

IN CONFIDENCE



POPULATION SURVEY

NATIONAL HEALTH SURVEY 2001

CHILD'S FORM

Interviewer: Commence interview at Q.19

PSU, BLOCK, DWELLING, HH, PERSON identification fields with bubble grids.

1. OFFICE USE ONLY with bubble grid for digits 02-12.

2. SEX with bubbles for Male (1) and Female (2).

3. AGE Years ... with bubbles for years and months.

4. DATE OF BIRTH with fields for DD, MM, YYYY and bubble grids.

5. INDIGENOUS STATUS with bubbles for Neither, Aboriginal, Torres Strait Islander, Both.

6. COUNTRY OF BIRTH with bubbles for Australia, England, New Zealand, Italy, Viet Nam, Scotland, Greece, Germany, Philippines, Netherlands, and Other.

7. YEAR OF ARRIVAL with bubbles for years 19 and 20.

<p>10. HOUSEHOLD TYPE</p> <p>1 (Nothing further) ... <input type="checkbox"/> 1</p> <p>2 <input type="checkbox"/> 2</p> <p>3 <input type="checkbox"/> 3</p> <p>4 <input type="checkbox"/> 4</p> <p>5 <input type="checkbox"/> 5</p> <p>6 (Complete Q.12) ... <input type="checkbox"/> 6</p> <p>7 (Complete Q.12) ... <input type="checkbox"/> 7</p> <p>8 (Complete Q.12) ... <input type="checkbox"/> 8</p> <p>9 (Complete Q.13) ... <input type="checkbox"/> 9</p>	16. OFFICE USE ONLY (CHILD)				
<p>11. Husband (Complete Q.14) ... <input type="checkbox"/> 1</p> <p>Wife (Complete Q.14) ... <input type="checkbox"/> 2</p> <p>Son/daughter (Complete Q.14) ... <input type="checkbox"/> 3</p>	<p>A Relationship</p> <p><input type="checkbox"/> 0 <input type="checkbox"/> 0</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2 <input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6</p> <p><input type="checkbox"/> 7</p> <p><input type="checkbox"/> 8</p> <p><input type="checkbox"/> 9</p>	<p>B Family Number</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6</p> <p><input type="checkbox"/> 7</p> <p><input type="checkbox"/> 8</p> <p><input type="checkbox"/> 9</p>	<p>C UR Scope Exclusion</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p>	<p>D Initial Schedule Response</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6</p>	<p>E Incomplete Schedule Response</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6</p>
<p>12. Father/mother (Complete Q.14) ... <input type="checkbox"/> 1</p> <p>Son/daughter (Complete Q.14) ... <input type="checkbox"/> 2</p>	<p>F Income</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p>	<p>G Compulsion Queried</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p>	<p>H Number of people aged 0-6 in household</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6</p> <p><input type="checkbox"/> 7</p> <p><input type="checkbox"/> 8</p> <p><input type="checkbox"/> 9</p>	<p>I Number of people aged 7-14 in household</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6</p> <p><input type="checkbox"/> 7</p> <p><input type="checkbox"/> 8</p> <p><input type="checkbox"/> 9</p>	<p>J Number of people aged 15-17 in household</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6</p> <p><input type="checkbox"/> 7</p> <p><input type="checkbox"/> 8</p> <p><input type="checkbox"/> 9</p>
<p>13. Parent (Complete Q.14) ... <input type="checkbox"/> 1</p> <p>Partner/spouse (Complete Q.14) ... <input type="checkbox"/> 2</p> <p>Son/daughter in couple family (Complete Q.14) ... <input type="checkbox"/> 3</p> <p>Son/daughter in lone parent family (Complete Q.14) ... <input type="checkbox"/> 4</p> <p>Other relative (Complete Q.14) ... <input type="checkbox"/> 5</p> <p>Not related (Complete Q.14) ... <input type="checkbox"/> 6</p>	<p>K Number of people aged 18 or over in household</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6</p> <p><input type="checkbox"/> 7</p> <p><input type="checkbox"/> 8</p> <p><input type="checkbox"/> 9</p>	<p>M Social Marital Status</p> <p><input type="checkbox"/> 0</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6</p> <p><input type="checkbox"/> 7</p> <p><input type="checkbox"/> 8</p> <p><input type="checkbox"/> 9</p>	<p>Q Child attending educational institution (full-time 15-17)</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p>	<p>S Registered Marital Status</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p>	
<p>14. Child proxy is selected adult (Complete Q.15) ... <input type="checkbox"/> 1</p> <p>Child proxy not selected adult (Complete Q.15) ... <input type="checkbox"/> 2</p>	17. OFFICE USE ONLY (CHILD PROXY)				
<p>15. DATE OF INTERVIEW</p> <p>Enter date/...../.....</p> <p style="text-align: center;">DD MM YYYY</p> <p><input type="checkbox"/> 0 <input type="checkbox"/> 0 <input type="checkbox"/> 0 <input type="checkbox"/> 0 19 <input type="checkbox"/> 0 <input type="checkbox"/> 0</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 1 <input type="checkbox"/> 1 <input type="checkbox"/> 1 20 <input type="checkbox"/> 1 <input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2 <input type="checkbox"/> 2 <input type="checkbox"/> 2 <input type="checkbox"/> 2 <input type="checkbox"/> 2 <input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3 <input type="checkbox"/> 3 <input type="checkbox"/> 3 <input type="checkbox"/> 3 <input type="checkbox"/> 3 <input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4 <input type="checkbox"/> 4 <input type="checkbox"/> 4 <input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5 <input type="checkbox"/> 5 <input type="checkbox"/> 5 <input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6 <input type="checkbox"/> 6 <input type="checkbox"/> 6 <input type="checkbox"/> 6</p> <p><input type="checkbox"/> 7 <input type="checkbox"/> 7 <input type="checkbox"/> 7 <input type="checkbox"/> 7</p> <p><input type="checkbox"/> 8 <input type="checkbox"/> 8 <input type="checkbox"/> 8 <input type="checkbox"/> 8</p> <p><input type="checkbox"/> 9 <input type="checkbox"/> 9 <input type="checkbox"/> 9 <input type="checkbox"/> 9</p>	<p>A Sex</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p>	<p>B Age</p> <p><input type="checkbox"/> 0 <input type="checkbox"/> 0</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2 <input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3 <input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4 <input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5 <input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6 <input type="checkbox"/> 6</p> <p><input type="checkbox"/> 7 <input type="checkbox"/> 7</p> <p><input type="checkbox"/> 8 <input type="checkbox"/> 8</p> <p><input type="checkbox"/> 9 <input type="checkbox"/> 9</p>	<p>C Child proxy attending educational institution (full-time 18-24)</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p>	<p>D Indigenous Status</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p>	<p>E Country of Birth</p> <p><input type="checkbox"/> 0 <input type="checkbox"/> 0 <input type="checkbox"/> 0 <input type="checkbox"/> 0</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 1 <input type="checkbox"/> 1 <input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2 <input type="checkbox"/> 2 <input type="checkbox"/> 2 <input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3 <input type="checkbox"/> 3 <input type="checkbox"/> 3 <input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4 <input type="checkbox"/> 4 <input type="checkbox"/> 4 <input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5 <input type="checkbox"/> 5 <input type="checkbox"/> 5 <input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6 <input type="checkbox"/> 6 <input type="checkbox"/> 6 <input type="checkbox"/> 6</p> <p><input type="checkbox"/> 7 <input type="checkbox"/> 7 <input type="checkbox"/> 7 <input type="checkbox"/> 7</p> <p><input type="checkbox"/> 8 <input type="checkbox"/> 8 <input type="checkbox"/> 8 <input type="checkbox"/> 8</p> <p><input type="checkbox"/> 9 <input type="checkbox"/> 9 <input type="checkbox"/> 9 <input type="checkbox"/> 9</p>
<p>F Year of Arrival</p> <p>19 <input type="checkbox"/> 0 <input type="checkbox"/> 0</p> <p>20 <input type="checkbox"/> 1 <input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2 <input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3 <input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4 <input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5 <input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6 <input type="checkbox"/> 6</p> <p><input type="checkbox"/> 7 <input type="checkbox"/> 7</p> <p><input type="checkbox"/> 8 <input type="checkbox"/> 8</p> <p><input type="checkbox"/> 9 <input type="checkbox"/> 9</p>	<p>G Social Marital Status</p> <p><input type="checkbox"/> 0</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6</p> <p><input type="checkbox"/> 7</p> <p><input type="checkbox"/> 8</p> <p><input type="checkbox"/> 9</p>	<p>H Child proxy has child(ren) 0-14 in household</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p>	<p>I Child proxy has child(ren) 15-24 in household</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p>	<p>J Child proxy has child(ren) 15-24 who are full-time students</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p>	

19. Sequence Guide:

- . If child proxy is selected adult ... → **Q.58** 1
- . If first child's schedule ... → **Q.20** 2
- . Otherwise ... → **Q.58** 3

20. THE FIRST QUESTIONS ARE ABOUT LANGUAGE, EDUCATION AND WHETHER YOU ARE CURRENTLY WORKING.

THESE HELP US TO UNDERSTAND THE RELATIONSHIP BETWEEN HEALTH AND OTHER ISSUES IN PEOPLE'S LIVES.

DO YOU SPEAK A LANGUAGE OTHER THAN ENGLISH AT HOME?

Interviewer: If more than one language, prompt for language used most often

- No, English only ... 01
- Yes, Italian ... 02
- Yes, Greek ... 03
- Yes, Cantonese ... 04
- Yes, Mandarin ... 05
- Yes, Arabic ... 06
- Yes, Vietnamese ... 07
- Yes, German ... 08
- Yes, Spanish ... 09
- Yes, Tagalog (Filipino) ... 10
- Yes, Other (Specify) 11

21.

