YES 1 30/
NO 2
103. [Since (DATE OF LAST INTERVIEW)]/Have you ever had "the shakes" after stopping or cutting down on drinking (for example, your hands shake so that your coffee rattles in the saucer or you have trouble lighting a cigarette)?
- YES (SKIP TO Q.104) 1 31/
NO (ASK Q.103A) 2
- 103A. [Since (DATE OF LAST INTERVIEW)]/Have you ever had fits or seizures after stopping or cutting down on drinking?
- YES (SKIP TO Q.104) 1 32/
NO (ASK Q.103B) 2
- 103B. [Since (DATE OF LAST INTERVIEW)]/Have you ever had the DT's (hallucinations and fever) when you quit drinking?
- YES (SKIP TO Q.104) 1 33/
NO (ASK Q.103C) 2
- 103C. [Since (DATE OF LAST INTERVIEW)]/Have you ever seen or heard things that weren't really there after cutting down on drinking?
- YES 1 34/
NO 2
104. There are several health problems that can result form long stretches of pretty heavy drinking. [Since (DATE OF LAST INTERVIEW)]/Did drinking ever cause you to have . . .? CODE ALL THAT APPLY.
- A. liver disease or yellow jaundice 1 35/
B. vomiting blood or other stomach troubles 2 36/
C. trouble with tingling in the limbs 3 37/
D. memory troubles when you haven't been drinking (not blackouts) 4 38/
E. inflammation of yoiur pancreas or pancreatitis 5 39/
F. NONE 0
105. [During the period from (DATE OF LAST INTERVIEW) and now]/Have you ever continued to drink when you knew you had a serious physical illness that might be made worse by drinking?
- YES 1 40/
NO 2

106. Has there ever been a period in your life [since (DATE OF LAST INTERVIEW)], when you could not do your ordinary daily work well unless you had something to drink?

YES 1 41/
NO 2

107A. Now I am going to ask you about possible sleep problems. SHOW PARTICIPANT HAND CARD FF. [Since (DATE OF LAST INTERVIEW)]/Would you please look at this card and tell me if you have any of these sleep problems. Other than on this trip, do you routinely have sleep problems such as . . . (READ a-l)?

B. IF YES TO ANY SLEEP PROBLEMS, ASK FOR EACH: How long have you had this problem? (CONVERT INTO MONTHS)

	A. CURRENT PROBLEM	B. HOW LONG IN MONTHS	C. PAST PROBLEM
a. Trouble falling asleep	1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1 42-46/
b. Waking up during the night	2	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2 47-51/
c. Waking up too early and can't go back to sleep	3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	3 52-56/
d. Waking up unrefreshed	4	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4 57-61/
e. Involuntarily falling asleep during the day	5	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	5 62-66/
f. Great or disabling fatigue during the day	6	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	6 67-71/
g. Frightening dreams	7	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	7 72-76/
h. Talking in your sleep	8	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	BEGIN DECK 66 8 10-14/
i. Sleepwalking	9	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	9 15-19/
j. Abnormal movement/activity during the night	10	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	10 20-24/
k. Sleep problems requiring medication	11	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	11 25-29/
l. Snore loudly in all sleeping positions	12	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	12 30-34/
m. IF NO CURRENT SLEEP PROBLEMS, CODE "1" 1			35/

C. IF NO TO ANY OF THESE PROBLEMS, ASK: Would you please look at this card and tell me if you have had any of these sleep problems in the past? CODE ALL THAT APPLY

IF NO PAST SLEEP PROBLEMS, CODE "1" 1 36/

IF R (HAS/HAD) ANY OF THE SLEEP PROBLEMS LISTED IN Q.107 ASK QS.108-110.
 OTHERS SKIP TO Q.111, PAGE H-61.

108. SHOW PARTICIPANT HAND CARD FF. Did you consult a physician or other health care professional about (EACH SLEEP PROBLEM GIVEN IN Q.107)?

	YES	NO	
a. Trouble falling asleep	1	2	37/
b. Waking up during the night	1	2	38/
c. Waking up too early and can't go back to sleep	1	2	39/
d. Waking up unrefreshed	1	2	40/
e. Involuntarily falling asleep during the day	1	2	41/
f. Great or disabling fatigue during the day	1	2	42/
g. Frightening dreams	1	2	43/
h. Talking in your sleep	1	2	44/
i. Sleepwalking	1	2	45/
j. Abnormal movement/activity during the night	1	2	46/
k. Sleep problems requiring medication	1	2	47/
l. Snore loudly in all sleeping positions	1	2	48/

109. Did you take medication to relieve (READ EACH SLEEP PROBLEM GIVEN IN Q.107)?

	YES	NO	
a. Trouble falling asleep	1	2	49/
b. Waking up during the night	1	2	50/
c. Waking up too early and can't go back to sleep	1	2	51/
d. Waking up unrefreshed	1	2	52/
e. Involuntarily falling asleep during the day	1	2	53/
f. Great or disabling fatigue during the day	1	2	54/
g. Frightening dreams	1	2	55/
h. Talking in your sleep	1	2	56/
i. Sleepwalking	1	2	57/
j. Abnormal movement/activity during the night	1	2	58/
k. Sleep problems requiring medication	1	2	59/
l. Snore loudly in all sleeping positions	1	2	60/

110. Did (EACH SLEEP PROBLEM GIVEN IN Q.107, PAGE H-59) interfere with your life?

	YES	NO	
a. Trouble falling asleep	1	2	61/
b. Waking up during the night	1	2	62/
c. Waking up too early and can't go back to sleep	1	2	63/
d. Waking up unrefreshed	1	2	64/
e. Involuntarily falling asleep during the day	1	2	65/
f. Great or disabling fatigue during the day	1	2	66/
g. Frightening dreams	1	2	67/
h. Talking in your sleep	1	2	68/
i. Sleepwalking	1	2	69/
j. Abnormal movement/activity during the night	1	2	70/
k. Sleep problems requiring medication	1	2	71/
l. Snore loudly in all sleeping positions	1	2	72/

111. ASK THIS QUESTION FOR EVERYONE. On the average, how many hours do you sleep per night?

73-74/

HOURS

SECTION I: RECREATION, LEISURE, AND PHYSICAL ACTIVITIES

FOR THIS SECTION YOU WILL NEED:

- THE INTERVAL SUPPLEMENTAL RECORDING BOOK (I.S.R.B.)
- CALENDAR

10-17/R

1. Now we would like you to answer some questions about your leisure time activities. Have you ever participated three or more times in (READ EACH ITEM)?

	YES	NO	
Scuba diving	1	2	18/
Auto, boat, or motorcycle racing	1	2	19/
Skydiving	1	2	20/
Mountain climbing	1	2	21/
Hang gliding	1	2	22/
Plane racing or plane acrobatics, not including flight training or any assignments for the Armed Forces	1	2	23/
Surf board riding	1	2	24/
Sailing long distance in small sailing craft	1	2	25/
Skiing fast down a high mountain slope	1	2	26/
			27/R

SKIP TO Q.15 82 IN I.S.R.B. ON PAGE 15.

SECTION J: TOXIC SUBSTANCES

FOR THIS SECTION YOU WILL NEED

*** HAND CARD E**

1. Have any of the recreation, leisure, and/or physical activities you've participated in since (DATE OF LAST INTERVIEW) brought you in contact with any of the following substances ...?	1A. FOR EACH SUBSTANCE CODED YES, ASK A THROUGH D. Since (DATE OF LAST INTERVIEW), in what month and year did your recreation, leisure and/or physical activities first bring you in contact with (SUBSTANCE)?	1B. Since (DATE OF LAST INTERVIEW), for how many years did you continue to come in contact with (SUBSTANCE)?
<p style="text-align: right;">YES NO</p> <p>Asbestos? 1 2 28/</p>	<p style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR 29-32/ </p>	<p style="text-align: center;"> <input type="text"/><input type="text"/> YEARS 33-34/ </p>
<p>Industrial Chemicals? 1 2 35/</p>	<p style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR 36-39/ </p>	<p style="text-align: center;"> <input type="text"/><input type="text"/> YEARS 40-41/ </p>
<p>Insecticides or Pesticides? 1 2 42/</p>	<p style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR 43-46/ </p>	<p style="text-align: center;"> <input type="text"/><input type="text"/> YEARS 47-48/ </p>
<p>Degreasing Chemicals? 1 2 49/</p>	<p style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR 50-53/ </p>	<p style="text-align: center;"> <input type="text"/><input type="text"/> YEARS 54-55/ </p>
<p>Defoliants or Herbicides? 1 2 56/</p>	<p style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR 57-60/ </p>	<p style="text-align: center;"> <input type="text"/><input type="text"/> YEARS 61-62/ </p>
<p>X-ray or Nuclear Radiation? 1 2 63/</p>	<p style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR 64-67/ </p>	<p style="text-align: center;"> <input type="text"/><input type="text"/> YEARS 68-69/ </p>

1. (Continued)

