

PROXY (PRIMARY/SECONDARY) 1

SECTION B: HEALTH STATUS

B1. Next I have some questions about your health. Would you say your health is excellent, very good, good, fair, or poor?

| | | | | |
|--------------|-----------------|---------|---------|---------|
| 1. EXCELLENT | 2. VERY GOOD | 3. GOOD | 4. FAIR | 5. POOR |
|--------------|-----------------|---------|---------|---------|

B2. Compared with 1 year ago, would you say that your health is much better now, somewhat better now, about the same, somewhat worse, or much worse than it was then?

| | | | | |
|-------------------|-----------------------|---------|----------------------|------------------|
| 1. MUCH BETTER | 2. SOMEWHAT BETTER | 3. SAME | 4. SOMEWHAT WORSE | 5. MUCH WORSE |
|-------------------|-----------------------|---------|----------------------|------------------|

B3. What about your emotional health--how good you feel or how stressed, anxious or depressed you feel? Is it excellent, very good, good, fair, or poor?

| | | | | |
|--------------|--------------|---------|---------|---------|
| 1. EXCELLENT | 2. VERY GOOD | 3. GOOD | 4. FAIR | 5. POOR |
|--------------|--------------|---------|---------|---------|

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B4. (RB, TOP OF P. 1) We are interested in how much difficulty people have with various activities because of a health or physical problem. Please look at the answer categories at the top of page one of the booklet and tell me how difficult each activity is for you. Exclude any difficulties that you expect to last less than three months.

| How difficult is it for you to... | NOT AT ALL DIFFICULT (1) | A LITTLE DIFFICULT (2) | SOMEWHAT DIFFICULT (3) | VERY DIFFICULT/CAN'T DO (4) | DON'T DO (6) |
|---|--------------------------|------------------------|------------------------|-----------------------------|--------------|
| B4a. ...run or jog about a mile? (Is this not at all difficult, a little difficult, somewhat difficult, very difficult, or something that you can't do at all?) | GO TO B4e | | | | |
| B4b. ...walk several blocks? | GO TO B4e | | | | |
| B4c. ...walk one block? | GO TO B4e | | | | |
| B4d. ...walk across a room? | | | | | |
| B4e. ...sit for about 2 hours? | | | | | |
| B4f. ...get up from a chair after sitting for long periods? | | | | | |
| B4g. ...get in and out of bed without help? | | | | | |
| B4h. How difficult is it for you to climb several flights of stairs without resting? | GO TO B4k | | | | |
| B4j. ...climb one flight of stairs without resting? | | | | | |
| B4k. ...lift or carry weights <u>over</u> 10 pounds, like a heavy bag of groceries? | | | | | |
| B4m. How difficult is it for you to stoop, kneel, or crouch? | | | | | |
| B4n. ...pick up a dime from a table? | | | | | |

| How difficult is it for you to... | NOT AT ALL DIFFICULT (1) | A LITTLE DIFFICULT (2) | SOMEWHAT DIFFICULT (3) | VERY DIFFICULT/CAN'T DO (4) | DON'T DO (6) |
|--|--------------------------|------------------------|------------------------|-----------------------------|--------------|
| B4p. ...bathe or shower without help? | | | | | |
| B4q. ...reach or extend your arms above shoulder level? | | | | | |
| B4r. ...pull or push large objects like a living room chair? | | | | | |
| B4s. ...eat without help? | | | | | |
| B4t. ...dress without help? | | | | | |

B5. (RB, STILL ON TOP OF P. 1) Here are some other activities that people may have difficulty with.

| How difficult is it for you to... | NOT AT ALL DIFFICULT (1) | A LITTLE DIFFICULT (2) | SOMEWHAT DIFFICULT (3) | VERY DIFFICULT/CAN'T DO (4) | DON'T DO (6) |
|---|--------------------------|------------------------|------------------------|-----------------------------|--------------|
| B5a. ...use a map to figure out how to get around in a strange place? | | | | | |
| B5b. ...use a microwave oven after reading the instructions? | | | | | |
| B5c. ...use a calculator to help balance your checkbook? | | | | | |
| B5d. ...use a computer or wordprocessor? | | | | | |

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B6. Now, not using the booklet, has a doctor ever told you that you have high blood pressure or hypertension?

1. YES 5. NO —GO TO B7

V

B6a. Are you taking medication for your blood pressure now?

1. YES 5. NO

B6b. Do you have high blood pressure or hypertension at the present time?

1. YES 5. NO 2. CONTROLLED BY MEDICINE [VOL]

B7. (Has a doctor ever told you that you have) Diabetes or high blood sugar?