22. Sequence Guide:

- . If English only (code '01') in Q.20 → **Q.24** 1
- . Otherwise ... → **Q.23** 2

23. DO YOU CONSIDER YOU SPEAK ENGLISH VERY WELL, WELL OR NOT WELL?

- Very well ... 1
- Well ... 2
- Not well ... 3
- Not at all ... 4

24. Sequence Guide:

- . If aged 25 or more ... → **Q.26** 1
- . If currently attending school, TAFE, university, or other educational institution full-time (column G on HF) → **Q.28** 2
- . Otherwise ... → **Q.25** 3

25. ARE YOU CURRENTLY ATTENDING A TAFE, UNIVERSITY, OR OTHER EDUCATIONAL INSTITUTION ON A PART-TIME BASIS?

- Yes ... 1
- No ... 2

25A. → **Q.28**

26. ARE YOU CURRENTLY ATTENDING A TAFE, UNIVERSITY, OR OTHER EDUCATIONAL INSTITUTION?

- Yes ... 1
- No ... → **Q.28** 2

27. IS THIS ON A FULL-TIME OR PART-TIME BASIS?

- Full-time ... 1
- Part-time ... 2

28. AT WHAT AGE DID YOU MOST RECENTLY LEAVE PRIMARY OR SECONDARY SCHOOL?

- Never went to school ... → **Q.30** 01
- 13 years and under ... 02
- 14 years ... 03
- 15 years ... 04
- 16 years ... 05
- 17 years ... 06
- 18 years ... 07
- 19 years ... 08
- 20 years ... 09
- 21 years and over ... 10
- Still at school ... 11

29. WHAT IS THE HIGHEST YEAR OF PRIMARY OR SECONDARY SCHOOL YOU HAVE COMPLETED?

- Year 12 or equivalent ... 1
- Year 11 ... 2
- Year 10 ... 3
- Year 9 ... 4
- Year 8 or lower ... 5

30. (SINCE LEAVING SECONDARY SCHOOL,) HAVE YOU COMPLETED A TRADE CERTIFICATE, DIPLOMA, DEGREE, OR ANY OTHER EDUCATIONAL QUALIFICATION?

- Yes ... 1
- No ... → **Q.35** 2

31. WHAT IS THE NAME OF THE HIGHEST QUALIFICATION YOU HAVE COMPLETED?

Interviewer: If 'certificate', 'diploma' or 'degree', prompt for the type

- Secondary school qualification ... → **Q.35** 01
- Nursing qualification ... → **Q.32** 02
- Teaching qualification → **Q.33** 03
- Trade Certificate/Apprenticeship ... → **Q.35** 04
- Technician's Certificate/Advanced Certificate ... → **Q.35** 05
- Certificate other than above ... → **Q.34** 06
- Associate Diploma ... → **Q.34** 07
- Undergraduate Diploma → **Q.34** 08
- Bachelor Degree ... → **Q.35** 09
- Postgraduate Diploma/Graduate Certificate ... → **Q.35** 10
- Masters Degree/Doctorate → **Q.35** 11
- Other ... → **Q.34** 12

32. WHAT IS THE NAME OF THE HIGHEST NURSING QUALIFICATION YOU HAVE COMPLETED?

- Mothercraft Nurse ... → **Q.35** 1
- Enrolled Nurse ... → **Q.35** 2
- Nursing Aide/Auxiliary Nurse/Psychiatric Aide → **Q.35** 3
- Registered Nurse/Sister → **Q.35** 4
- Triple/Double Certificate Nurse/Theatre Nurse/Registered Midwife ... → **Q.35** 5
- Other ... → **Q.34** 6

33. WHAT IS THE NAME OF THE HIGHEST TEACHING QUALIFICATION YOU HAVE COMPLETED?

- Teaching certificate/TPTC/TSTC/TITC ... → **Q.35** 1
- Diploma of Teaching (Dip T) ... → **Q.35** 2
- Graduate Certificate/Diploma of Education (Dip Ed) ... → **Q.35** 3
- Other ... → 4

34. HOW LONG DOES THAT (CERTIFICATE/DIPLOMA/QUALIFICATION) TAKE TO COMPLETE, STUDYING FULL-TIME?

- Less than 1 semester ... 1
- 1 semester to less than 1 year ... 2
- 1 year to less than 3 years ... 3
- 3 years or more ... 4

35. THE NEXT FEW QUESTIONS ARE ABOUT WHETHER YOU ARE WORKING OR LOOKING FOR WORK.

I WOULD LIKE TO ASK YOU ABOUT LAST WEEK, THAT IS, THE WEEK STARTING MONDAY THE AND ENDING (LAST SUNDAY THE/YESTERDAY).

LAST WEEK, DID YOU DO ANY WORK AT ALL IN A JOB, BUSINESS OR FARM?

- Yes ... → **Q.38** 1
- No ... 2
- Permanently unable to work → **Q.58** 3
- Permanently not intending to work (if aged 65+ only) → **Q.58** 4

36. LAST WEEK, DID YOU DO ANY WORK WITHOUT PAY IN A FAMILY BUSINESS?

- Yes ... → **Q.38** 1
- No ... 2
- Permanently not intending to work (if aged 65+ only) ... → **Q.58** 3

37. DID YOU HAVE A JOB, BUSINESS OR FARM THAT YOU WERE AWAY FROM BECAUSE OF HOLIDAYS, SICKNESS OR ANY OTHER REASON?

- Yes ... 1
- No ... → **Q.51** 2
- Permanently not intending to work (if aged 65+ only) ... → **Q.58** 3

38. DID YOU HAVE MORE THAN 1 JOB OR BUSINESS (LAST WEEK)?

- Yes ... 1
- No ... → **Q.40** 2

39. I WOULD NOW LIKE TO ASK YOU ABOUT THE JOB OR BUSINESS IN WHICH YOU USUALLY WORK THE MOST HOURS.

40. DID YOU WORK FOR AN EMPLOYER, OR IN YOUR OWN BUSINESS?

- Employer ... 1
- Own business ... → **Q.43** 2
- Other/Uncertain ... → **Q.42** 3

41. ARE YOU PAID A WAGE OR SALARY, OR SOME OTHER FORM OF PAYMENT?

- Wage/Salary ... → **Q.45** 1
- Other/Uncertain ... 2

<p>42. WHAT ARE YOUR (WORKING/PAYMENT) ARRANGEMENTS?</p> <p>Unpaid voluntary work → Q.51 <input type="checkbox"/> 01</p> <p>Contractor/Subcontractor <input type="checkbox"/> 02</p> <p>Own business/Partnership <input type="checkbox"/> 03</p> <p>Commission only <input type="checkbox"/> 04</p> <p>Commission with retainer → Q.45 <input type="checkbox"/> 05</p> <p>In a family business without pay → Q.45 <input type="checkbox"/> 06</p> <p>Payment in kind → Q.45 <input type="checkbox"/> 07</p> <p>Paid by the piece/item produced → Q.45 <input type="checkbox"/> 08</p> <p>Wage/salary earner → Q.45 <input type="checkbox"/> 09</p> <p>Other → Q.45 <input type="checkbox"/> 10</p>	<p>47. WHAT IS THE NAME OF YOUR (EMPLOYER/BUSINESS)?</p> <p>.....</p> <p>.....</p> <p>.....</p>
<p>43. DO YOU HAVE EMPLOYEES (IN THAT BUSINESS)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p>	<p>48. (IN YOUR JOB WITH (Specify employer/business in Q.47),) DID YOU DO ANY SHIFT WORK AT ANY TIME DURING THE LAST 4 WEEKS?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.50 <input type="checkbox"/> 2</p>
<p>44. IS THAT BUSINESS INCORPORATED?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p>	<p>49. IS YOUR SHIFT -</p> <p>A ROTATING SHIFT WHICH CHANGES PERIODICALLY? <input type="checkbox"/> 1</p> <p>A REGULAR EVENING, NIGHT OR GRAVEYARD SHIFT? <input type="checkbox"/> 2</p> <p>A REGULAR MORNING SHIFT? <input type="checkbox"/> 3</p> <p>A REGULAR AFTERNOON SHIFT? <input type="checkbox"/> 4</p> <p>WHAT KIND OF SHIFT IS IT?</p> <p>Irregular shift <input type="checkbox"/> 5</p> <p>Split shift (consisting of 2 distinct periods each day) <input type="checkbox"/> 6</p> <p>On call <input type="checkbox"/> 7</p> <p>Other <input type="checkbox"/> 8</p>
<p>45. WHAT IS YOUR OCCUPATION IN (THAT/YOUR MAIN) (JOB/BUSINESS)?</p> <p>(Title)</p> <p>.....</p> <p>.....</p> <p>WHAT ARE YOUR MAIN TASKS AND DUTIES?</p> <p>(Main tasks/duties)</p> <p>.....</p> <p>.....</p>	<p>50. HOW MANY HOURS DO YOU USUALLY WORK EACH WEEK IN (THAT JOB/THAT BUSINESS/ ALL YOUR JOBS)?</p> <p>Number of hours <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> → Q.58</p> <p>Less than 1 hour/ No hours <input type="checkbox"/> 96</p>
<p>46. WHAT KIND OF BUSINESS OR SERVICE IS CARRIED OUT BY YOUR (EMPLOYER AT THE PLACE WHERE YOU WORK/BUSINESS)?</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>a</p> <p>b</p>	<p>51. AT ANY TIME DURING THE LAST 4 WEEKS, HAVE YOU BEEN LOOKING FOR FULL-TIME WORK?</p> <p>Yes → Q.53 <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p> <p>52. HAVE YOU BEEN LOOKING FOR PART-TIME WORK AT ANY TIME DURING THE LAST 4 WEEKS?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.58 <input type="checkbox"/> 2</p>

53. AT ANY TIME IN THE LAST 4 WEEKS HAVE YOU -

WRITTEN, PHONED OR APPLIED IN PERSON TO AN EMPLOYER FOR WORK? 01

ANSWERED AN ADVERTISEMENT FOR A JOB? 02

LOOKED IN NEWSPAPERS?