<p>1C. Since (DATE OF LAST INTERVIEW), how many days per year did you come in contact with (SUBSTANCE)?</p>	<p>1D. On the days you came in contact with (SUBSTANCE) how often did you use protective clothing or gear or wash to remove (SUBSTANCE)--all of the time, some of the time, or never?</p>	<p>1E. SHOW PARTICIPANT HAND CARD E. Which of the following did you use? CODE ALL THAT APPLY.</p>
<p style="text-align: right;">73/</p> <p style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> DAYS </p> <p style="text-align: right;">70-72/</p>	<p>All of the time .(ASK E) 1</p> <p>Some of the time .(ASK E) 2</p> <p>Never 3</p>	<p>Air Filter 1 74/ Goggles 2 75/ Face Shield 3 76/ Special Clothing 4 77/ Washing Facilities 5 78/ Self Contained or Supplied Air Breathing Apparatus 6 79/ NONE 0 80/</p>
<p style="text-align: right;">13/</p> <p style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> BEGIN DECK 68 DAYS 10-12/ </p>	<p>All of the time .(ASK E) 1</p> <p>Some of the time .(ASK E) 2</p> <p>Never 3</p>	<p>Air Filter 1 14/ Goggles 2 15/ Face Shield 3 16/ Special Clothing 4 17/ Washing Facilities 5 18/ Self Contained or Supplied Air Breathing Apparatus 6 19/ NONE 0 20/</p>
<p style="text-align: right;">24/</p> <p style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> DAYS </p> <p style="text-align: right;">21-23/</p>	<p>All of the time .(ASK E) 1</p> <p>Some of the time .(ASK E) 2</p> <p>Never 3</p>	<p>Air Filter 1 25/ Goggles 2 26/ Face Shield 3 27/ Special Clothing 4 28/ Washing Facilities 5 29/ Self Contained or Supplied Air Breathing Apparatus 6 30/ NONE 0 31/</p>
<p style="text-align: right;">35/</p> <p style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> DAYS </p> <p style="text-align: right;">32-34/</p>	<p>All of the time .(ASK E) 1</p> <p>Some of the time .(ASK E) 2</p> <p>Never 3</p>	<p>Air Filter 1 36/ Goggles 2 37/ Face Shield 3 38/ Special Clothing 4 39/ Washing Facilities 5 40/ Self Contained or Supplied Air Breathing Apparatus 6 41/ NONE 0 42/</p>
<p style="text-align: right;">46/</p> <p style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> DAYS </p> <p style="text-align: right;">43-45/</p>	<p>All of the time .(ASK E) 1</p> <p>Some of the time .(ASK E) 2</p> <p>Never 3</p>	<p>Air Filter 1 47/ Goggles 2 48/ Face Shield 3 49/ Special Clothing 4 50/ Washing Facilities 5 51/ Self Contained or Supplied Air Breathing Apparatus 6 52/ NONE 0 53/</p>
<p style="text-align: right;">57/</p> <p style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> DAYS </p> <p style="text-align: right;">54-56/</p>	<p>All of the time .(ASK E) 1</p> <p>Some of the time .(ASK E) 2</p> <p>Never 3</p>	<p>Air Filter 1 58/ Goggles 2 59/ Face Shield 3 60/ Special Clothing 4 61/ Washing Facilities 5 62/ Self Contained or Supplied Air Breathing Apparatus 6 63/ NONE 0 64/</p>

SECTION K: INCOME
FOR THIS SECTION YOU WILL NEED
- HAND CARD GG.

1. Now I have some questions about your income. **SHOW PARTICIPANT HAND CARD GG.** Please tell me which letter on this card best represents the total household income in 1991 before taxes or other deductions for all people in your household, not including roomers. This amount should include wages, net income from business, interest, dividends, pensions, and any other money income. Tell me the letter that comes closest.

65/R
66-67/

- A. \$5,000 - \$9,999 01
- B. \$10,000 - \$14,999 02
- C. \$15,000 - \$19,999 03
- D. \$20,000 - \$24,999 04
- E. \$25,000 - \$29,999 05
- F. \$30,000 - \$34,999 06
- G. \$35,000 - \$39,999 07
- H. \$40,000 - \$44,999 08
- I. \$45,000 - \$49,999 09
- J. \$50,000 - \$54,999 10
- K. \$55,000 - \$59,999 11
- L. \$60,000 - \$64,999 12
- M. \$65,000 - \$69,999 13
- N. \$70,000 - \$74,999 14
- O. \$75,000 - \$79,999 15
- P. \$80,000 - \$84,999 16
- Q. \$85,000 - \$89,999 17
- R. \$90,000 - \$94,999 18
- S. \$95,000 - \$99,999 19
- T. \$100,000 or more 20

2. Did you earn any income from any job during 1991? Do not include income from retirement plans or pensions.
- YES (ASK Q.2A) 1 68/
NO (SKIP TO Q.3) 2

2A. SHOW PARTICIPANT HAND CARD GG. In which of these groups did your earnings from jobs in 1991 fall -- that is, before taxes or other deductions? Tell me the letter that come closest. THE AMOUNT IN Q.2A SHOULD BE EQUAL TO OR LESS THAN AMOUNT IN Q.1.

- A. \$5,000 - \$9,999 01 69-70/
- B. \$10,000 - \$14,999 02
- C. \$15,000 - \$19,999 03
- D. \$20,000 - \$24,999 04
- E. \$25,000 - \$29,999 05
- F. \$30,000 - \$34,999 06
- G. \$35,000 - \$39,999 07
- H. \$40,000 - \$44,999 08
- I. \$45,000 - \$49,999 09
- J. \$50,000 - \$54,999 10
- K. \$55,000 - \$59,999 11
- L. \$60,000 - \$64,999 12
- M. \$65,000 - \$69,999 13
- N. \$70,000 - \$74,999 14
- O. \$75,000 - \$79,999 15
- P. \$80,000 - \$84,999 16
- Q. \$85,000 - \$89,999 17
- R. \$90,000 - \$94,999 18
- S. \$95,000 - \$99,999 19
- T. \$100,000 or more 20

3a. HAVE PARTICIPANT COMPLETE DIETARY ASSESSMENT FORM.

3b. INTERVIEWER:

RECORD TIME ENDED : AM
PM

71-74/

B-217

INTERVIEWER REMARKS

INTERVIEWER: Please complete these remarks as soon as you have finished the questionnaire.

1. Length of the interview:

MINUTES

75-77/

2. Date of the interview:

MONTH

DAY

YEAR

BEGIN DECK 69

10-15/

3. Race of Respondent:

- White 1 16/
- Black 2
- Other 3

4. In general, what was the respondent's attitude toward the interview?

- Friendly and interested 1 17/
- Cooperative but not particularly interested 2
- Impatient and restless 3
- Hostile 4

5. In general, was the respondent's understanding of the questions ...

- Good? 1 18/
- Fair? 2
- Poor? 3

6. List questions that confused, angered, or caused discomfort to the respondent or questions that you feel the respondent did not answer truthfully. EXPLAIN.

NONE 0 19/

Section		Question				
A.	<input type="checkbox"/> <input type="checkbox"/> 20-21/	<input type="checkbox"/> 22-26/				
B.	<input type="checkbox"/> <input type="checkbox"/> 27-28/	<input type="checkbox"/> 29-33/				
C.	<input type="checkbox"/> <input type="checkbox"/> 34-35/	<input type="checkbox"/> 36-40/				

Describe Problem: _____ 41/

7. List questions with skip errors, questions that were confusing to you, or questions that otherwise didn't work. EXPLAIN.

NONE 0 42/

Section		Question				
A.	<input type="checkbox"/> <input type="checkbox"/> 43-44/	<input type="checkbox"/> 45-49/				
B.	<input type="checkbox"/> <input type="checkbox"/> 50-51/	<input type="checkbox"/> 52-56/				
C.	<input type="checkbox"/> <input type="checkbox"/> 57-58/	<input type="checkbox"/> 59-63/				

Describe Problem: _____ 64/

8. Please record your interviewer ID #: 65-70/

9. Please sign your name here: _____

BEGIN DECK 70

10. PRINT THE RESPONDENT'S FULL NAME:

FIRST _____ MIDDLE _____ 10-39/

LAST _____ 40-59/

**LOG OF AUTHORIZATION FORMS TO BE RETURNED
TO AIR FORCE BY PARTICIPANT**

A Verification on Participant Condition		B Verification on Dependent Condition		C Patient's Name	D Condition to be Verified	E Q.# where Doctor or Facility Info is recorded
Y	N	Y	N	_____	_____	_____
Y	N	Y	N	_____	_____	_____
Y	N	Y	N	_____	_____	_____
Y	N	Y	N	_____	_____	_____
Y	N	Y	N	_____	_____	_____
Y	N	Y	N	_____	_____	_____
Y	N	Y	N	_____	_____	_____
Y	N	Y	N	_____	_____	_____
Y	N	Y	N	_____	_____	_____
Y	N	Y	N	_____	_____	_____
Y	N	Y	N	_____	_____	_____
Y	N	Y	N	_____	_____	_____
Y	N	Y	N	_____	_____	_____
Y	N	Y	N	_____	_____	_____
Y	N	Y	N	_____	_____	_____