1. YES 5. NO —NEXT PAGE, B9

V

B7a. In what year was that first diagnosed? _____ YEAR

B7b. Have you ever been hospitalized because of your diabetes or high blood sugar?

1. YES 5. NO

B7c. Do you have diabetes now?

1. YES 5. NO

B7d. During the last 12 months, have you seen a doctor for your diabetes?

1. YES 5. NO

B8. Are you now using any of the following to treat or control your diabetes?

| | YES (1) | NO (5) |
|-----------------------------------|------------|-----------|
| B8a. A special diet? | | |
| B8b. Weight loss? | | |
| B8c. Medication that you swallow? | | |
| B8d. Insulin injection? | | |

B9. (Has a doctor ever told you that you have) Cancer or a malignant tumor of any kind except skin cancer?

1. YES

5. NO

NEXT PAGE, B15

∨

B9a. How many such cancers have you had?

OF CANCERS

| | ONLY OR MOST RECENT CANCER | SECOND MOST RECENT CANCER |
|--|--|--|
| B10. In what year was your (most recent/next most recent) cancer diagnosed? | _____ YEAR | _____ YEAR |
| B11. In which organ or part of your body did this cancer occur? | _____ ORGAN/PART OF BODY | _____ ORGAN/PART OF BODY |
| B12. During the last 12 months, have you seen a doctor about this cancer? | <input type="checkbox"/> 1. YES <input type="checkbox"/> 5. NO | <input type="checkbox"/> 1. YES <input type="checkbox"/> 5. NO |
| B13. During the last 12 months, what sort of treatments have you received for this cancer? [CHECK ALL THAT APPLY.] | <input type="checkbox"/> A. CHEMOTHERAPY/ MEDICATION <input type="checkbox"/> B. SURGERY OR BIOPSY <input type="checkbox"/> C. RADIATION/ X-RAY <input type="checkbox"/> D. OTHER (SPECIFY:) _____ <input type="checkbox"/> NONE | <input type="checkbox"/> A. CHEMOTHERAPY/ MEDICATION <input type="checkbox"/> B. SURGERY OR BIOPSY <input type="checkbox"/> C. RADIATION/ X-RAY <input type="checkbox"/> D. OTHER (SPECIFY:) _____ <input type="checkbox"/> NONE |
| B14. INTERVIEWER CHECKPOINT | SEE B9a <input type="checkbox"/> TWO OR MORE CANCERS—GO BACK TO B10, SECOND MOST RECENT CANCER <input type="checkbox"/> ALL OTHERS -->NEXT PAGE, B15 | |

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B15. Not including asthma, has a doctor ever told you that you have chronic lung disease such as chronic bronchitis or emphysema?

1. YES 5. NO —GO TO B16
 ↓
 V

| | YES (1) | NO (5) |
|--|------------|-----------|
| B15a. Are you taking medication or other treatments for your lung condition? | | |
| B15b. Are you sometimes short of breath because of your lung condition? | | |
| B15c. Do you sometimes have wheezing or persistent cough, or bring up phlegm because of your lung condition? | | |
| B15d. Does your condition limit your usual activities such as household chores or going to work? | | |

B16. (Has a doctor ever told you that you had) A heart attack, coronary heart disease, angina, congestive heart failure, or other heart problems?

1. YES 5. NO —TURN TO P.12, B22
 ↓
 V

B16a. Did you have a heart attack or myocardial infarction?

1. YES 5. NO —GO TO B17
 ↓
 V

B16b. In what year did you have your (last) heart attack or myocardial infarction?

_____ YEAR

B17. Do you currently have any angina or chest pains due to your heart?

1. YES 5. NO —NEXT PAGE, B18
 ↓
 V

B17a. Are you taking or carrying any medications because of your chest pain?

1. YES 5. NO

B18. Has a doctor ever told you that you have congestive heart failure?

1. YES

5. NO —GO TO B19

↓
V

B18a. Are you taking any medications for this?

1. YES

5. NO

B18b. Does your congestive heart failure sometimes cause you to be weak or short of breath?

1. YES

5. NO

B19. During the last 12 months, have you seen a doctor for any of your heart problems?

1. YES

5. NO

B20. Have you ever had a special test or treatment of your heart where tubes were inserted into your veins or arteries (cardiac catheterization, coronary angiogram or angioplasty)?

1. YES

5. NO

B21. Have you ever had surgery on your heart?

1. YES

5. NO

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B22. Has a doctor ever told you that you had a stroke?

| | | |
|---------------------------------|--------------------------------|------------|
| <input type="checkbox"/> 1. YES | <input type="checkbox"/> 5. NO | —GO TO B23 |
| ↓ | | |
| V | | |

B22a. In what year did you last have a stroke?