Yes

No

CHECKED FACTORY NOTICE BOARDS, OR USED THE TOUCHSCREENS AT CENTRELINK OFFICES? 03

AT ANY TIME IN THE LAST 4 WEEKS HAVE YOU -

BEEN REGISTERED WITH CENTRELINK AS A JOBSEEKER? 04

CHECKED OR REGISTERED WITH AN EMPLOYMENT AGENCY? 05

DONE ANYTHING ELSE TO FIND A JOB?

Advertised or tendered for work 06

Contacted friends/relatives 07

Other → Q.58 08

Only looked in newspapers → Q.58 09

None of these → Q.58 10

54. IF YOU HAD FOUND A (PART-TIME) JOB COULD YOU HAVE STARTED WORK LAST WEEK?

Yes 1

No → Q.58 2

Don't know 3

55. WHEN DID YOU BEGIN LOOKING FOR WORK?

a Enter date

Less than 2 years ago / /

DD MM YY

2 years or more ago / /

MM YY

5 years or more ago / /

YY

Day	Month	Year
<input type="checkbox"/> 0	<input type="checkbox"/> 0	<input type="checkbox"/> 0
<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3
<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4
<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5
<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6
<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7
<input type="checkbox"/> 8	<input type="checkbox"/> 8	<input type="checkbox"/> 8
<input type="checkbox"/> 9	<input type="checkbox"/> 9	<input type="checkbox"/> 9

b Did not look for work 1

56. WHEN DID YOU LAST WORK FOR AT LEAST 2 WEEKS IN A JOB OF 35 HOURS OR MORE A WEEK?

a Enter date

Less than 2 years ago / /

DD MM YY

2 years or more ago / /

MM YY

5 years or more ago / /

YY

Day	Month	Year
<input type="checkbox"/> 0	<input type="checkbox"/> 0	<input type="checkbox"/> 0
<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3
<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4
<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5
<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6
<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7
<input type="checkbox"/> 8	<input type="checkbox"/> 8	<input type="checkbox"/> 8
<input type="checkbox"/> 9	<input type="checkbox"/> 9	<input type="checkbox"/> 9

b Has never worked in a job of 35+ hrs/week (for 2 weeks or more) 1

<p>58. (I WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT,)</p> <p>WHAT IS YOUR RELATIONSHIP TO</p> <p>Mother <input type="checkbox"/> 1</p> <p>Step-mother <input type="checkbox"/> 2</p> <p>Father <input type="checkbox"/> 3</p> <p>Step-father <input type="checkbox"/> 4</p> <p>Grandparent <input type="checkbox"/> 5</p> <p>Other relative <input type="checkbox"/> 6</p> <p>Other <input type="checkbox"/> 7</p>	<p>66. IS PAID A WAGE OR SALARY, OR SOME OTHER FORM OF PAYMENT?</p> <p>Wage/Salary → Q.70 <input type="checkbox"/> 1</p> <p>Other/Uncertain <input type="checkbox"/> 2</p>
<p>59. <i>Sequence Guide:</i></p> <p>. If child aged less than 15 years ... → Q.100 <input type="checkbox"/> 1</p> <p>. Otherwise → Q.60 <input type="checkbox"/> 2</p>	<p>67. WHAT ARE (WORKING/PAYMENT) ARRANGEMENTS?</p> <p>Unpaid voluntary work ... → Q.73 <input type="checkbox"/> 01</p> <p>Contractor/Subcontractor <input type="checkbox"/> 02</p> <p>Own business/Partnership <input type="checkbox"/> 03</p> <p>Commission only <input type="checkbox"/> 04</p> <p>Commission with retainer → Q.70 <input type="checkbox"/> 05</p> <p>In a family business without pay → Q.70 <input type="checkbox"/> 06</p> <p>Payment in kind → Q.70 <input type="checkbox"/> 07</p> <p>Paid by the piece/item produced → Q.70 <input type="checkbox"/> 08</p> <p>Wage/salary earner → Q.70 <input type="checkbox"/> 09</p> <p>Other → Q.70 <input type="checkbox"/> 10</p>
<p>60. THE NEXT FEW QUESTIONS ARE ABOUT WHETHER IS CURRENTLY WORKING OR LOOKING FOR WORK, AND (HIS/HER) INCOME. THEY MAY BE EASIER TO ANSWER IF PROVIDES RESPONSES.</p> <p>I WOULD LIKE TO ASK YOU ABOUT LAST WEEK, THAT IS, THE WEEK STARTING MONDAY THE AND ENDING (LAST SUNDAY THE/YESTERDAY).</p> <p>LAST WEEK, DID DO ANY WORK AT ALL IN A JOB, BUSINESS OR FARM?</p> <p>Yes → Q.63 <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p> <p>Permanently unable to work → Q.79 <input type="checkbox"/> 3</p>	<p>68. DOES HAVE EMPLOYEES (IN THAT BUSINESS)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p>
<p>61. LAST WEEK DID DO ANY WORK WITHOUT PAY IN A FAMILY BUSINESS?</p> <p>Yes → Q.63 <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p>	<p>69. IS THAT BUSINESS INCORPORATED?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p>
<p>62. DID HAVE A JOB, BUSINESS OR FARM THAT (HE/SHE) WAS AWAY FROM BECAUSE OF HOLIDAYS, SICKNESS OR ANY OTHER REASON?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.73 <input type="checkbox"/> 2</p>	<p>70. IN MAIN JOB, DID (HE/SHE) DO ANY SHIFT WORK AT ANY TIME DURING THE LAST 4 WEEKS?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.72 <input type="checkbox"/> 2</p>
<p>63. DID HAVE MORE THAN 1 JOB OR BUSINESS (LAST WEEK)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.65 <input type="checkbox"/> 2</p>	<p>71. IS SHIFT -</p> <p>A ROTATING SHIFT WHICH CHANGES PERIODICALLY? <input type="checkbox"/> 1</p> <p>A REGULAR EVENING, NIGHT OR GRAVEYARD SHIFT? <input type="checkbox"/> 2</p> <p>A REGULAR MORNING SHIFT? <input type="checkbox"/> 3</p> <p>A REGULAR AFTERNOON SHIFT? <input type="checkbox"/> 4</p> <p>WHAT KIND OF SHIFT IS IT?</p> <p>Irregular shift <input type="checkbox"/> 5</p> <p>Split shift (consisting of 2 distinct periods each day) <input type="checkbox"/> 6</p> <p>On call <input type="checkbox"/> 7</p> <p>Other <input type="checkbox"/> 8</p>
<p>64. I WOULD NOW LIKE TO ASK YOU ABOUT THE JOB OR BUSINESS IN WHICH USUALLY WORKS THE MOST HOURS.</p>	
<p>65. DID WORK FOR AN EMPLOYER, OR IN (HIS/HER) OWN BUSINESS?</p> <p>Employer <input type="checkbox"/> 1</p> <p>Own business → Q.68 <input type="checkbox"/> 2</p> <p>Other/Uncertain → Q.67 <input type="checkbox"/> 3</p>	

72. HOW MANY HOURS DOES USUALLY WORK EACH WEEK IN (THAT JOB/THAT BUSINESS/ ALL (HIS/HER) JOBS)?

Number of hours → **Q.79**

Less than 1 hour/
No hours 96

73. AT ANY TIME DURING THE LAST 4 WEEKS, HAS BEEN LOOKING FOR FULL-TIME WORK?

Yes → **Q.75**

No

74. HAS BEEN LOOKING FOR PART-TIME WORK AT ANY TIME DURING THE LAST 4 WEEKS?

Yes

No → **Q.79**

75. AT ANY TIME IN THE LAST 4 WEEKS HAS -

WRITTEN, PHONED OR APPLIED IN PERSON TO AN EMPLOYER FOR WORK?

ANSWERED AN ADVERTISEMENT FOR A JOB?

LOOKED IN NEWSPAPERS?

Yes

No

CHECKED FACTORY NOTICE BOARDS, OR USED THE TOUCHSCREENS AT CENTRELINK OFFICES?

AT ANY TIME IN THE LAST 4 WEEKS HAS -

BEEN REGISTERED WITH CENTRELINK AS A JOBSEEKER?

CHECKED OR REGISTERED WITH AN EMPLOYMENT AGENCY?

DONE ANYTHING ELSE TO FIND A JOB?

Advertised or tendered for work

Contacted friends/relatives

Other → **Q.79**

Only looked in newspapers → **Q.79**

None of these → **Q.79**

76. IF HAD FOUND A (PART-TIME) JOB COULD (HE/SHE) HAVE STARTED WORK LAST WEEK?

Yes

No → **Q.79**

Don't know

77. WHEN DID BEGIN LOOKING FOR WORK?

a Enter date

Less than 2 years ago / /
DD MM YY

2 years or more ago /
MM YY

5 years or more ago
YY

Day Month Year

19
 20

b Did not look for work

78. WHEN DID LAST WORK FOR AT LEAST 2 WEEKS IN A JOB OF 35 HOURS OR MORE A WEEK?

a Enter date

Less than 2 years ago / /
DD MM YY

2 years or more ago /
MM YY

5 years or more ago
YY

Day Month Year

19
 20

b Has never worked in a job of 35+ hrs/week (for 2 weeks or more)

79. Interviewer: Show Prompt Card 1

DOES CURRENTLY RECEIVE INCOME FROM ANY OF THESE SOURCES?