INFORMATION SHEET
1992 AIR FORCE HEALTH STUDY

05/13/92

CASE-ID

RESPONDENT

SOCIAL SECURITY NUMBER

DATE OF LAST INTERVIEW

01 DATE OF BIRTH

02 DEGREE LAST OBTAINED

03 MILITARY STATUS : Discharged, Retired or Separate

BRANCH : Non-active Duty

COUNTRY :

DATE OF ASSIGNMENT :

04A SPOUSES/PARTNERS NAMED IN ROUND III : *****

04 MARITAL STATUS AT LAST INTERVIEW : Married

05 PARTNER AT LAST INTERVIEW? (ID#/NAME): No

06 SPOUSE AT LAST INTERVIEW? (ID#/NAME): Yes

07 SPOUSES/PARTNERS SINCE LAST INTERVIEW:

<input type="checkbox"/>	<input type="checkbox"/>	-----	-----	-----	-----
		LAST	FIRST	MIDDLE	MAIDEN
<input type="checkbox"/>	<input type="checkbox"/>	-----	-----	-----	-----
<input type="checkbox"/>	<input type="checkbox"/>	-----	-----	-----	-----
<input type="checkbox"/>	<input type="checkbox"/>	-----	-----	-----	-----
<input type="checkbox"/>	<input type="checkbox"/>	-----	-----	-----	-----

Case-ID :
Respondent:

05/13/92
4563

CHILDREN'S RECORD FORM
Respondent's Biological Children
(Interviewer: Please emphasize these are his *natural* children)

Child's Name	Mother's Id	Child's Id	First Name	Last Name	Sex	DOB	DOD	80+ DEF	82+ DEF	85+ DEF	87+ DEF
											YES NO
											YES NO

B-222

(SG) : INFORMATION MISSING
80+, 82+, 85+ DEF - 'YES': BIRTH DEFECT, OR LEARNING DISABILITY, OR PHYSICAL, MENTAL, OR MOTOR IMPAIRMENTS HAVE BEEN REPORTED
• • NONE OF THESE
80+ DEF - PREPRINT 'YES' AND 'NO'

PRIVACY ACT STATEMENT—EPIDEMIOLOGIC STUDY

AUTHORITY: Section 133, 1071-87, 3012, 5031 and 8012, Title 10, United States Code and Executive Order 9397.

PRINCIPAL AND PURPOSE(S): The purpose of requesting personal information is to assist medical/technical personnel in developing records relative to your participation in an approved epidemiologic investigation. The Social Security (SSN) and Armed Forces Service Number (AFSN) are necessary to identify the person and records.

ROUTINE USES: This information will be used to initiate, coordinate, and conduct the investigation. It will be used to compile statistical data, but information allowing identification of the individual volunteer will not be included. Data and results from this investigation may be used to supplement other approved research studies conducted at the USAF School of Aerospace Medicine or at other Federal agencies engaged in the conduct of similar studies.

WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY, AND EFFECT ON INDIVIDUAL FOR NOT PROVIDING INFORMATION: Disclosure or requested information is voluntary. If the information is not furnished, acceptance as a subject is not possible. This is an all-inclusive Privacy Act Statement which will apply to all request for personnel during the time you are a volunteer subject. A copy of this form will be placed in your investigation subject folder as evidence of this notification.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

Signature of Volunteer

AFSN

SSN

DATE



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____

Social Security Number: _____ - _____ - _____

Name of Doctor: _____

Name of Facility: _____

Address of Facility: _____

Condition: _____

Date of Medical Care: _____

The United States Air Force, under the direction of the White House, is currently conducting a study of Air Force personnel exposed to the complex environment of Southeast Asia. Part of this study examines the past medical history of Vietnam veterans and their families.

As a participant in this study, medical information is needed to validate data which was provided during a personal interview, self-administered questionnaire, and/or physical examination. The data will be maintained in compliance with the Privacy Act of 1974. No individually recognizable data will be released. Only statistical aggregate data will be released to the U.S. Congress and to the U.S. Public.

You are hereby authorized and requested to release the complete clinical record to:

USAFSAM/EKEO
Brooks AFB TX 78235
Attn: Mr. Vince Elequin

The authorization is null and void 120 days after the date signed below without expressed revocation, although it may be revoked by the undersigned at any time except to the extent that action has been taken in reliance thereon.

Witness: _____

Date Signed: _____

Signature: _____

Date Signed: _____

Case ID#: |__| |__| |__| |__| |__| |__|

AFTER COMPLETING AUTHORIZATION FORMS, CONTINUE FILLING OUT QUESTIONNAIRE

HEALTH CARE PROVIDER FORM SECTION F: CHILD AND FAMILY HEALTH

FOR EACH PARTICIPANT'S CHILDREN THAT HAS CANCER, A DISABILITY, OR DEFECT, COLLECT INFORMATION REGARDING (1) THE DOCTOR WHO FIRST DESCRIBED THE CONDITION, (2) THE DIAGNOSIS ITSELF, AND (3) THE DOCTOR WHO LAST SAW THE CHILD. IF CHILD HAS MORE THAN ONE KIND OF CANCER, DEFECT, OR DISABILITY, FILL OUT A NEW FORM FOR EACH CONDITION. COMPLETE A YELLOW MEDICAL AUTHORIZATION FORM FOR EACH DOCTOR THAT HAS SEEN THE CHILD.

29 What is the child's name?

Last First

30 What is (CHILD'S) date of birth?

M|_|_| D|_|_| Y|_|_|

Is (CHILD'S) defect or disability best described as a learning disability, physical or motor impairment, mental impairment, cancer, or birth defect? (CIRCLE APPROPRIATE NUMBER)

- Learning disability 1
- Physical or motor impairment 2
- Mental impairment 3
- Cancer 4
- Birth defect 5

COLUMN 1: What is the name and address of the medical facility and doctor(s) who first described (diagnosed) the child's cancer, defect, or disability?

31-A	Facility Name:
31-A	Building:
31-A	Street:
31-B	City State Zip Code
31-C	Physician Name:
31-C	Physician Name:

COLUMN 2: THE DIAGNOSIS ITSELF

32-A What is/was the diagnosis? (PROBE: That is, the doctor's description of the cancer, defect, or disability.)

In what month and year did the doctor(s) FIRST describe the cancer, defect, or disability?

32-B M|_|_| Y|_|_|

In what month and year did the child LAST see a doctor about this cancer, defect, or disability?

32-C M|_|_| Y|_|_|

COLUMN 3: What is the name and address of the medical facility and doctor(s) who LAST saw the child about the cancer, defect or disability?

• IF MEDICAL FACILITY AND DOCTOR INFORMATION IS THE SAME FOR THE FIRST AND LAST VISITS, CHECK BOX, GO TO NEXT HEALTH CARE PROVIDER FORM.

• IF BOX IS NOT CHECKED, COMPLETE PHYSICIAN/FACILITY INFORMATION BELOW.

33-A	Facility Name:
33-A	Building:
33-A	Street:
33-B	City State Zip Code
33-B	Physician Name:
33-C	Physician Name:

34. COMPLETE A YELLOW MEDICAL AUTHORIZATION FORM FOR EACH DOCTOR SEEN.

35. IF OTHER CANCERS, BIRTH DEFECTS, OR DISABILITIES FOR THIS CHILD, FILL OUT ANOTHER HEALTH CARE PROVIDER FORM.

CASE ID NO. : |_|_|_|_|_|_|_|_|

1992 AIR FORCE HEALTH STUDY (#4563)
CHILDREN'S SUPPLEMENTAL RECORD FORM

CHILD'S ID#	FULL NAME	SEX (M/F)	DATE OF BIRTH	AGE	MOTHER'S MAIDEN NAME	MOTHER'S ID #	CONDITION	DATE OF DEATH
_____	_____	_____	___/___/___	_____	_____	_ _	_____	___/___/___
				CIRCLE: YR/MO				
_____	_____	_____	___/___/___	_____	_____	_ _	_____	___/___/___
				CIRCLE: YR/MO				
_____	_____	_____	___/___/___	_____	_____	_ _	_____	___/___/___
				CIRCLE: YR/MO				
_____	_____	_____	___/___/___	_____	_____	_ _	_____	___/___/___
				CIRCLE: YR/MO				
_____	_____	_____	___/___/___	_____	_____	_ _	_____	___/___/___
				CIRCLE: YR/MO				
_____	_____	_____	___/___/___	_____	_____	_ _	_____	___/___/___
				CIRCLE: YR/MO				

B-226

**SELF-ADMINISTERED FORM 2
RESIDENCE HISTORY
(FROM PAGE G-7 IN INTERVAL QUEX)**

We would like you to tell us all the places you've lived since you were born. Please list all the places you've lived for more than 12 months starting with the first place since birth.

EXAMPLE: I lived in Chicago, Illinois for 6 years.