_____ YEAR

B22b. Do you still have any remaining health problems because of your stroke, such as muscle weakness or difficulty speaking?

| | |
|---------------------------------|--------------------------------|
| <input type="checkbox"/> 1. YES | <input type="checkbox"/> 5. NO |
|---------------------------------|--------------------------------|

B22c. During the last 12 months, have you seen a doctor because of your stroke?

| | |
|---------------------------------|--------------------------------|
| <input type="checkbox"/> 1. YES | <input type="checkbox"/> 5. NO |
|---------------------------------|--------------------------------|

B22d. Are you taking any medications because of your stroke and its complications?

| | |
|---------------------------------|--------------------------------|
| <input type="checkbox"/> 1. YES | <input type="checkbox"/> 5. NO |
|---------------------------------|--------------------------------|

B23. (Has a doctor ever told you that you had) Emotional, nervous, or psychiatric problems?

| | |
|---------------------------------|--------------------------------|
| <input type="checkbox"/> 1. YES | <input type="checkbox"/> 5. NO |
|---------------------------------|--------------------------------|

B24. During the last 12 months, have you had any emotional, nervous, or psychiatric problems?

| | | |
|---------------------------------|--------------------------------|-----------------|
| <input type="checkbox"/> 1. YES | <input type="checkbox"/> 5. NO | —NEXT PAGE, B25 |
| ↓ | | |
| V | | |

B24a. Do you now get psychiatric or psychological treatment for your problems?

| | |
|---------------------------------|--------------------------------|
| <input type="checkbox"/> 1. YES | <input type="checkbox"/> 5. NO |
|---------------------------------|--------------------------------|

B24b. Do you now use tranquilizers, antidepressants, or pills for nerves?

| | |
|---------------------------------|--------------------------------|
| <input type="checkbox"/> 1. YES | <input type="checkbox"/> 5. NO |
|---------------------------------|--------------------------------|

B25. Have you ever had, or has a doctor ever told you that you have, arthritis or rheumatism?

1. YES 5. NO — GO TO B26
 ↓
 V

| | |
|--|--------------------------------|
| B25a. Do you sometimes have pain, stiffness, or swelling in your joints? | |
| <input type="checkbox"/> 1. YES | <input type="checkbox"/> 5. NO |
| B25b. Are you currently taking any medication or other treatments for your arthritis or rheumatism? | |
| <input type="checkbox"/> 1. YES | <input type="checkbox"/> 5. NO |
| B25c. During the last 12 months, have you seen a doctor specifically for your arthritis or rheumatism? | |
| <input type="checkbox"/> 1. YES | <input type="checkbox"/> 5. NO |

B26. Do you have any of the following health problems?

| | YES (1) | NO (5) |
|---|------------|-----------|
| B26a. Asthma? | | |
| B26b. Problems with your back? | | |
| B26c. Problems with your feet and legs? | | |
| B26d. Kidney or bladder problems? | | |
| B26e. Stomach or intestinal ulcers? | | |
| B26f. High cholesterol? | | |

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B27. Have you had a fracture or broken bone since you were 45 years old?

| | | |
|--------|-------|------------------------------|
| 1. YES | 5. NO | 0. R IS NOT YET 45 YEARS OLD |
|--------|-------|------------------------------|

GO TO B28

V

B27a. In what year did you last break a bone?

YEAR

B28. Have you ever been unconscious due to a head injury?

| | | |
|--------|-------|---------------|
| 1. YES | 5. NO | 8. DON'T KNOW |
|--------|-------|---------------|

B29. Are you often troubled with pain?

| | | |
|--------|-------|---------------|
| 1. YES | 5. NO | 8. DON'T KNOW |
|--------|-------|---------------|

NEXT PAGE, B30

V

B29a. When the pain is at its worst, is it mild, moderate, or severe?

| | | |
|---------|-------------|-----------|
| 1. MILD | 2. MODERATE | 3. SEVERE |
|---------|-------------|-----------|

GO TO B29c

V

B29b. How bad is the pain most of the time: mild, moderate or severe?

| | | |
|---------|-------------|-----------|
| 1. MILD | 2. MODERATE | 3. SEVERE |
|---------|-------------|-----------|

B29c. Does the pain make it difficult for you to do normal work?

| | |
|--------|-------|
| 1. YES | 5. NO |
|--------|-------|

B29d. Is any of the pain in your lower back?