Interviewer: If 'yes', prompt for which ones

Wages or salary **a**

Profit or loss from a business or rental property **b**

Any government pension, benefit or allowance **c**

Any other regular source **d**

None of the above ... → **Q.200** **e**

80. BEFORE INCOME TAX IS TAKEN OUT, HOW MUCH DOES USUALLY RECEIVE FROM (THIS/THESE) SOURCE(S) IN TOTAL?

Interviewer: If respondent unable to answer, prompt for best estimate

(a) \$

--	--	--	--	--	--	--

Don't know → **Q.82** 999998

<input type="checkbox"/>	0
<input type="checkbox"/>	1
<input type="checkbox"/>	2
<input type="checkbox"/>	3
<input type="checkbox"/>	4
<input type="checkbox"/>	5
<input type="checkbox"/>	6
<input type="checkbox"/>	7
<input type="checkbox"/>	8
<input type="checkbox"/>	9

(b) Profit 1
 Loss 2

81. WHAT PERIOD DOES THAT COVER?

Interviewer: Record period

Weeks

		1
--	--	---

<input type="checkbox"/>	0
<input type="checkbox"/>	1
<input type="checkbox"/>	2
<input type="checkbox"/>	3
<input type="checkbox"/>	4
<input type="checkbox"/>	5
<input type="checkbox"/>	6
<input type="checkbox"/>	7
<input type="checkbox"/>	8
<input type="checkbox"/>	9

Months

		2
--	--	---

<input type="checkbox"/>	0
<input type="checkbox"/>	1
<input type="checkbox"/>	2
<input type="checkbox"/>	3
<input type="checkbox"/>	4
<input type="checkbox"/>	5
<input type="checkbox"/>	6
<input type="checkbox"/>	7
<input type="checkbox"/>	8
<input type="checkbox"/>	9

82. Sequence Guide

. If more than 1 source selected in Q.79 → **Q.83** 1

. Otherwise → **Q.200** 2

83. WHAT IS MAIN SOURCE OF INCOME?

Interviewer: Show Prompt Card 2

Wages or salary (including from own incorporated business) 1

Profit or loss from own unincorporated business or share in a partnership 2

Profit or loss from rental property ... 3

Dividends or interest 4

Any government pension or allowance 5

Child support or maintenance 6

Superannuation or annuity 7

Workers' compensation 8

Other 9

100. Sequence Guide:

. If child aged 0-6 years → **Q.101** 1

. Otherwise → **Q.200** 2

101. THE FOLLOWING QUESTIONS ARE ABOUT CHILDHOOD VACCINATIONS.

DO YOU HAVE ANY CARDS OR RECORDS WHICH WOULD HELP YOU ANSWER THESE QUESTIONS? (COULD YOU PLEASE FIND THEM?)

Cards/record produced 1

Immunisation register advice 2

Other 3

Cards/record not produced 4

102. Sequence Guide:

. If child aged less than 1 month → **Q.103** 1

. Otherwise → **Q.104** 2

103. WAS GIVEN A SEPARATE HEPATITIS B (HEP B) VACCINATION -

WITHIN 7 DAYS OF BIRTH? → **Q.108** 1

ANYTIME AFTER 7 DAYS OF BIRTH? → **Q.108** 2

Not given → **Q.106** 3

Don't know → **Q.150** 4

104. HAS RECEIVED THE RECOMMENDED VACCINATIONS FOR (HIS/HER) AGE (THAT IS AT 2, 4, 6, 12 OR 18 MONTHS OR 4 OR 5 YEARS OLD)?

Yes → **Q.108** 1

No 2

Don't know 3

105. HAS RECEIVED ANY (VACCINATIONS/ INJECTIONS)?

Yes → **Q.107** 1

No 2

Don't know → **Q.150** 3

106. WHAT IS THE MAIN REASON HAS NOT BEEN IMMUNISED?

- No perceived need 01
- Opposed to immunisation 02
- Concerned about side effects 03
- Advised against it 04
- Too young 05
- Didn't know about the immunisation schedule 06
- Haven't got around to it 07
- Sick when due for immunisation 08
- Forgot about older age shots 09
- Didn't receive reminder 10
- Other 11

106A. → *Q.150*

107. WHAT IS THE MAIN REASON DID NOT CONTINUE WITH THE IMMUNISATION SCHEDULE?

- No perceived need 01
- Opposed to immunisation 02
- Concerned about side effects 03
- Advised against it 04
- Too young 05
- Didn't know about the immunisation schedule 06
- Haven't got around to it 07
- Sick when due for immunisation 08
- Forgot about older age shots 09
- Didn't receive reminder 10
- Other 11

107A. → *Q.110*

108. Interviewer: Show Prompt Card 3

WHICH OF THESE HAS INFLUENCED YOUR DECISION TO IMMUNISE ?

- For child's health *a* 1
- The right thing to do *b* 2
- Reminder notifications from the Register *c* 3
- Payment *d* 4
- Child must be immunised to go to child care/school *e* 5
- Local access to clinic or doctor *f* 6
- More awareness of immunisation schedule *g* 7
- Promotion through TV/radio/other media/clinics *h* 8
- Other *i* 9

109. Sequence Guide:

- . *If child aged less than 1 month* → *Q.150* 1
- . *Otherwise* → *Q.110* 2

110. WAS GIVEN A SEPARATE HEPATITIS B (HEP B) VACCINATION -

- WITHIN 7 DAYS OF BIRTH? 1
- ANYTIME AFTER 7 DAYS OF BIRTH? 2
- Not given → *Q.112* 3
- Don't know → *Q.112* 4

111. HOW MANY SEPARATE HEPATITIS B (HEP B) VACCINATIONS HAS BEEN GIVEN IN TOTAL?

- 1 1
- 2 2
- 3 3
- 4 or more 4
- Don't know 5

112. HAS EVER BEEN GIVEN ANY DTP INJECTIONS, (THAT IS DIPHTHERIA, TETANUS AND WHOOPING COUGH VACCINATIONS) OR TRIPLE ANTIGEN INJECTIONS?

- Yes 1
- No → *Q.117* 2
- Don't know → *Q.117* 3

<p>113. INCLUDING BOOSTERS, HOW MANY VACCINATIONS HAS RECEIVED AGAINST DIPHTHERIA, TETANUS AND WHOOPING COUGH (THAT IS TA, DTPa, DTPw OR DTPa-HepB)?</p> <p>1 <input type="checkbox"/> 1</p> <p>2 <input type="checkbox"/> 2</p> <p>3 <input type="checkbox"/> 3</p> <p>4 <input type="checkbox"/> 4</p> <p>5 or more <input type="checkbox"/> 5</p> <p>Don't know <input type="checkbox"/> 6</p>	<p>120. INCLUDING BOOSTERS, HOW MANY (ORAL) POLIO VACCINATIONS HAS BEEN GIVEN?</p> <p>1 <input type="checkbox"/> 1</p> <p>2 <input type="checkbox"/> 2</p> <p>3 <input type="checkbox"/> 3</p> <p>4 or more <input type="checkbox"/> 4</p> <p>Don't know <input type="checkbox"/> 5</p>
<p>114. DID (THIS/ANY OF THESE) VACCINATION(S) INCLUDE A HEPATITIS B (HEP B) VACCINE?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2 → Q.117</p> <p>Don't know <input type="checkbox"/> 3 → Q.117</p>	<p>121. HAS EVER BEEN GIVEN THE HIB (THAT IS, HAEMOPHILUS INFLUENZAE TYPE B) VACCINE?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2 → Q.127</p> <p>Don't know <input type="checkbox"/> 3 → Q.127</p>
<p>115. <i>Sequence Guide:</i></p> <p>. If code '2-5' in Q.113 <input type="checkbox"/> 1 → Q.116</p> <p>. Otherwise <input type="checkbox"/> 2 → Q.117</p>	<p>122. WHAT WAS THE BRAND OF HIB VACCINE THAT WAS GIVEN?</p> <p>PedvaxHIB/PRP-OMP <input type="checkbox"/> 1 a</p> <p>HibTITER/HbOC <input type="checkbox"/> 2 b</p> <p>Other <input type="checkbox"/> 3 c</p> <p>Don't know <input type="checkbox"/> 4 d</p>
<p>116. HOW MANY OF THESE (DTP) VACCINATIONS INCLUDED HEPATITIS B (HEP B)?</p> <p>1 <input type="checkbox"/> 1</p> <p>2 <input type="checkbox"/> 2</p> <p>3 <input type="checkbox"/> 3</p> <p>4 or more <input type="checkbox"/> 4</p> <p>Don't know <input type="checkbox"/> 5</p>	<p>123. INCLUDING BOOSTERS, HOW MANY (HIB/HIB-HEP B) VACCINATIONS HAS BEEN GIVEN?</p> <p>1 <input type="checkbox"/> 1</p> <p>2 <input type="checkbox"/> 2</p> <p>3 <input type="checkbox"/> 3</p> <p>4 or more <input type="checkbox"/> 4</p> <p>Don't know <input type="checkbox"/> 5</p>
<p>117. (APART FROM DTP,) HAS EVER BEEN GIVEN ANY COMBINED DIPHTHERIA AND TETANUS INJECTIONS (THAT IS A CDT)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2 → Q.119</p> <p>Don't know <input type="checkbox"/> 3 → Q.119</p>	<p>124. DID (THIS/ANY OF THESE) VACCINATION(S) INCLUDE A HEPATITIS B (HEP B) VACCINE?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2 → Q.127</p> <p>Don't know <input type="checkbox"/> 3 → Q.127</p>
<p>118. INCLUDING BOOSTERS, HOW MANY VACCINATIONS HAS RECEIVED AGAINST DIPHTHERIA AND TETANUS (THAT IS A CDT)?</p> <p>1 <input type="checkbox"/> 1</p> <p>2 <input type="checkbox"/> 2</p> <p>3 <input type="checkbox"/> 3</p> <p>4 <input type="checkbox"/> 4</p> <p>5 or more <input type="checkbox"/> 5</p> <p>Don't know <input type="checkbox"/> 6</p>	<p>125. <i>Sequence Guide:</i></p> <p>. If code '2-4' in Q.123 <input type="checkbox"/> 1 → Q.126</p> <p>. Otherwise <input type="checkbox"/> 2 → Q.127</p>
<p>119. HAS EVER BEEN GIVEN A POLIO VACCINE (THAT IS AN IPV) OR AN ORAL SABIN (THAT IS AN OPV)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2 → Q.121</p> <p>Don't know <input type="checkbox"/> 3 → Q.121</p>	<p>126. HOW MANY OF THESE (HIB) VACCINATIONS INCLUDED HEPATITIS B (HEP B)?</p> <p>1 <input type="checkbox"/> 1</p> <p>2 <input type="checkbox"/> 2</p> <p>3 <input type="checkbox"/> 3</p> <p>4 or more <input type="checkbox"/> 4</p> <p>Don't know <input type="checkbox"/> 5</p>

127. HAS EVER BEEN GIVEN A MEASLES, MUMPS AND RUBELLA COMBINATION VACCINE, THAT IS AN MMR?

Yes 1

No → *Q.129* 2

Don't know → *Q.129* 3

128. INCLUDING BOOSTERS, HOW MANY MMR VACCINATIONS HAS BEEN GIVEN?

1 1

2 or more 2

Don't know 3

129. APART FROM ANY VACCINATIONS YOU HAVE ALREADY TOLD ME ABOUT, HAS EVER BEEN GIVEN A SEPARATE TETANUS VACCINATION?

Yes 1

No 2

Don't know 3

150. *Sequence Guide:*

. If child aged 0-3 years → *Q.151* 1

. Otherwise → *Q.200* 2

151. THE NEXT FEW QUESTIONS ARE ABOUT BREASTFEEDING.

HAS EVER BEEN BREASTFED?