CITY/TOWN	STATE	COUNTRY	# YEARS
Chicago	IL		6

A. What is the name of the (first/next) city or town you lived in for more than 12 months since birth?	B. What state is that in?	C. What country is that in? (IF OTHER THAN USA)	D. How many years did you live there?
CITY/TOWN	STATE	COUNTRY	# YEARS

1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

____|____|____|____|____|____|
CASE ID

A.
What is the name of the
(first/next) city or town
you lived in for more than
12 months since birth?

CITY/TOWN

B.
What
state
is that
in?

STATE

C.
What country
is that in?
(IF OTHER
THAN USA)

COUNTRY

D.
How many years
did you live there?

YEARS

11.	_____	____|____|	_____
12.	_____	____|____|	_____
13.	_____	____|____|	_____
14.	_____	____|____|	_____
15.	_____	____|____|	_____
16.	_____	____|____|	_____
17.	_____	____|____|	_____
18.	_____	____|____|	_____
19.	_____	____|____|	_____
20.	_____	____|____|	_____

C	D	E	F	G
<p>Do you have (CONDITION) now?</p>	<p>Are you currently taking any prescribed medicines for your (CONDITION)?</p>	<p>What are the names of medicines you are taking? Any others?</p>	<p>When did you last consult a doctor for (CONDITION) between (DATE OF LAST INTERVIEW) and now?</p>	<p>What is the full name and address of the doctor or medical facility you last consulted? IF DIFFERENT DOCTOR FROM B, COMPLETE MEDICAL AUTHORIZATION FORM.</p>
<p>YES 1 NO 2 26/</p>	<p>YES 1 NO. (SKIP TO F FOR THIS CONDITION) 2 27/</p>	<p>1) _____ 28-30/ 2) _____ 31-33/ 3) _____ 34-36/</p>	<p>____|____|____|____| MONTH YEAR 37-40/</p>	<p>_____ PHYSICIAN'S LAST NAME 41/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____|_____|_____|_____| CITY STATE INTERVIEWER: BEFORE ASKING ABOUT THYROID PROBLEMS, SKIP TO Q.IS25 IN I.S.R.B. PAGE 7.</p>
<p>YES 1 NO 2 42/</p>	<p>YES 1 NO. (SKIP TO F FOR THIS CONDITION) 2 43/</p>	<p>1) _____ 44-46/ 2) _____ 47-49/ 3) _____ 50-52/</p>	<p>____|____|____|____| MONTH YEAR 53-56/</p>	<p>_____ PHYSICIAN'S LAST NAME 57/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____|_____|_____|_____| CITY STATE</p>

DECK A _____

Case ID

01-06

INTERVIEWER: ASK A THROUGH G FOR EACH CONDITION CODED YES.

		A	B
<p>Since (DATE OF LAST INTERVIEW) has a doctor told you for the first time that you had. . . ?</p>		<p>Between (DATE OF LAST INTERVIEW) and now, in what month and year <u>did a doctor first tell you that you had (CONDITION)?</u></p>	<p>What is the full name and address of the doctor who first made the diagnosis or the medical facility where the diagnosis was first made? REVIEW MEDICAL AUTHORIZATION FORMS. IF FORM NOT COMPLETED FOR THIS DOCTOR, COMPLETE FORM NOW.</p>
<p>Question # <input type="text"/> <input type="text"/> 10-11/</p>	<p>YES 1 NO. 2 12/</p>	<p><input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> MONTH YEAR 13-16/</p>	<p>_____ PHYSICIAN'S LAST NAME 17/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____ CITY <input type="text"/> <input type="text"/> STATE <input type="text"/> <input type="text"/></p>
<p>Question # <input type="text"/> <input type="text"/> 18-19/</p>	<p>YES 1 NO. 2 20/</p>	<p><input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> MONTH YEAR 21-24/</p>	<p>_____ PHYSICIAN'S LAST NAME 25/ _____ FIRST NAME OR _____ FACILITY NAME _____ STREET ADDRESS _____ CITY <input type="text"/> <input type="text"/> STATE <input type="text"/> <input type="text"/></p>

INTERVIEWER: CODE ONE

PERIOD 1.....1
 PERIOD 2.....2 10/
 PERIOD 3.....3

BEGIN DECK _____

SIDE A: FOR YOU

There are many reasons that some couples find it difficult or impossible to conceive a child. Please read this card and circle the number on Side A for each reason which applied to you for this period. Side B provides reasons appropriate for your spouse. Circle as many responses as appropriate.

For each reason, please record the year this occurred or became known to you.

- A. Vasectomy 01 11-12 YEAR: 19 13-14/
- B. Prostatectomy 02 15-16/ 19 17-18/
- C. Sterility due to other surgery
 (PLEASE SPECIFY)

 _____ 03 19-20/ 19 22-23/
 21/
- D. Sterility due to injury, accident, or illness
 (PLEASE SPECIFY)

 _____ 04 24-25/ 19 27-28/
 26/
- E. Impotence 05 29-30/ 19 31-32/
- F. Other medical or physical condition (PLEASE SPECIFY)

 _____ 06 33-34/ 19 36-37/
 35/
- G. Sterility due to unknown causes 07 38-39/ 19 40-41/
- H. No reason applies to me; reasons
 only apply to my spouse 08 42-43/

PLEASE USE SIDE B FOR REASONS APPROPRIATE
 FOR YOUR SPOUSE

NO MEDICAL RELEASE REQUIRED.

SELF-ADMINISTERED FORM 1

SIDE B: FOR YOUR SPOUSE

Please circle the number on Side B for each reason which applied to your spouse for this period. Circle as many responses as appropriate.

For each reason, please record the year this occurred or became known to you.

- A. Tubal ligation 01 44-45 YEAR: 19 46-47/
- B. Hysterectomy 02 48-49/ 19 50-51/
- C. Infertility due to other surgery
(PLEASE SPECIFY)
- _____
- _____ 03 52-53/ 19 55-56/
54/
- D. Infertility due to injury, accident, or illness
(PLEASE SPECIFY)
- _____
- _____ 04 57-58/ 19 60-61/
59/
- E. Other medical or physical condition (PLEASE SPECIFY)
- _____
- _____ 05 62-63/ 19 65-66/
64/
- F. Infertility due to unknown causes 06 67-68/ 19 69-70/
- G. No reason applies to my spouse;
reasons only apply to me 07 71-72/

INSTRUCTIONS

Please use an ordinary No. 2 pencil to answer all questions. Fill in the appropriate response circles completely, or write requested information in the boxes provided. The form is designed to be read by optical-scanning equipment, so it is important that you make **NO STRAY MARKS** and keep any write-in responses **WITHIN** the spaces provided. Should you need to change a response, erase the incorrect mark completely. If you have any comments, please write them on a separate piece of paper.

EXAMPLE 1.

MARK YOUR AVERAGE USE OF EACH SPECIFIC FOOD FOR A PERIOD OF TIME REQUESTED. FOR EXAMPLE, IF A FOOD SUCH AS TOMATOES IS EATEN 4 TIMES A WEEK DURING THE APPROXIMATE 3 MONTHS THAT IT IS IN SEASON, THEN THE AVERAGE USE WOULD BE ONCE PER WEEK.

VEGETABLES										
Tomatoes (1) or Tomato juice (small glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>						
Spring beans (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Broccoli (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cabbage, cauliflower, or Brussels sprouts (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Carrots, raw (1/2 carrot or 2-4 sticks)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Carrots, cooked (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

EXAMPLE 2.

KEEP HANDWRITING WITHIN BORDERS OF THE RESPONSE BOX.
What kind of cold breakfast cereal do you usually use?
 (e.g. Kelloggs Cracklin Oat Bran)

6. Which cold breakfast cereal do you usually eat? Yes No Don't eat cold breakfast cereal

Specify brand and type

Kelloggs Cracklin Oat Bran

EXAMPLE 3.

MARK "YES" OR "NO" AND THE NUMBER OF YEARS AND DOSE OF A VITAMIN PREPARATION

<p>Zinc?</p> <p><input type="radio"/> No <input checked="" type="radio"/> Yes → If YES,</p>	<p>How many years? <input type="radio"/> 0-1 yr. <input checked="" type="radio"/> 2-4 years <input type="radio"/> 5-9 years <input type="radio"/> 10+ years <input type="radio"/> Don't know</p> <p>What dose per day? <input type="radio"/> Less than 25 mg. <input type="radio"/> 25 to 74 mg. <input type="radio"/> 75 to 100 mg. <input checked="" type="radio"/> 101 mg. or more <input type="radio"/> Don't know</p>
<p>Calcium? (Include Calcium in Dolomites and Turns, etc.)</p> <p><input checked="" type="radio"/> No <input type="radio"/> Yes → If YES,</p>	<p>How many years? <input type="radio"/> 0-1 yr. <input type="radio"/> 2-4 years <input type="radio"/> 5-9 years <input type="radio"/> 10+ years <input type="radio"/> Don't know</p> <p>What dose per day? <input type="radio"/> Less than 400 mg. <input type="radio"/> 400 to 900 mg. <input type="radio"/> 901 to 1300 mg. <input type="radio"/> 1301 mg. or more <input type="radio"/> Don't know</p>

THANK YOU FOR COMPLETING THE FOOD FREQUENCY QUESTIONNAIRE.