| | |
|--------|-------|
| 1. YES | 5. NO |
|--------|-------|

NEXT PAGE, B30

B29e. Does your back pain ever get severe enough for you to miss work?

| | | |
|--------|-------|------------------------|
| 1. YES | 5. NO | 6. NOT WORKING FOR PAY |
|--------|-------|------------------------|

B29f. Is your back pain due to a slipped disk, is it due to arthritis, or is it due to some other condition?

| | | |
|------------------|---------------|-------------------------------|
| 01. SLIPPED DISK | 02. ARTHRITIS | 97. OTHER (SPECIFY:) _____ |
|------------------|---------------|-------------------------------|

B30. Do you usually spend more than 10 minutes a day on your own health problems or conditions, such as preparing and taking medicines, applying treatments, taking care of surgical problems or doing any kind of rehabilitation?

 1. YES

 5. NO ---->GO TO B31

↓

B30a. On average, how many minutes a day do you spend on this?

_____ MINUTES/DAY

 998. DON'T KNOW

B31. Do you wear eyeglasses or contact lenses?

 1. YES

 5. NO

B32. (With your glasses) Is your eyesight excellent, very good, good, fair, or poor?

 1. EXCELLENT

 2. VERY GOOD

 3. GOOD

 4. FAIR

 5. POOR

B33. Do you wear a hearing aid?

 1. YES

 5. NO ---->GO TO B34

B33a. How often do you usually wear a hearing aid these days--almost always, often, sometimes, or almost never?

 1. ALMOST
ALWAYS

 2. OFTEN

 3. SOMETIMES

 4. ALMOST
NEVER

B34. (Using your hearing aid) Is your hearing excellent, very good, good, fair, or poor?

 1. EXCELLENT

 2. VERY GOOD

 3. GOOD

 4. FAIR

 5. POOR

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B35. Have you ever smoked cigarettes?

1. YES

5. NO

---->GO TO B36

DEFINITION: BY SMOKING WE MEAN MORE THAN 100 CIGARETTES IN R'S LIFETIME; DO NOT INCLUDE PIPES OR CIGARS.

B35a. Do you smoke cigarettes now?

1. YES 5. NO ---->GO TO B35c

V

B35b. About how many cigarettes or packs do you usually smoke in a day now? [ACCEPT A RANGE]

OR

_____ _____
CIGARETTES/DAY PACKS/DAY

GO TO B36

B35c. About how many years ago did you stop smoking?

_____ YEARS AGO 96. LESS THAN 1 YEAR AGO

B35d. When you were smoking the most, about how many cigarettes or packs did you usually smoke in a day? [ACCEPT A RANGE]

OR

_____ _____
CIGARETTES/DAY PACKS/DAY

B36. Do you ever drink any alcoholic beverages such as beer, wine, or liquor?

1. YES

5. NO

NEXT PAGE, B37a

V

B36a. In general, do you have less than one drink a day, one to two drinks a day, three or four drinks a day, or five or more drinks a day?

1. LESS THAN ONE A DAY

2. 1-2 A DAY

3. 3-4 A DAY

4. 5 OR MORE A DAY

| | YES (1) | NO (5) |
|---|------------|-----------|
| B37a. Have you <u>ever</u> felt you should cut down on your drinking? | | |
| B37b. Have people <u>ever</u> annoyed you by criticizing your drinking? | | |
| B37c. Have you <u>ever</u> felt bad or guilty about drinking? | | |
| B37d. Have you <u>ever</u> taken a drink first thing in the morning to steady your nerves or get rid of a hangover? | | |

B38. (RB, BOTTOM OF P. 1) The next few questions are about exercise. Looking at the answer categories at the bottom of page 1, how often do you participate in light physical activity--such as walking, dancing, gardening, golfing, bowling, etc.? (Would you say 3 or more times a week, 1 or 2 times a week, 1 to 3 times a month, less than once a month, or never?)

- 1. 3+ TIMES
A WEEK
- 2. 1-2 TIMES
A WEEK
- 3. 1 TO 3 TIMES
A MONTH
- 4. LESS THAN
ONCE A
MONTH
- 5. NEVER

B39. (RB, STILL ON BOTTOM OF P. 1) How often do you participate in vigorous physical exercise or sports--such as aerobics, running, swimming, or bicycling? (Would you say 3 or more times a week, 1 or 2 times a week, 1 to 3 times a month, less than once a month, or never?)

- 1. 3+ TIMES
A WEEK
- 2. 1-2 TIMES
A WEEK
- 3. 1 TO 3 TIMES
A MONTH
- 4. LESS THAN
ONCE A
MONTH
- 5. NEVER

B40. (RB, STILL ON BOTTOM OF P. 1) How often do you do heavy housework like scrubbing floors or washing windows?