Yes 1

No → *Q.154* 2

Don't know → *Q.154* 3

152. IS CURRENTLY BEING BREASTFED?

Yes 1

No 2

Don't know 3

153. WAS BREASTFED WHEN (HE/SHE) FIRST CAME HOME FROM HOSPITAL?

Yes 1

No 2

No hospital 3

154. HAS EVER BEEN GIVEN INFANT FORMULA REGULARLY?

Yes 1

No → *Q.156* 2

Don't know → *Q.156* 3

155. AT WHAT AGE WAS FIRST GIVEN INFANT FORMULA REGULARLY?

Weeks 1 1 1 1 1

Months 2 2 2 2 2

Less than 1 week ... 997 7 7 7 7

Don't know 998 8 8 8 8

156. HAS EVER BEEN GIVEN COW'S MILK REGULARLY?

Yes 1

No → *Q.158* 2

Don't know → *Q.158* 3

157. AT WHAT AGE WAS FIRST GIVEN COW'S MILK REGULARLY?

Weeks 1 1 1 1 1

Months 2 2 2 2 2

Less than 1 week ... 997 7 7 7 7

Don't know 998 8 8 8 8



158. (APART FROM BREAST MILK/INFANT FORMULA/
COW'S MILK,
HAS EVER BEEN GIVEN ANY (OTHER) TYPE OF
MILK SUBSTITUTE ON A REGULAR BASIS?

Yes 1

No → Q.161 2

Don't know → Q.161 3

159. WHAT TYPE OF MILK SUBSTITUTES DID HAVE?

Soya bean milk/soy milk a 1

Goat's milk b 2

Evaporated milk c 3

Other d 4

160. AT WHAT AGE WAS FIRST GIVEN (THIS/ANY OF
THESE) MILK SUBSTITUTE(S) REGULARLY?

Weeks 1 1 1 1 1

Months 2 2 2 2 2

Less than 1 week ... 997 7 7 7 7

Don't know 998 8 8 8 8 9 9

161. *Sequence Guide:*
 . If child aged less than 6 months → Q.162 1
 . Otherwise → Q.163 2

162. HAS EVER BEEN GIVEN SOLID FOOD?

Yes 1

No → Q.164 2

163. AT WHAT AGE WAS FIRST GIVEN SOLID FOOD
REGULARLY?

Weeks 1 1 1 1 1

Months 2 2 2 2 2

Less than 1 week ... 997 7 7 7 7

Don't know 998 8 8 8 8 9 9

164. *Sequence Guide:*
 . If breastfed, but not currently
 (code '2') in Q.152 → Q.165 1
 . Otherwise → Q.200 2

165. INCLUDING TIMES OF WEANING, WHAT IS THE
TOTAL TIME WAS BREASTFED?

Weeks 1 1 1 1 1

Months 2 2 2 2 2

Less than 1 week ... 997 3 3 3 3 4 4 4 4

Don't know 998 5 5 5 5 6 6 6 6 7 7 7 7 8 8 8 8 9 9

166. WHAT IS THE MAIN REASON (YOU/..... MOTHER)
STOPPED BREASTFEEDING ?

Teething 1

Child bored 2

Felt it was time to stop 3

Resumed work 4

Pregnant 5

Not producing any/
adequate milk 6

Other problems with breastfeeding
e.g. cracked nipples 7

Other 8

200. Sequence Guide:
 . If child aged 15 years or more → Q.202 1
 . Otherwise ... → Q.226 2

202. I WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT HEALTH.

IN GENERAL, WOULD YOU SAY THAT HEALTH IS EXCELLENT, VERY GOOD, GOOD, FAIR OR POOR?

Excellent 1
 Very good 2
 Good 3
 Fair 4
 Poor 5

203. COMPARED TO 1 YEAR AGO, HOW WOULD YOU RATE HEALTH IN GENERAL NOW?

WOULD YOU SAY IT WAS MUCH BETTER, SOMEWHAT BETTER, ABOUT THE SAME, SOMEWHAT WORSE OR MUCH WORSE (THAN 1 YEAR AGO)?

Much better now than 1 year ago 1
 Somewhat better now than 1 year ago 2
 About the same as 1 year ago 3
 Somewhat worse now than 1 year ago 4
 Much worse now than 1 year ago 5

204. DO YOU CONSIDER TO BE ACCEPTABLE WEIGHT, UNDERWEIGHT OR OVERWEIGHT?

Acceptable weight 1
 Underweight 2
 Overweight 3

205. HOW MUCH DOES WEIGH?

Interviewer: Record reported weight in appropriate category

Kilograms 0 [] [] [] [] 1
 Stone/pounds [] [] [] [] 2
 Pounds 0 [] [] [] [] 3
 Don't know 99998

0 1 2 3 4 5 6 7 8 9
 1 2 3 4 5 6 7 8 9
 1 2 3 4 5 6 7 8 9
 1 2 3 4 5 6 7 8 9
 1 2 3 4 5 6 7 8 9

206. HOW TALL IS WITHOUT SHOES?

Interviewer: Record reported height in appropriate category

Centimetres [] [] [] [] 1
 Feet/inches ... [] [] [] [] 2
 Don't know 9998

1 2 3 4 5 6 7 8 9
 1 2 3 4 5 6 7 8 9
 1 2 3 4 5 6 7 8 9
 1 2 3 4 5 6 7 8 9
 1 2 3 4 5 6 7 8 9

Sample

207. IN THE LAST 2 WEEKS, HAS WALKED FOR SPORT, RECREATION OR FITNESS?

Yes 1

No → **Q.210** 2

208. HOW MANY TIMES DID WALK IN THE LAST 2 WEEKS?

Interviewer: Record number

Number

0 1
 2 3
 4 5
 6 7
 8 9

209. WHAT WAS THE TOTAL AMOUNT OF TIME SPENT WALKING IN THE LAST 2 WEEKS?

Interviewer: Record appropriate time

Hours/minutes

100 hours or more 9999

0 1 2 3
 4 5 6 7
 8 9

210. I WILL NOW ASK YOU ABOUT MODERATE AND VIGOROUS EXERCISE APART FROM WALKING.

Interviewer: Show Prompt Card 5

IN THE LAST 2 WEEKS, DID DO ANY EXERCISE WHICH CAUSED A MODERATE INCREASE IN (HIS/HER) HEART RATE OR BREATHING, THAT IS, MODERATE EXERCISE?

Yes 1

No → **Q.213** 2

211. HOW MANY TIMES DID DO ANY MODERATE EXERCISE IN THE LAST 2 WEEKS?

Interviewer: Record number

Number

0 1
 2 3
 4 5
 6 7
 8 9

212. WHAT WAS THE TOTAL AMOUNT OF TIME SPENT DOING MODERATE EXERCISE IN THE LAST 2 WEEKS?

Interviewer: Record appropriate time

Hours/minutes

100 hours or more 9999

0 1 2 3
 4 5 6 7
 8 9

213. IN THE LAST 2 WEEKS, DID DO ANY (OTHER) EXERCISE WHICH CAUSED A LARGE INCREASE IN (HIS/HER) HEART RATE OR BREATHING, THAT IS, VIGOROUS EXERCISE?

Interviewer: Show Prompt Card 5

Yes 1

No → **Q.226** 2

214. HOW MANY TIMES DID DO ANY VIGOROUS EXERCISE IN THE LAST 2 WEEKS?

Interviewer: Record number

Number

0 1
 2 3
 4 5
 6 7
 8 9

215. WHAT WAS THE TOTAL AMOUNT OF TIME SPENT DOING VIGOROUS EXERCISE IN THE LAST 2 WEEKS?

Interviewer: Record appropriate time

Hours/minutes

100 hours or more 9999

0 1 2 3
 4 5 6 7
 8 9

226. THE FOLLOWING QUESTIONS ARE ABOUT SUN PROTECTION.

Interviewer: Show Prompt Card 6

IN THE LAST MONTH, HAS TAKEN ANY MEASURES, SUCH AS THESE, TO PROTECT (HIMSELF/HERSELF) FROM THE SUN?

- Yes 1
- No → **Q.228** 2
- Not exposed to sun ... → **Q.228** 3

227. WHICH PROTECTIVE MEASURES DID TAKE?

- Sunscreen **a** 1
- Umbrella **b** 2
- Hat **c** 3
- Clothing **d** 4
- Sunglasses **e** 5
- Avoided sun/limited time spent in the sun **f** 6
- Other **g** 7

228. DOES , OR ANYONE ELSE, REGULARLY CHECK (HIS/HER) SKIN FOR CHANGES IN FRECKLES AND MOLES?

- Yes 1
- No 2

300. *Sequence Guide:*

- . If child aged 12 years or more → **Q.301** 1
- . Otherwise → **Q.359** 2

301. THE NEXT FEW QUESTIONS ARE ABOUT NUTRITION.

WHAT TYPE OF MILK DOES USUALLY CONSUME?