DIET ASSESSMENT

ID:
 1 2 3 4 5 6 7 8 9 0 1 2 3 4 5 6 7 8 9 0 1 2 3 4 5 6 7 8 9 0 1 2 3 4 5 6 7 8 9 0

1. Do you currently take multiple vitamins? (Please report individual vitamins under question 2.)

No Yes → If yes, a) How many do you take per week? 2 or less 3-5 6-9 10 or more

b) What specific brand do you usually use? _____ Specify exact brand and type

2. Not counting multiple vitamins, do you take any of the following preparations:

a) Vitamin A? No Yes, seasonal only Yes, most months } If Yes, How many years? → 0-1 yr. 2-4 yrs. 5-9 yrs. 10+ yrs. Don't know

What dose per day? → Less than 8,000 IU 8,000 to 12,000 IU 13,000 to 22,000 IU 23,000 IU or more Don't know

b) Vitamin C? No Yes, seasonal only Yes, most months } If Yes, How many years? → 0-1 yr. 2-4 yrs. 5-9 yrs. 10+ yrs. Don't know

What dose per day? → Less than 400 mg. 400 to 700 mg. 750 to 1250 mg. 1300 mg. or more Don't know

c) Vitamin B₆? No Yes → If yes, How many years? → 0-1 yr. 2-4 yrs. 5-9 yrs. 10+ yrs. Don't know

What dose per day? → Less than 10 mg. 10 to 39 mg. 40 to 79 mg. 80 mg. or more Don't know

d) Vitamin E? No Yes → If yes, How many years? → 0-1 yr. 2-4 yrs. 5-9 yrs. 10+ yrs. Don't know

What dose per day? → Less than 100 IU 100 to 250 IU 300 to 500 IU 600 IU or more Don't know

e) Selenium? No Yes → If yes, How many years? → 0-1 yr. 2-4 yrs. 5-9 yrs. 10+ yrs. Don't know

What dose per day? → Less than 80 mcg. 80 to 130 mcg. 140 to 250 mcg. 260 mcg. or more Don't know

f) Iron? No Yes → If yes, How many years? → 0-1 yr. 2-4 yrs. 5-9 yrs. 10+ yrs. Don't know

What dose per day? → Less than 61 mg. 61 to 200 mg. 201 to 400 mg. 401 mg. or more Don't know

g) Zinc? No Yes → If yes, How many years? → 0-1 yr. 2-4 yrs. 5-9 yrs. 10+ yrs. Don't know

What dose per day? → Less than 25 mg. 25 to 74 mg. 75 to 100 mg. 101 mg. or more Don't know

h) Calcium? No Yes → If yes, How many years? → 0-1 yr. 2-4 yrs. 5-9 yrs. 10+ yrs. Don't know

What dose per day? → Less than 400 mg. 400 to 800 mg. 801 to 1300 mg. 1301 mg. or more Don't know

i) Are there other supplements that you take on a regular basis? Please mark if yes:

Folic acid Vitamin D B-Complex Vitamins Cod liver Oil Omega-3 Fatty-acids Iodine Copper Brewer's Yeast Beta-Carotene Magnesium Other (please specify): _____

3. For each food listed, fill in the circle indicating how often on average you have used the amount specified during the past year.

	AVERAGE USE LAST YEAR								
	Never, or less than once per month	1-3 per mo.	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-6 per day	8+ per day
DAIRY FOODS									
Skim or low fat milk (8 oz. glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Whole milk (8 oz. glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Cream, e.g. coffee, whipped (Tbs)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Sour cream (Tbs)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Non-dairy coffee whitener (tsp.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Sherbet or ice milk (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Ice cream (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Yogurt (1 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Cottage or ricotta cheese (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Cream cheese (1 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Other cheese, e.g. American, cheddar, etc., plain or as part of a dish (1 slice or 1 oz. serving)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Mergarine (pat), added to food or bread: exclude use in cooking	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Butter (pat), added to food or bread: exclude use in cooking	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					

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3. (Continued) Please fill in your average use, during the past year, of each specified food.

Please try to average your seasonal use of foods over the entire year. For example, if a food such as cantaloupe is eaten 4 times a week during the approximate 3 months that it is in season, then the average use would be once per week.

	Never, or less than once per month	1-3 per mo.	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day
FRUITS									
Raisins (1 oz. or small pack) or grapes	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Prunes (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Bananas (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Cantaloupe (1/2 melon)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Watermelon (1 slice)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Fresh apples or pears (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Apple juice or cider (small glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Oranges (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Orange juice (small glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Grapefruit (1/2)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Grapefruit juice (small glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Other fruit juices (small glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Strawberries, fresh, frozen or canned (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Blueberries, fresh, frozen or canned (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Peaches, apricots or plums (1 fresh, or 1/2 cup canned)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					

	Never, or less than once per month	1-3 per mo.	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day
VEGETABLES									
Tomatoes (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Tomato juice (small glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Tomato sauce (1/2 cup) e.g. spaghetti sauce	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Red chili sauce (1 Tbs)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Tofu or soybeans (3-4 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
String beans (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Broccoli (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Cabbage or cole slaw (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Cauliflower (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Brussels sprouts (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Carrots, raw (1/2 carrot or 2-4 sticks)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Carrots, cooked (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Corn (1 ear or 1/2 cup frozen or canned)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Peas, or lima beans (1/2 cup fresh, frozen, canned)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Mixed vegetables (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Beans or lentils, baked or dried (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Yellow (winter) squash (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Eggplant, zucchini, or other summer squash (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Yams or sweet potatoes (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Spinach, cooked (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Spinach, raw as in salad	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Kale, mustard or chard greens (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Iceberg or head lettuce (serving)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Romaine or leaf lettuce (serving)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Celery (4" stick)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Beets (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Alfalfa sprouts (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Garlic, fresh or powdered (1 clove or shake)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					

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	Never, or less than once per month	1-3 per mo.	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day
EGGS, MEAT, ETC.									
Eggs (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Chicken or turkey, with skin (4-6 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Chicken or turkey, without skin (4-6 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Bacon (2 slices)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Hot dogs (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					

3. (Continued) Please fill in your average use, during the past year, of each specified food.

	Never, or less than once per month	1-3 per mo.	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day
MEATS (CONTINUED)									
Processed meats, e.g. sausage, salami, bologna, etc. (piece or slice)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Liver (3-4 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Hamburger (1 patty)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Beef, pork, or lamb as a sandwich or mixed dish, e.g. stew, casserole, lasagne, etc.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Beef, pork, or lamb as a main dish, e.g. steak, roast, ham, etc. (4-6 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Canned tuna fish (3-4 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Dark meat fish, e.g. mackerel, salmon, sardines, bluefish, swordfish (3-5 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Other fish (3-5 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Shrimp, lobster, scallops as a main dish	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					

	Never, or less than once per month	1-3 per mo.	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day
BREADS, CEREALS, STARCHES									
Cold breakfast cereal (1 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Cooked oatmeal (1 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Other cooked breakfast cereal (1 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
White bread (slice), including pita bread	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Dark bread (slice)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
English muffins, bagels, or rolls (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Muffins or biscuits (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Brown rice (1 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
White rice (1 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Pasta, e.g. spaghetti, noodles, etc. (1 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Other grains, e.g. bulgur, kasha, couscous, etc. (1 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Pancakes or waffles (serving)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
French fried potatoes (4 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Potatoes, baked, boiled (1) or mashed (1 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Potato chips or corn chips (small bag or 1 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Crackers, Triskets, Wheat Thins (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Pizza (2 slices)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					

		Never, or less than once per month	1-3 per mo.	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day
BEVERAGES										
CARBONATED BEVERAGES	Low Calorie (sugar-free) types	Low calorie cola, e.g. Tab with caffeine	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>				
		Low calorie caffeine-free cola, e.g. Pepsi Free	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>				
		Other low calorie carbonated beverage, e.g. Fresca, Diet 7-Up, diet ginger ale	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>				
	Regular types (not sugar-free)	Coke, Pepsi, or other cola with sugar	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>				
		Caffeine Free Coke, Pepsi, or other cola with sugar	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>				
		Other carbonated beverage with sugar, e.g. 7-Up, ginger ale	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>				
OTHER BEVERAGES	Hawaiian Punch, lemonade, or other non-carbonated fruit drinks (1 glass, bottle, can)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	Decaffeinated coffee (1 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	Coffee (1 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	Tea (1 cup), not herbal teas	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	Beer (1 glass, bottle, can)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	Red wine (4 oz. glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	White wine (4 oz. glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Liquor, e.g. whiskey, gin, etc. (1 drink or shot)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		

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ID:

0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9

3. (Continued) Please fill in your average use during the past year of each specified food.