- 1. 3+ TIMES
A WEEK
- 2. 1-2 TIMES
A WEEK
- 3. 1 TO 3 TIMES
A MONTH
- 4. LESS THAN
ONCE A
MONTH
- 5. NEVER

B41. (Not using the booklet,) About how much do you weigh? _____
POUNDS

B42. How much did you weigh a year ago?

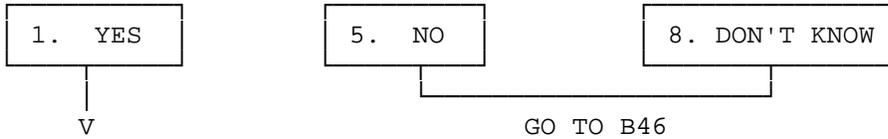
_____ 998. DK
POUNDS

B43. About how tall are you? _____

B44. (RB, TOP OF P. 2) Please look at the top of page 2 of the booklet and tell me how often you have experienced the following feelings during the past week--all or almost all of the time, most of the time, some of the time, or none or almost none of the time.

| | ALL OR ALMOST ALL (1) | MOST OF THE TIME (2) | SOME OF THE TIME (3) | NONE OR ALMOST NONE (4) |
|--|--------------------------------|----------------------------|----------------------------|----------------------------------|
| B44a. During the past week, I felt depressed. (All or almost all of the time, most of the time, some of the time, or none or almost none of the time?) | | | | |
| B44b. I felt that everything I did was an effort. | | | | |
| B44c. My sleep was restless. | | | | |
| B44d. (During the past week) I was happy. | | | | |
| B44e. I felt lonely. | | | | |
| B44f. I felt people were unfriendly. | | | | |
| B44g. I enjoyed life. | | | | |
| B44h. (During the past week) I felt sad. | | | | |
| B44j. I felt that people disliked me. | | | | |
| B44k. I could not "get going." | | | | |
| B44m. I did not feel like eating; my appetite was poor. | | | | |
| B44n. (During the past week) I had a lot of energy. | | | | |
| B44p. I felt tired. | | | | |
| B44q. I felt really rested when I woke up in the morning. | | | | |

B45. During the last 12 months, since (MONTH) of 1991, have you been a patient in a hospital overnight?



B45a. How many times were you a patient in a hospital overnight?

_____ NUMBER OF TIMES

↓
V

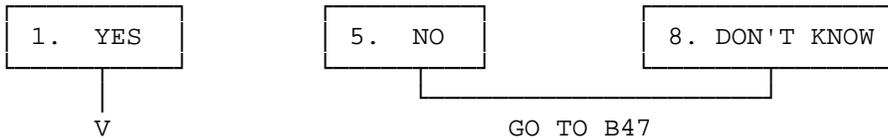
98. DON'T KNOW
GO TO B46

B45b. Altogether, how many nights were you a patient in a hospital in the last 12 months?

_____ NIGHTS OR _____ WKS OR _____ MOS.

998. DON'T KNOW

B46. During the last 12 months, have you been a patient in a nursing home overnight?



B46a. How many times were you a patient in a nursing home overnight?

_____ NUMBER OF TIMES

↓
V

98. DON'T KNOW
GO TO B47

B46b. Altogether, how many nights were you a patient in a nursing home in the last 12 months?

_____ NIGHTS OR _____ WKS OR _____ MOS

998. DON'T KNOW

B47. (Not counting overnight hospital or nursing home stays) During the last 12 months, since (MONTH) of 1991, how many times have you seen or talked to a medical doctor about your health, including emergency room or clinic visits?

00. NONE _____ NUMBER OF TIMES 98. DON'T KNOW

DEFINITION: DOCTORS INCLUDE SPECIALISTS SUCH AS DERMATOLOGISTS, PSYCHIATRISTS, OPHTHALMOLOGISTS, AS WELL AS GENERAL PRACTITIONERS AND OSTEOPATHS.

B48. (Aside from any hospital or nursing home stays) How many days did you stay in bed more than half the day because of illness or injury during the last 12 months?

00. NONE _____ DAYS OR _____ WKS OR _____ MOS 998. DON'T KNOW

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B49. During the last 12 months, [since (MONTH) of 1991], did you require any professional nursing care in your own home?

1. YES

5. NO

8. DON'T KNOW

↓
V

NEXT PAGE, SECTION D

B49a. On how many days in the last 12 months did you have home nursing care?

_____ DAYS OR _____ WKS OR _____ MOS

998. DON'T KNOW