- Whole 1
- Low/reduced fat 2
- Skim 3
- Evaporated or sweetened condensed 4
- Soy milk 5
- None of the above 6
- Don't know 7

302. THIS QUESTION IS ABOUT USUAL CONSUMPTION OF VEGETABLES, INCLUDING FRESH, FROZEN AND TINNED VEGETABLES.

Interviewer: Show Prompt Card 9

HOW MANY SERVES OF VEGETABLES DOES USUALLY EAT EACH DAY?

- 1 serve or less 1
- 2-3 serves 2
- 4-5 serves 3
- 6 serves or more 4
- Doesn't eat vegetables 5

303. THIS QUESTION IS ABOUT USUAL CONSUMPTION OF FRUIT, INCLUDING FRESH, DRIED, FROZEN AND TINNED FRUIT.

Interviewer: Show Prompt Card 10

HOW MANY SERVES OF FRUIT DOES USUALLY EAT EACH DAY?

- 1 serve or less 1
- 2-3 serves 2
- 4-5 serves 3
- 6 serves or more 4
- Doesn't eat fruit 5

304. HOW OFTEN DOES ADD SALT TO (HIS/HER) FOOD AFTER IT IS COOKED?

IS IT, NEVER, RARELY, SOMETIMES OR USUALLY?

- Never/rarely 1
- Sometimes 2
- Usually 3

359. THE NEXT QUESTIONS ARE ABOUT LONG TERM HEALTH CONDITIONS. PLEASE INCLUDE ONLY THOSE CONDITIONS THAT HAVE LASTED, OR ARE EXPECTED TO LAST, FOR 6 MONTHS OR MORE.

THE NEXT FEW QUESTIONS ARE ABOUT ASTHMA.

HAS EVER BEEN TOLD BY A DOCTOR OR NURSE THAT (HE/SHE) HAS ASTHMA?

Yes 1

No → Q.400 2

Don't know → Q.400 3

360. DOES STILL GET ASTHMA?

Yes 1

No → Q.400 2

361. DOES HAVE A WRITTEN ASTHMA ACTION PLAN?

Yes 1

No → Q.364 2

Never heard of one ... → Q.364 3

Don't know → Q.364 4

362. DID GET THIS ACTION PLAN FROM A -

DOCTOR? 1

NURSE? 2

CHEMIST? 3

Other 4

363. IS ACTION PLAN SIMILAR TO THIS?

Interviewer: Show Prompt Card 13

Yes 1

No 2

364. THE NEXT FEW QUESTIONS ARE ABOUT MEDICATION THAT MAY HAVE USED OR TAKEN FOR (HIS/HER) ASTHMA IN THE LAST 2 WEEKS.

PLEASE EXCLUDE VITAMIN AND MINERAL SUPPLEMENTS, AS WELL AS ANY NATURAL OR HERBAL MEDICINES, FROM YOUR ANSWER. THESE WILL BE RECORDED LATER.

HAS TAKEN ANY MEDICATION FOR ASTHMA IN THE LAST 2 WEEKS?

Yes 1

No → Q.375 2

Don't know → Q.375 3

365. (IT MIGHT BE EASIER TO ANSWER THESE QUESTIONS IF YOU HAVE THE MEDICATION IN FRONT OF YOU.)

WHAT ARE THE NAMES OR BRANDS OF ALL THE ASTHMA MEDICATION HAS USED IN THE LAST 2 WEEKS?

Interviewer: Write a maximum of 3 names or brands

(a)

(b)

(c)

Interviewer: Mark number of medications reported in a-c

..... 1

..... 2

..... 3

or

Mark if 4 or more medications reported 4

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366.	367.	368.															
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369. WAS (Specify brand 'a' in Q.365) USED FOR PREVENTION, RELIEF OR BOTH?

Prevention 1

Relief 2

Both 3

Neither 4

Don't know 5

370. *Sequence Guide:*

. If more than 1 medication reported in Q.365 → Q.371 1

. Otherwise → Q.374 2

371. WAS (Specify brand 'b' in Q.365) USED FOR PREVENTION, RELIEF OR BOTH?

Prevention 1

Relief 2

Both 3

Neither 4

Don't know 5

372. *Sequence Guide:*

. If more than 2 medications reported in Q.365 → Q.373 1

. Otherwise → Q.374 2

373. WAS (Specify brand 'c' in Q.365) USED FOR PREVENTION, RELIEF OR BOTH?

Prevention 1

Relief 2

Both 3

Neither 4

Don't know 5

374. DURING THE LAST 2 WEEKS, HAS USED A NEBULISER TO ADMINISTER (THIS/ANY OF THESE) MEDICATION(S) FOR (HIS/HER) ASTHMA?

Yes 1

No 2

Don't know 3

375. *Interviewer: Show Prompt Card 14*

HAS TAKEN ANY OF THESE ACTIONS FOR (HIS/HER) ASTHMA IN THE LAST 2 WEEKS?

Yes 1

No 2 → Q.400

376. WHICH ONES?

Admitted to hospital as an inpatient a 01

Visited outpatient clinic b 02

Visited casualty/emergency c 03

Visited day clinic d 04

Consulted doctor (General Practitioner or specialist) e 05

Consulted other health practitioner f 06

Had day(s) away from work/school g 07

Had other days of reduced activity h 08

Taken vitamin/mineral supplements i 09

Used natural/herbal medicines ... j 10

400. THE NEXT FEW QUESTIONS ARE ABOUT CANCER.

HAS EVER BEEN TOLD BY A DOCTOR OR NURSE THAT (HE/SHE) HAS CANCER?

Yes 1

No 2 → Q.450

401. WHAT TYPE OF CANCER WAS TOLD (HE/SHE) HAD?

Skin cancer (include melanoma, basal cell carcinoma, squamous cell carcinoma) ... a 01

Colon/rectum/bowel cancer (colorectal) ... b 02

Breast ... c 03

Prostate ... d 04

Lung (include trachea, pleura and bronchus) ... e 05

Female reproductive organs (include cervix, uterus, ovary) ... f 06

Bladder/kidney ... g 07

Stomach ... h 08

Leukaemia ... i 09

Lymphoma (include Non-Hodgkin's Lymphoma) ... j 10

Cancer of unknown primary site k 11

Other (Specify) l 12

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402.

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403. *Sequence Guide:*

. If skin cancer (code '01') in Q.401 → Q.404 1

. Otherwise ... → Q.405 2

404. WHAT TYPE OF SKIN CANCER WAS THIS?

Melanoma ... a 1

Basal cell carcinoma (BCC) ... b 2

Squamous cell carcinoma (SCC) c 3

Other form of skin cancer ... d 4

Don't know ... e 5

405. *Sequence Guide:*

. If breast cancer (code '03') in Q.401 → Q.406 1

. Otherwise ... → Q.407 2

<p>406. AT WHAT AGE WAS FIRST DIAGNOSED WITH BREAST CANCER?</p> <p><i>Interviewer: Record age in years</i></p> <p>Age <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/></p> <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;"> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 </div> <div style="margin-left: 10px;"> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 </div> </div>	<p>411. WHAT TYPE OF SKIN CANCER IS THIS?</p> <p>Melanoma a <input type="checkbox"/> 1</p> <p>Basal cell carcinoma (BCC) ... b <input type="checkbox"/> 2</p> <p>Squamous cell carcinoma (SCC) c <input type="checkbox"/> 3</p> <p>Other form of skin cancer ... d <input type="checkbox"/> 4</p> <p>Don't know e <input type="checkbox"/> 5</p>
<p>407. INCLUDING CANCER WHICH IS IN REMISSION, DOES CURRENTLY HAVE CANCER?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.450 <input type="checkbox"/> 2</p>	<p>412. THE NEXT FEW QUESTIONS ARE ABOUT MEDICATION THAT MAY HAVE USED OR TAKEN FOR CANCER IN THE <u>LAST 2 WEEKS</u>.</p> <p>WE ARE ONLY INTERESTED IN MEDICATION IS USING OR TAKING WHICH IS DIRECTLY RELATED TO THE CONDITION(S) YOU HAVE TOLD ME ABOUT.</p> <p>INCLUDING ANY VITAMIN AND MINERAL SUPPLEMENTS, AS WELL AS ANY NATURAL OR HERBAL MEDICINES, HAS USED ANY MEDICATION FOR CANCER IN THE <u>LAST 2 WEEKS</u>?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.450 <input type="checkbox"/> 2</p>
<p>408. WHAT TYPE OF CANCER DOES HAVE?</p> <p>Skin cancer (include melanoma, basal cell carcinoma, squamous cell carcinoma) a <input type="checkbox"/> 01</p> <p>Colon/rectum/bowel cancer (colorectal) b <input type="checkbox"/> 02</p> <p>Breast c <input type="checkbox"/> 03</p> <p>Prostate d <input type="checkbox"/> 04</p> <p>Lung (include trachea, pleura and bronchus) e <input type="checkbox"/> 05</p> <p>Female reproductive organs (include cervix, uterus, ovary) ... f <input type="checkbox"/> 06</p> <p>Bladder/kidney g <input type="checkbox"/> 07</p> <p>Stomach h <input type="checkbox"/> 08</p> <p>Leukaemia i <input type="checkbox"/> 09</p> <p>Lymphoma (include Non-Hodgkin's Lymphoma) j <input type="checkbox"/> 10</p> <p>Cancer of unknown primary site k <input type="checkbox"/> 11</p> <p>Other (<i>Specify</i>) <input type="checkbox"/> 12</p> <p>..... l <input type="checkbox"/> 12</p>	<p>413. (IT MIGHT BE EASIER TO ANSWER THESE QUESTIONS IF YOU HAVE THE MEDICATION IN FRONT OF YOU.)</p> <p>IN THE <u>LAST 2 WEEKS</u>, FOR CANCER, HAS TAKEN ANY -</p> <p>VITAMIN OR MINERAL SUPPLEMENTS? a <input type="checkbox"/> 1</p> <p>HERBAL OR NATURAL TREATMENTS OR REMEDIES? ... b <input type="checkbox"/> 2</p> <p>Neither of these → Q.415 c <input type="checkbox"/> 3</p>
<p>410. <u>Sequence Guide:</u></p> <p>. If skin cancer (code '01') in Q.408 → Q.411 <input type="checkbox"/> 1</p> <p>. Otherwise → Q.412 <input type="checkbox"/> 2</p>	<p>414. OTHER THAN THE VITAMINS OR HERBAL TREATMENTS YOU JUST TOLD ME ABOUT, HAS USED OR TAKEN ANY MEDICATION FOR CANCER IN THE <u>LAST 2 WEEKS</u>?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.450 <input type="checkbox"/> 2</p>
<p style="text-align: center;">OFFICE USE ONLY</p> <p style="text-align: center;">409.</p> <div style="display: flex; justify-content: center; gap: 10px;"> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> </div>	<p>415. WHAT ARE THE NAMES OR BRANDS OF ALL THE MEDICATION HAS USED FOR CANCER IN THE <u>LAST 2 WEEKS</u>?</p> <p><i>Interviewer: Write a maximum of 3 names or brands</i></p> <p>(a)</p> <p>(b)</p> <p>(c)</p> <p><i>Interviewer: Mark number of medications reported in a-c</i></p> <div style="display: flex; justify-content: flex-end; gap: 10px;"> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 </div> <p>or</p> <p><i>Mark if 4 or more medications reported</i> <input type="checkbox"/> 4</p>
<p>OFFICE USE ONLY</p>	
<p>416.</p> <div style="display: flex; justify-content: center; gap: 10px;"> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> </div>	<p>417.</p> <div style="display: flex; justify-content: center; gap: 10px;"> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> </div>
<p>418.</p> <div style="display: flex; justify-content: center; gap: 10px;"> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> </div>	<p>418.</p> <div style="display: flex; justify-content: center; gap: 10px;"> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> </div>