	Never, or less than once per month	1-3 per mo.	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day										
SWEETS, BAKED GOODS, MISCELLANEOUS																			
Chocolate (bars or pieces) e.g. Hershey's, M&M's	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Candy bars, e.g. Snickers, Milky Way, Reeses	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Candy without chocolate (1 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Cookies, home baked (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Cookies, ready made (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Brownies (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Doughnuts (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Cake, home baked (slice)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Cake, ready made (slice)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Sweet roll, coffee cake or other pastry, home baked (serving)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Sweet roll, coffee cake or other pastry, ready made (serving)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Pie, homemade (slice)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Pie, ready made (slice)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Jams, jellies, preserves, syrup, or honey (1 Tbs)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Peanut butter (Tbs)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Popcorn (1 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Nuts (small packet or 1 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Bran, added to food (1 Tbs)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Wheat germ (1 Tbs)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Chowder or cream soup (1 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Oil and vinegar dressing, e.g. Italian (1 Tbs)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Mayonnaise or other creamy salad dressing (1 Tbs)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Mustard, dry or prepared (1 tsp)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Pepper (1 shake)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															
Salt (1 shake)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>															

4. How much of the visible fat on your meats do you remove before eating?
 Remove all visible fat Remove small part of fat
 Remove majority Remove none
 (Don't eat meat)

5. What kind of fat do you usually use for frying and sautéing? (Exclude "Pam"-type spray)
 Real butter Vegetable oil Lard
 Margarine Vegetable shortening

6. What kind of fat do you usually use for baking?
 Real butter Vegetable oil Lard
 Margarine Vegetable shortening

7. What form of margarine do you usually use?
 None Stick Tub Spread
 Low-calorie stick Low-calorie tub

8. How often do you eat food that is fried at home? (Exclude the use of "Pam"-type spray)
 Daily 4-6 times per week
 1-3 times per week Less than once a week

9. How often do you eat fried food away from home? (e.g. french fries, fried chicken, fried fish)
 Daily 4-6 times per week
 1-3 times per week Less than once a week

10. How many teaspoons of sugar do you add to your beverages or food each day? _____ tsp.

11. What type of cooking oil do you usually use? _____
Specify type and brand

12. What kind of cold breakfast cereal do you usually use? _____
Specify type and brand

13. Are there any other important foods that you usually eat at least once per week?
 Include for example: pâté, tortillas, yeast, cream sauce, custard, horseradish, parsnips, rhubarb, radishes, fava beans, carrot juice, coconut, avocado, mango, papaya, dried apricots, dates, figs.
 (Do not include dry spices and do not list something that has been listed in the previous sections.)

	Other foods that you usually use at least once per week	Usual serving size	Servings per week
(a)			
(b)			
(c)	B-237		
(d)			

Project No: 4563

**Air Force Health Study
Third Followup Examinations
1992-1993**

Interval Supplementary Recording Book

OCCUPATIONAL EXPOSURE TO HEAVY METALS AND VIBRATING POWER TOOLS

THIS SECTION CONTAINS QUESTIONS IS1 - IS17

IS1. Now I am going to ask you a few questions about equipment or metals you may have been regularly exposed to at work in any of the jobs you have ever had, not just the recent one(s) that you just told me about.

First, in any job you have held, have you ever worked for 30 days or more with vibrating power equipment or tools?

YES 1
NO (SKIP TO Q.IS5) 2

IS2. In what year did you start working with vibrating power equipment or tools?

RECORD YEAR: 1 9 |__|__|

IS3. In what year did you last work with vibrating power equipment or tools?

RECORD YEAR: 1 9 |__|__|

IS4. For how many months in all did you work with vibrating power equipment or tools?

RECORD NUMBER OF MONTHS: |__|__|

IS5. In any job you have held, have you ever worked for 30 days or more with lead?

YES 1
NO (SKIP TO Q.IS9) 2

IS6. In what year did you start working with lead?

RECORD YEAR: 1 9 |__|__|

IS7. In what year did you last work with lead?

RECORD YEAR: 1 9 |__|__|

IS8. For how many months in all did you work with lead?

RECORD NUMBER OF MONTHS: |__|__|

IS9. In any job you have held, have you ever worked for 30 days or more with mercury--either metallic mercury or mercury vapor?

YES 1
NO (SKIP TO Q.IS13) 2

IS10. In what year did you start working with mercury?

RECORD YEAR: 1 9 |__|__|

IS11. In what year did you last work with mercury?

RECORD YEAR: 1 9 |__|__|

IS12. For how many months in all did you work with mercury?

RECORD NUMBER OF MONTHS: |__|__|

IS13. In any job you have held, have you ever worked for 30 days or more with any other heavy metal, such as chromium, nickel, or copper?

YES 1

(IF ANY CIVILIAN JOBS, RETURN TO SECTION C, Q.21, PAGE C-13 IN INTERVAL Q. IF NO CIVILIAN JOBS, RETURN TO SECTION D, Q.1, PAGE D-1 IN INTERVAL Q.)

NO 2

IS14. What (other) type(s) of heavy metals did you work with? CODE ALL THAT APPLY:

- CHROMIUM 01
- NICKEL 02
- COOPER 03
- CADMIUM 04
- MANGANESE 05
- ARSENIC 06
- SELENIUM 07
- MOLYBDENUM 08
- OTHER (SPECIFY) 97

IS15. In what year did you start working with one of these (other) heavy metals?

RECORD YEAR: 1 9 |__|__|

IS16. In what year did you last work with one of these (other) heavy metals?

RECORD YEAR: 1 9 |__|__|

IS17. For how many months in all did you work with one or more of these (other) heavy metals?

RECORD NUMBER OF MONTHS: |__|__| MONTHS

IF ANY CIVILIAN JOBS, RETURN TO SECTION C, Q.21 ON PAGE C-13 IN INTERVAL Q.
IF NO CIVILIAN JOBS, RETURN TO SECTION D, Q.1 ON PAGE D-1 IN INTERVAL Q.

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FAMILY HEALTH HISTORY
THIS SECTION CONTAINS QUESTIONS IS18 - IS24

IS18. The next few questions are about (other) possible medical conditions of your immediate family, that is, your biological mother, father, sisters, and brothers.

First, has anyone in your immediate family ever had diabetes or sugar diabetes? Do not count stepparents or adopted, step or half brothers and sisters.

- YES 1
- NO (SKIP TO Q. IS21) 2
- DON'T KNOW (SKIP TO Q. IS21) 8

IS19. Which members of your immediate family have or had diabetes? CODE ALL THAT APPLY.

- MOTHER 1
- FATHER 2
- SISTER(S) 3
- BROTHER(S) 4

IS20. Did any of these family members first have diabetes when they were younger than age 30?

- YES 1
- NO 2

IS21. Has anyone in your immediate family ever had heart trouble or heart disease? (Do not count stepparents or adopted, step or half brothers and sisters.)

- YES 1
- NO

(SKIP BACK TO SECTION F, Q.28
ON PAGE F-15 IN INTERVAL Q)

 2
- DON'T KNOW

(SKIP BACK TO SECTION F, Q.28
ON PAGE F-15 IN INTERVAL Q)

 8

IS22. Which members of your immediate family have or had heart trouble or heart disease? CIRCLE ALL THAT APPLY.

- MOTHER 1
- FATHER 2
- SISTER(S) 3
- BROTHER(S) 4

IS23. What type or types of heart trouble or heart disease did (he/she/they) have? CODE ALL THAT APPLY.

- HYPERTENSION OR HIGH BLOOD PRESSURE 1
 - A STROKE 2
 - A HEART ATTACK 3
 - OTHER HEART TROUBLE OR DISEASE 4
- SPECIFY: _____
- _____

IS24. Did any of these family members first have heart trouble or heart disease when they were younger than age 45?

- YES 1
- NO 2

SKIP BACK TO SECTION F, Q 28 ON PAGE F-15 IN THE INTERVAL QUESTIONNAIRE

DIABETES
THIS SECTION CONTAINS QUESTIONS IS25 - IS49

IS25. Have you ever been told by a doctor or other health professional, such as a nurse or physician's assistant, that you had diabetes or sugar diabetes? (Do not include pre-, potential, or borderline diabetes.)

YES 1

(SKIP BACK TO SECTION G, Q.37
ON PAGE G-14 IN INTERVAL Q)

NO 2

IS26. How old were you when the (doctor/health professional) first told you that you had diabetes?

YEARS OLD |__|__|

IS27. What is the full name and address of the doctor who first made the diagnosis, or the medical facility where the diagnosis was first made? REVIEW MEDICAL AUTHORIZATION FORMS. COMPLETE NEW MEDICAL AUTHORIZATION FORM, IF NECESSARY.

LAST NAME

FIRST NAME

OR

FACILITY NAME

STREET ADDRESS

CITY STATE

IS28. Have you ever been told that you have acidosis or ketoacidosis due to a high blood sugar level?

YES 1

NO 2

IS29. IF PARTICIPANT MENTIONED INSULIN AS ONE OF THE MEDICATIONS THAT HE IS CURRENTLY TAKING FOR HIS DIABETES IN RESPONSE TO QUESTION 36E IN SECTION G OF THE INTERVAL QUESTIONNAIRE, VERIFY THIS WITH PARTICIPANT, THEN CIRCLE "YES" FOR THIS QUESTION.

OTHERWISE ASK: Have you ever taken insulin injections?

YES 1
NO (SKIP TO Q. IS35) 2

IS30. Have you been taking insulin injections for most of the past 12 months?

YES 1
NO 2

IS31. IF PARTICIPANT MENTIONED INSULIN AS ONE OF THE MEDICATIONS THAT HE IS CURRENTLY TAKING FOR HIS DIABETES IN RESPONSE TO QUESTION 1E IN SECTION G OF THE INTERVAL QUESTIONNAIRE, VERIFY THIS WITH PARTICIPANT, THEN CIRCLE "YES" FOR THIS QUESTION.

OTHERWISE ASK: Are you now taking insulin injections?

YES 1
NO 2

IS32. How many years (have you been taking/did you take) insulin injections?

YEARS |__|__| [LESS THAN A YEAR = 00]

IS33. Have you ever had an insulin reaction?

YES 1
NO (SKIP TO Q. IS35) 2

IS34. About how many insulin reactions have you had during the past 12 months?

ENTER NUMBER: |__|__| [NONE = 00]

IS35. During the past 12 months, about how often, either on your own or with the help of a family member or friend, did you check your blood for glucose or sugar?

NEVER 0

TIMES PER DAY |__|__|__|

OR

TIMES PER WEEK |__|__|__|

OR

TIMES PER MONTH |__|__|__|

OR

TIMES PER YEAR |__|__|__|

IS36. In the past 12 months, about how many times has a health professional checked your blood for glucose or sugar?

TIMES |__|__| NONE = 00

IS37. IF PARTICIPANT HAS NEVER CHECKED HIS OWN BLOOD GLUCOSE OR SUGAR LEVEL OR HAD IT CHECK BY A PROFESSIONAL (HIS ANSWER TO QUESTION IS35 WAS "NEVER" AND HIS ANSWER TO QUESTION IS36 WAS "NONE") CIRCLE "0" (NO TEST IN PAST 12 MONTHS) FOR THIS QUESTION.

OTHERWISE ASK: Based on all your blood sugar tests during the past 12 months, how often would you say your blood sugar level has been too high? Would you say always, most of the time, some of the time, rarely, or never?

NO TEST IN PAST 12 MONTHS 0
ALWAYS 1
MOST OF THE TIME 2
SOME OF THE TIME 3
RARELY 4
NEVER 5

IS38. IF PARTICIPANT MENTIONED DIABETES PILLS (OR ORAL HYPOGLYCEMICS) AS MEDICATIONS THAT HE IS CURRENTLY TAKING FOR HIS DIABETES IN RESPONSE TO QUESTION 36E IN SECTION G OF THE INTERVAL QUESTIONNAIRE, VERIFY THIS WITH PARTICIPANT, THEN CIRCLE "YES" FOR THIS QUESTION.

OTHERWISE ASK: Have you ever taken diabetes pills?

YES 1
NO (SKIP TO Q. IS43) 2

IS39. Have you been taking diabetes pills most of the past 12 months?

YES 1
NO 2

IS40. IF PARTICIPANT MENTIONED DIABETES PILLS (OR ORAL HYPOGLYCEMICS) AS MEDICATIONS THAT HE IS CURRENTLY TAKING FOR HIS DIABETES IN RESPONSE TO QUESTION 1E IN SECTION G OF THE INTERVAL QUESTIONNAIRE, VERIFY THIS WITH PARTICIPANT, THEN CIRCLE "YES" FOR THIS QUESTION.

OTHERWISE ASK: Are you now taking diabetes pills?

YES 1
NO (SKIP TO Q. IS43) 2

IS41. IF PARTICIPANT GAVE YOU THE NAME OF THE MEDICINE IN QUESTION 1E IN SECTION G OF THE INTERVAL QUESTIONNAIRE, RECORD IT AGAIN BELOW.

OTHERWISE ASK: What is the name of the medicine that you are taking?

SPECIFY: _____

IS42. How many years (have you been taking/did you take) diabetes pills?

YEARS |__|__| LESS THAN A YEAR = 00

IS43. Has a doctor, nurse, or other health professional ever given you a diet or instructions on what foods to eat for your diabetes?

YES 1
NO (SKIP TO Q. IS46) 2

IS44. Do you now follow the diet or instructions for your diabetes?

YES 1
NO 2

IS45. How many years (have you been/were you) following a diet or instructions for your diabetes?

YEARS |__|__| LESS THAN A YEAR = 00

IS46. Do you carry or wear anything that identifies you as having diabetes?

YES 1
NO 2

IS47. IF PARTICIPANT WAS DIAGNOSED WITH DIABETES SINCE HIS LAST INTERVIEW, AND GAVE YOU THE DATE WHEN HE LAST SAW A DOCTOR ABOUT HIS DIABETES IN QUESTION 36F IN SECTION G OF THE INTERVAL QUESTIONNAIRE, CIRCLE THE CATEGORY BELOW THAT CONTAINS THAT DATE.

OTHERWISE ASK: When did you last see or talk to a doctor or other health professional about your diabetes?

DURING PAST 2 WEEKS 1
OVER 2 WEEKS TO 6 MONTHS 2
OVER 6 MONTHS TO 12 MONTHS 3
OVER 12 MONTHS TO 2 YEARS 4
OVER 2 YEARS TO 5 YEARS 5
OVER 5 YEARS AGO 6

(SKIP BACK TO SECTION G, Q.37 ON PAGE G-14 IN INTERVAL Q)
(SKIP BACK TO SECTION G, Q.37 ON PAGE G-14 IN INTERVAL Q)
(SKIP BACK TO SECTION G, Q.37 ON PAGE G-14 IN INTERVAL Q)

IS48. Was the doctor or other health professional pleased with the degree of control you have over the level of sugar or glucose in your blood?

YES 1
NO 2

IS49. About how many times a year do you see a doctor or other health professional about your diabetes?

LESS THAN ONCE A YEAR 1
ONCE A YEAR 2
TWICE A YEAR 3
3 TO 4 TIMES A YEAR 4
5 OR MORE TIMES A YEAR 5
NO REGULAR SCHEDULE 6

SKIP BACK TO SECTION G, Q.37 ON PAGE G-14 IN THE INTERVAL QUESTIONNAIRE.

HEPATITIS B

THIS SECTION CONTAINS QUESTION IS50

IS50. Vaccination against hepatitis B has been recommended for health care workers and others at risk for hepatitis B infection since a plasma-derived vaccine first became available in June 1982. The hepatitis B vaccine is different from the hepatitis A vaccine, because the hepatitis B is administered in the arm. Since June of 1982, have you ever been vaccinated against the hepatitis B virus (HBV)?

YES 1
NO 2

SKIP BACK TO SECTION G, Q.51 ON PAGE G-30 IN THE INTERVAL QUESTIONNAIRE

PAIN IN LEGS

THIS SECTION CONTAINS QUESTIONS IS51 - IS61

IS51. Do you get a pain in either or both of your legs while walking?

- YES 1
- NO (SKIP TO Q. IS61) 2

IS52. Does this pain ever begin when you are standing still or sitting?

- YES 1
- NO 2

(SKIP BACK TO SECTION G, Q.59
ON PAGE G-54 IN INTERVAL Q)

IS53. Do you get this pain in either or both of your calf muscles?

- YES 1

- NO 2

(SKIP BACK TO SECTION G, Q.59
ON PAGE G-54 IN INTERVAL Q)

IS54. Do you get it when you walk uphill or hurry?

- YES 1

- NO 2
- NEVER HURRIES OR WALKS UPHILL 0

(SKIP BACK TO SECTION G, Q.59
ON PAGE G-54 IN INTERVAL Q)

IS55. Do you get it when you walk at an ordinary pace on level ground?

- YES 1
- NO 2

IS56. Does the pain ever disappear while you are still walking?

- YES 1
- NO 2

PHYSICAL EXERCISE
THIS SECTION CONTAINS QUESTIONS IS62 - IS77

IS62. These next few questions are about physical exercise. INTERVIEWER: FROM OBSERVATION OR PREVIOUS INFORMATION, IS R PHYSICALLY HANDICAPPED?

- YES 1
- NO (SKIP TO Q. IS65) 2

IS63. HAND R CALENDAR. In the past two weeks, beginning Monday (DATE) and ending this past Sunday (DATE), have you done any exercises, sports, or physically active hobbies?

- YES 1
- NO (SKIP TO Q. IS69) 2
- DON'T KNOW (SKIP TO Q. IS69) 8

IS64. What were they? RECORD IN QUESTION IS65.

PROBE: Anything else?

READ ONLY CATEGORIES IN Q. IS65 THAT PARTICIPANT COULD PERFORM WITH HIS HANDICAP.