450. THE NEXT FEW QUESTIONS ARE ABOUT CONDITIONS OF THE HEART AND CIRCULATORY SYSTEMS.

Interviewer: Show Prompt Card 15

THIS CARD SHOWS SOME EXAMPLES OF THESE CONDITIONS.

INCLUDING ANY CONDITIONS WHICH CAN BE CONTROLLED WITH MEDICATION, HAS EVER BEEN TOLD BY A DOCTOR OR NURSE THAT (HE/SHE) HAS ANY HEART OR CIRCULATORY CONDITIONS?

- Yes 1
- No → **Q.500** 2

451. WHAT ARE THE NAMES OF THESE CONDITIONS?

- Rheumatic heart disease a 01
- Heart attack b 02
- Stroke (including after effects of stroke) c 03
- Angina d 04
- High blood pressure/hypertension e 05
- Hardening of the arteries/ atherosclerosis/arteriosclerosis ... f 06
- Fluid problems/fluid retention/ oedema g 07
- High cholesterol h 08
- Rapid or irregular heartbeats/ tachycardia/palpitations i 09
- Heart murmur/heart valve disorder j 10
- Haemorrhoids k 11
- Varicose veins l 12
- Other
(Interviewer: Write in the names of up to 3 conditions below)
- (a) m 13
- (b) n 14
- (c) o 15

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452(a). <input style="width: 100%; height: 20px;" type="text"/>	452(b). <input style="width: 100%; height: 20px;" type="text"/>	452(c). <input style="width: 100%; height: 20px;" type="text"/>
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453. INCLUDING ANY CONDITIONS WHICH IS CONTROLLING WITH MEDICATION, DOES (HE/SHE) CURRENTLY HAVE ANY HEART OR CIRCULATORY CONDITIONS?

- Yes 1
- No → **Q.500** 2

454. WHAT ARE THE NAMES OF THESE HEART OR CIRCULATORY CONDITIONS?

- Rheumatic heart disease a 01
- Heart attack b 02
- Stroke (including after effects of stroke) c 03
- Angina d 04
- High blood pressure/hypertension e 05
- Hardening of the arteries/ atherosclerosis/arteriosclerosis ... f 06
- Fluid problems/fluid retention/ oedema g 07
- High cholesterol h 08
- Rapid or irregular heartbeats/ tachycardia/palpitations i 09
- Heart murmur/heart valve disorder j 10
- Haemorrhoids k 11
- Varicose veins l 12
- Other
(Interviewer: Write in the names of up to 3 conditions below)
- (a) m 13
- (b) n 14
- (c) o 15

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455(a). <input style="width: 100%; height: 20px;" type="text"/>	455(b). <input style="width: 100%; height: 20px;" type="text"/>	455(c). <input style="width: 100%; height: 20px;" type="text"/>
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456. *Sequence Guide:*

- . If shaded box marked in Q.454 → **Q.457** 1
- . Otherwise → **Q.459** 2

457. (AGAIN REMEMBERING TO INCLUDE ANY CONDITIONS WHICH CAN BE CONTROLLED WITH MEDICATION,)

(HAS THIS/HAVE ANY OF THESE) CONDITION(S) LASTED, OR (IS IT/ARE THEY) EXPECTED TO LAST, FOR 6 MONTHS OR MORE?

- Yes 1
- No → **Q.500** 2

<p>458. WHICH CONDITIONS ARE THEY?</p> <p>Angina a <input type="checkbox"/> 01</p> <p>High blood pressure/hypertension b <input type="checkbox"/> 02</p> <p>Hardening of the arteries/ atherosclerosis/arteriosclerosis ... c <input type="checkbox"/> 03</p> <p>Fluid problems/fluid retention/ oedema d <input type="checkbox"/> 04</p> <p>High cholesterol e <input type="checkbox"/> 05</p> <p>Rapid or irregular heartbeats/ tachycardia/palpitations f <input type="checkbox"/> 06</p> <p>Heart murmur/heart valve disorder g <input type="checkbox"/> 07</p> <p>Haemorrhoids h <input type="checkbox"/> 08</p> <p>Varicose veins i <input type="checkbox"/> 09</p> <p>Condition '(a)' from Q.454 j <input type="checkbox"/> 10</p> <p>Condition '(b)' from Q.454 k <input type="checkbox"/> 11</p> <p>Condition '(c)' from Q.454 l <input type="checkbox"/> 12</p>	<p>463. OTHER THAN THE VITAMINS OR HERBAL TREATMENTS YOU JUST TOLD ME ABOUT, HAS USED OR TAKEN ANY OTHER MEDICATION FOR (HIS/HER) HEART OR CIRCULATORY CONDITIONS IN THE <u>LAST 2 WEEKS</u>?</p> <p>Yes → Q.489 <input type="checkbox"/> 1</p> <p>No → Q.500 <input type="checkbox"/> 2</p> <p>Don't know → Q.500 <input type="checkbox"/> 3</p>
<p>459. Sequence Guide:</p> <p>. If 1 box <u>only</u> marked in Q.454 → Q.464 <input type="checkbox"/> 1</p> <p>. Otherwise → Q.460 <input type="checkbox"/> 2</p>	<p>464. (THE NEXT FEW QUESTIONS ARE ABOUT MEDICATION THAT MAY HAVE USED OR TAKEN, IN THE <u>LAST 2 WEEKS</u>, WHICH ARE DIRECTLY RELATED TO (HIS/HER) HEART OR CIRCULATORY CONDITION(S)).</p> <p>INCLUDING ANY VITAMIN AND MINERAL SUPPLEMENTS, AS WELL AS ANY NATURAL OR HERBAL MEDICINES, HAS USED ANY MEDICATION FOR (<i>Specify name of condition 1 recorded in Q.454</i>) IN THE <u>LAST 2 WEEKS</u>?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.471 <input type="checkbox"/> 2</p> <p>Don't know → Q.471 <input type="checkbox"/> 3</p>
<p>460. THE NEXT FEW QUESTIONS ARE ABOUT MEDICATION THAT MAY HAVE USED OR TAKEN, IN THE <u>LAST 2 WEEKS</u>, WHICH ARE DIRECTLY RELATED TO (HIS/HER) HEART OR CIRCULATORY CONDITIONS.</p> <p>INCLUDING ANY VITAMIN AND MINERAL SUPPLEMENTS, AS WELL AS ANY NATURAL OR HERBAL MEDICINES, HAS USED ANY MEDICATION FOR ANY OF (HIS/HER) HEART OR CIRCULATORY CONDITIONS IN THE <u>LAST 2 WEEKS</u>?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.500 <input type="checkbox"/> 2</p>	<p>465. (IT MIGHT BE EASIER TO ANSWER THESE QUESTIONS IF YOU HAVE THE MEDICATION IN FRONT OF YOU.)</p> <p>IN THE <u>LAST 2 WEEKS</u>, FOR (<i>Specify name of condition 1 recorded in Q.454</i>), HAS (HE/SHE) TAKEN ANY -</p> <p>VITAMIN OR MINERAL SUPPLEMENTS? a <input type="checkbox"/> 1</p> <p>HERBAL OR NATURAL TREATMENTS OR REMEDIES? b <input type="checkbox"/> 2</p> <p>Neither of these → Q.467 c <input type="checkbox"/> 3</p>
<p>461. DO YOU KNOW WHICH CONDITIONS IS TAKING EACH MEDICATION FOR?</p> <p>Yes → Q.464 <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p> <p>Some → Q.464 <input type="checkbox"/> 3</p>	<p>466. OTHER THAN THE VITAMINS OR HERBAL TREATMENTS YOU JUST TOLD ME ABOUT, HAS USED OR TAKEN ANY MEDICATION FOR (<i>Specify name of condition 1 recorded in Q.454</i>) IN THE <u>LAST 2 WEEKS</u>?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.471 <input type="checkbox"/> 2</p> <p>Don't know → Q.471 <input type="checkbox"/> 3</p>
<p>462. (IT MIGHT BE EASIER TO ANSWER THESE QUESTIONS IF YOU HAVE THE MEDICATION IN FRONT OF YOU.)</p> <p>IN THE <u>LAST 2 WEEKS</u>, FOR HEART OR CIRCULATORY CONDITIONS, HAS (HE/SHE) TAKEN ANY -</p> <p>VITAMIN OR MINERAL SUPPLEMENTS? a <input type="checkbox"/> 1</p> <p>HERBAL OR NATURAL TREATMENTS OR REMEDIES? b <input type="checkbox"/> 2</p> <p>Neither of these → Q.489 c <input type="checkbox"/> 3</p>	