<p>IS65. HAND R CALENDAR. In the past two weeks (outlined on that calendar), beginning Monday (DATE) and ending this past Sunday (DATE), have you done any of the following exercises, sports, or physically active hobbies . . .</p> <p style="text-align: right;"><u>Yes</u> <u>No</u></p>	<p>IS66. How many times in the past 2 weeks did you [go/do] (ACTIVITY)?</p>	<p>IS67. On the average, how many minutes did you actually spend doing (ACTIVITY) each time?</p>	<p>IS68. What usually happened to your heart rate or breathing when you [did/went] (ACTIVITY)? Did you have a small, moderate, or large increase or no increase at all in your heartbreathing?</p> <p>(1 = SMALL, 2 = MODERATE, 3 = LARGE, 0 = NONE, 8 = DON'T KNOW)</p>
<p>A. Walking for exercise? 1 2</p>	<p style="text-align: center;">|_|_|</p>	<p style="text-align: center;">|_|_|</p>	<p style="text-align: center;">1 2 3 0 8</p>
<p>B. Gardening or yard work? 1 2</p>	<p style="text-align: center;">|_|_|</p>	<p style="text-align: center;">|_|_|</p>	<p style="text-align: center;">1 2 3 0 8</p>
<p>C. Stretching exercises? 1 2</p>	<p style="text-align: center;">|_|_|</p>	<p style="text-align: center;">|_|_|</p>	
<p>D. Weightlifting or other exercises to increase muscle strength? 1 2</p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;">1 2 3 0 8</p>
<p>E. Jogging or running? 1 2</p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;">1 2 3 0 8</p>
<p>F. Hiking? 1 2</p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;">1 2 3 0 8</p>

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<p>IS65. HAND R CALENDAR. In the past two weeks (outlined on that calendar), beginning Monday (DATE) and ending this past Sunday (DATE), have you done any of the following exercises, sports, or physically active hobbies . . .</p> <p style="text-align: right;"><u>Yes</u> <u>No</u></p>	<p>IS66. How many times in the past 2 weeks did you [go/do] (ACTIVITY)?</p>	<p>IS67. On the average, how many minutes did you actually spend doing (ACTIVITY) each time?</p>	<p>IS68. What usually happened to your heart rate or breathing when you [did/went] (ACTIVITY)? Did you have a small, moderate, or large increase or no increase at all in your heartbreathing?</p> <p>(1 = SMALL, 2 = MODERATE, 3 = LARGE, 0 = NONE, 8 = DON'T KNOW)</p>
<p>G. Aerobics or aerobic dancing?</p> <p style="text-align: right;">1 2</p>	<p style="text-align: center;">|_|_|</p>	<p style="text-align: center;">|_|_|</p>	<p style="text-align: center;">1 2 3 0 8</p>
<p>H. Calisthenics or general exercise?</p> <p style="text-align: right;">1 2</p>	<p style="text-align: center;">|_|_|</p>	<p style="text-align: center;">|_|_|</p>	<p style="text-align: center;">1 2 3 0 8</p>
<p>I. Riding a bicycle or exercise bike?</p> <p style="text-align: right;">1 2</p>	<p style="text-align: center;">|_|_|</p>	<p style="text-align: center;">|_|_|</p>	<p style="text-align: center;">1 2 3 0 8</p>
<p>J. Stair climbing?</p> <p style="text-align: right;">1 2</p>	<p style="text-align: center;">|_|_|</p>	<p style="text-align: center;">|_|_|</p>	<p style="text-align: center;">1 2 3 0 8</p>
<p>K. Swimming for exercise?</p> <p style="text-align: right;">1 2</p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;">1 2 3 0 8</p>
<p>L. Playing tennis?</p> <p style="text-align: right;">1 2</p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;">1 2 3 0 8</p>
<p>M. Bowling?</p> <p style="text-align: right;">1 2</p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;">1 2 3 0 8</p>

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IS65. HAND R CALENDAR. In the past two weeks (outlined on that calendar), beginning Monday (DATE) and ending this past Sunday (DATE), have you done any of the following exercises, sports, or physically active hobbies . . . <div style="text-align: right;"> Yes No </div>	IS66. How many times in the past 2 weeks did you [go/do] (ACTIVITY)?	IS67. On the average, how many minutes did you actually spend doing (ACTIVITY) each time?	IS68. What usually happened to your heart rate or breathing when you [did/went] (ACTIVITY)? Did you have a small, moderate, or large increase or no increase at all in your heartbreathing? (1 = SMALL, 2 = MODERATE, 3 = LARGE, 0 = NONE, 8 = DON'T KNOW)
N. Playing golf?	|_|_|		
O. Playing baseball or softball?	|_|_|	|_|_|	1 2 3 0 8
P. Playing handball, racquetball, or squash?	_ _	_ _	1 2 3 0 8
Q. Skiing? (1) Downhill?	_ _		
(2) Cross-country?	_ _	_ _	1 2 3 0 8
R. Water skiing?	_ _		

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<p>IS65. HAND R CALENDAR. In the past two weeks (outlined on that calendar), beginning Monday (DATE) and ending this past Sunday (DATE), have you done any of the following exercises, sports, or physically active hobbies . . .</p> <p style="text-align: right;"><u>Yes</u> <u>No</u></p>	<p>IS66. How many times in the past 2 weeks did you [go/do] (ACTIVITY)?</p>	<p>IS67. On the average, how many minutes did you actually spend doing (ACTIVITY) each time?</p>	<p>IS68. What usually happened to your heart rate or breathing when you [did/went] (ACTIVITY)? Did you have a small, moderate, or large increase or no increase at all in your heartbreathing?</p> <p>(1 = SMALL, 2 = MODERATE, 3 = LARGE, 0 = NONE, 8 = DON'T KNOW)</p>
<p>S. Playing basketball? 1 2</p>	<p style="text-align: center;">|_|_|</p>	<p style="text-align: center;">|_|_|</p>	<p style="text-align: center;">1 2 3 0 8</p>
<p>T. Playing volleyball? 1 2</p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;">1 2 3 0 8</p>
<p>U. Playing soccer? 1 2</p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;">1 2 3 0 8</p>
<p>V. Playing football? 1 2</p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;">1 2 3 0 8</p>

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<p>IS65. HAND R CALENDAR. In the past two weeks (outlined on that calendar), beginning Monday (DATE) and ending this past Sunday (DATE), have you done any of the following exercises, sports, or physically active hobbies . . .</p> <p style="text-align: center;"><u>Yes</u> <u>No</u></p>	<p>IS66. How many times in the past 2 weeks did you [go/do] (ACTIVITY)?</p>	<p>IS67. On the average, how many minutes did you actually spend doing (ACTIVITY) each time?</p>	<p>IS68. What usually happened to your heart rate or breathing when you [did/went] (ACTIVITY)? Did you have a small, moderate, or large increase or no increase at all in your heartbreathing?</p> <p>(1 = SMALL, 2 = MODERATE, 3 = LARGE, 0 = NONE, 8 = DON'T KNOW)</p>
<p>W. Have you done any (other) exercises, sports, or physically active hobbies in the past 2 weeks?</p> <p>(1) What were they? Anything else? IF LISTED ACTIVITY, MARK "YES" FOR THAT ACTIVITY. OTHERWISE, SPECIFY:</p> <p>_____</p>	<p style="text-align: center;"> _ _ </p> <p style="text-align: center;"> _ _ </p>	<p style="text-align: center;"> _ _ </p> <p style="text-align: center;"> _ _ </p>	<p style="text-align: center;">1 2 3 0 8</p> <p style="text-align: center;">1 2 3 0 8</p>
<p>(2) Anything else? IF "YES", CIRCLE AND SPECIFY:</p> <p>_____</p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;"> _ _ </p>	<p style="text-align: center;">1 2 3 0 8</p>

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IS69. Overall, was the amount of physical exercise you did over the past two weeks fairly typical for you? That is, would you say that you were physically more active, less active, or about as active as you usually are during a typical two week period?

- MORE ACTIVE 1
- LESS ACTIVE 2
- ABOUT AS ACTIVE 3

IS70. Do you exercise or play sports regularly?

- YES 1
- NO (SKIP TO Q. IS72) 2

IS71. For how long have you exercised or played sports regularly? RECORD NUMBER AND CIRCLE APPROPRIATE UNIT OF TIME:

- |_|_|_|
- DAYS 1
 - WEEKS 2
 - MONTHS 3
 - YEARS 4

IS72. Would you say that you are physically more active, less active, or about as active as other persons your age?

- MORE ACTIVE 1
- LESS ACTIVE (SKIP TO Q. IS73B) 2
- ABOUT AS ACTIVE (SKIP TO Q. IS74) 3

IS73A. Is that a lot more active or a little more active?

- A LOT MORE (SKIP TO Q. IS74) 1
- A LITTLE MORE (SKIP TO Q. IS74) 2

IS73B. Is that a lot less active or a little less active?

- A LOT LESS 3
- A LITTLE LESS 4

IS74. IF R IS NOT CURRENTLY WORKING, SKIP TO Q. IS76.

OTHERWISE ASK: How much hard physical work is required on your (current) job? Would you say a great deal, a moderate amount, a little, or none?

- GREAT DEAL 1
- MODERATE AMOUNT 2
- A LITTLE 3
- NONE 4

(SKIP BACK TO SECTION J, Q.1
ON PAGE J-1 IN INTERVAL Q)

IS75. About how many hours per day do you perform hard physical work on your job?

HOURS PER DAY |__|__|

SKIP BACK TO SECTION J, Q.1 ON PAGE J-1 IN THE INTERVAL QUESTIONNAIRE

IS76. How much hard physical exercise is required in your main daily activity? Would you say a great deal, a moderate amount, a little, or none?

- GREAT DEAL 1
- MODERATE AMOUNT 2
- A LITTLE 3
- NONE 4

(SKIP BACK TO SECTION J, Q.1
ON PAGE J-1 IN INTERVAL Q)

IS77. About how many hours per day do you perform hard physical work in your main daily activity?

HOURS PER DAY |__|__|

SKIP BACK TO SECTION J, Q.1 ON PAGE J-1 IN THE INTERVAL QUESTIONNAIRE