<p>467. WHAT ARE THE NAMES OR BRANDS OF ALL THE MEDICATION HAS USED FOR (Specify name of condition 1 recorded in Q.454) IN THE <u>LAST 2 WEEKS</u>?</p> <p><i>Interviewer: Write a maximum of 3 names or brands</i></p> <p>(a)</p> <p>(b)</p> <p>(c)</p> <p><i>Interviewer: Mark number of medications reported in a-c</i> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3</p> <p>or</p> <p>Mark if 4 or more medications reported <input type="checkbox"/> 4</p> <p>or</p> <p>Mark if no names or brands known <input type="checkbox"/> 8</p>	<p>475. WHAT ARE THE NAMES OR BRANDS OF ALL THE MEDICATION HAS USED FOR (Specify name of condition 2 recorded in Q.454) IN THE <u>LAST 2 WEEKS</u>?</p> <p><i>Interviewer: Write a maximum of 3 names or brands</i></p> <p>(a)</p> <p>(b)</p> <p>(c)</p> <p><i>Interviewer: Mark number of medications reported in a-c</i> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3</p> <p>or</p> <p>Mark if 4 or more medications reported <input type="checkbox"/> 4</p> <p>or</p> <p>Mark if no names or brands known <input type="checkbox"/> 8</p>												
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<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:16.6%; border: 1px solid #e67e22; text-align: center;">468.</td> <td style="width:16.6%; border: 1px solid #e67e22; text-align: center;">469.</td> <td style="width:16.6%; border: 1px solid #e67e22; text-align: center;">470.</td> <td style="width:16.6%; border: 1px solid #e67e22; text-align: center;">476.</td> <td style="width:16.6%; border: 1px solid #e67e22; text-align: center;">477.</td> <td style="width:16.6%; border: 1px solid #e67e22; text-align: center;">478.</td> </tr> <tr> <td style="border: 1px solid #e67e22; height: 20px;"></td> <td style="border: 1px solid #e67e22; height: 20px;"></td> <td style="border: 1px solid #e67e22; height: 20px;"></td> <td style="border: 1px solid #e67e22; height: 20px;"></td> <td style="border: 1px solid #e67e22; height: 20px;"></td> <td style="border: 1px solid #e67e22; height: 20px;"></td> </tr> </table>	468.	469.	470.	476.	477.	478.							
468.	469.	470.	476.	477.	478.								
<p>471. <i>Sequence Guide:</i></p> <p>. If <u>only 1</u> condition recorded in Q.454 → Q.500 <input type="checkbox"/> 1</p> <p>. If <u>more than 1</u> condition recorded in Q.454 → Q.472 <input type="checkbox"/> 2</p>	<p>479. <i>Sequence Guide:</i></p> <p>. If <u>only 2</u> conditions recorded in Q.454 → Q.487 <input type="checkbox"/> 1</p> <p>. If <u>more than 2</u> conditions recorded in Q.454 → Q.480 <input type="checkbox"/> 2</p>												
<p>472. INCLUDING ANY VITAMIN AND MINERAL SUPPLEMENTS, AS WELL AS ANY NATURAL OR HERBAL MEDICINES, HAS USED ANY MEDICATION FOR (Specify name of condition 2 recorded in Q.454) IN THE <u>LAST 2 WEEKS</u>?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.479 <input type="checkbox"/> 2</p> <p>Don't know → Q.479 <input type="checkbox"/> 3</p>	<p>480. INCLUDING ANY VITAMIN AND MINERAL SUPPLEMENTS, AS WELL AS ANY NATURAL OR HERBAL MEDICINES, HAS USED ANY MEDICATION FOR (Specify name of condition 3 recorded in Q.454) IN THE <u>LAST 2 WEEKS</u>?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.487 <input type="checkbox"/> 2</p> <p>Don't know → Q.487 <input type="checkbox"/> 3</p>												
<p>473. IN THE <u>LAST 2 WEEKS</u>, FOR (Specify name of condition 2 recorded in Q.454), HAS TAKEN ANY -</p> <p>VITAMIN OR MINERAL SUPPLEMENTS? a <input type="checkbox"/> 1</p> <p>HERBAL OR NATURAL TREATMENTS OR REMEDIES? b <input type="checkbox"/> 2</p> <p>Neither of these → Q.475 c <input type="checkbox"/> 3</p>	<p>481. IN THE <u>LAST 2 WEEKS</u>, FOR (Specify name of condition 3 recorded in Q.454), HAS TAKEN ANY -</p> <p>VITAMIN OR MINERAL SUPPLEMENTS? a <input type="checkbox"/> 1</p> <p>HERBAL OR NATURAL TREATMENTS OR REMEDIES? b <input type="checkbox"/> 2</p> <p>Neither of these → Q.483 c <input type="checkbox"/> 3</p>												
<p>474. OTHER THAN THE VITAMINS OR HERBAL TREATMENTS YOU JUST TOLD ME ABOUT, HAS USED OR TAKEN ANY MEDICATION FOR (Specify name of condition 2 recorded in Q.454) IN THE <u>LAST 2 WEEKS</u>?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.479 <input type="checkbox"/> 2</p> <p>Don't know → Q.479 <input type="checkbox"/> 3</p>	<p>482. OTHER THAN THE VITAMINS OR HERBAL TREATMENTS YOU JUST TOLD ME ABOUT, HAS USED OR TAKEN ANY MEDICATION FOR (Specify name of condition 3 recorded in Q.454) IN THE <u>LAST 2 WEEKS</u>?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.487 <input type="checkbox"/> 2</p> <p>Don't know → Q.487 <input type="checkbox"/> 3</p>												

483. WHAT ARE THE NAMES OR BRANDS OF ALL THE MEDICATION HAS USED FOR (Specify name of condition 3 recorded in Q.454) IN THE LAST 2 WEEKS?

Interviewer: Write a maximum of 3 names or brands

(a)

(b)

(c)

Interviewer: Mark number of medications reported in a-c 1
 2
 3

or

Mark if 4 or more medications reported 4

or

Mark if no names or brands known 8

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484.	485.	486.
<input type="text"/>	<input type="text"/>	<input type="text"/>

487. *Sequence Guide:*

. If yes (code '1') in Q.461 ... → **Q.500** 1

. If some (code '3') in Q.461 ... → **Q.488** 2

488. HAS USED OR TAKEN ANY OTHER MEDICATION FOR (HIS/HER) HEART OR CIRCULATORY CONDITIONS IN THE LAST 2 WEEKS?

Yes 1

No → **Q.500** 2

489. WHAT ARE THE NAMES OR BRANDS OF ALL THE (OTHER) MEDICATION HAS USED FOR (HIS/HER) HEART OR CIRCULATORY CONDITION(S) IN THE LAST 2 WEEKS?

Interviewer: Write a maximum of 3 names or brands

(a)

(b)

(c)

Interviewer: Mark number of medications reported in a-c 1
 2
 3

or

Mark if 4 or more medications reported 4

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490.	491.	492.
<input type="text"/>	<input type="text"/>	<input type="text"/>

500. THE NEXT FEW QUESTIONS ARE ABOUT DIABETES AND HIGH SUGAR LEVELS.

HAS EVER BEEN TOLD BY A DOCTOR OR NURSE THAT (HE/SHE) HAS -

DIABETES? a 1

HIGH SUGAR LEVELS IN (HIS/HER) BLOOD OR URINE? b 2

Neither → **Q.522** c 3

501. AT WHAT AGE WAS FIRST TOLD THAT (HE/SHE) HAD (DIABETES/HIGH SUGAR LEVELS)?

Interviewer: If diabetes and high sugar levels marked in Q.500, record age first told had diabetes

Years 0 1
 2 3
 4 5
 6 7
 8 9

Less than 1 year ... 97

Don't know ... 98

502. *Sequence Guide:*

. If diabetes (code '1') in Q.500 → **Q.503** 1

. Otherwise ... → **Q.506** 2

503. WHAT TYPE OF DIABETES WAS TOLD (HE/SHE) HAS?

Type 1 (Insulin Dependent Diabetes Mellitus/Juvenile Onset Diabetes) a 1

Type 2 (Non-Insulin Dependent Diabetes Mellitus/Adult Onset Diabetes) b 2

Gestational (pregnancy) c 3

Diabetes insipidus d 4

Other (Specify) e 5

Don't know f 6

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504.

<input type="text"/>	<input type="text"/>	<input type="text"/>
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505. *Sequence Guide:*

. If diabetes insipidus only (code '4') in Q.503 ... → **Q.522** 1

. Otherwise ... → **Q.506** 2

<p>520. <i>Interviewer: Show Prompt Card 17</i></p> <p>IN THE LAST 12 MONTHS, (HAS/HAVE) (DIABETES/HIGH SUGAR LEVELS) INTERFERED WITH ANYTHING (HE/SHE) USUALLY DOES?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → <i>Q.522</i> <input type="checkbox"/> 2</p>	<p>522. I WOULD NOW LIKE TO ASK YOU ABOUT EYESIGHT.</p> <p>IS COLOUR BLIND?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p>			
<p>521. WHICH ACTIVITIES?</p> <p>Work <i>a</i> <input type="checkbox"/> 1</p> <p>Study <i>b</i> <input type="checkbox"/> 2</p> <p>Other day to day activities <i>c</i> <input type="checkbox"/> 3</p>	<p>523. DOES CURRENTLY WEAR GLASSES OR CONTACT LENSES TO CORRECT, OR PARTIALLY CORRECT, (HIS/HER) EYESIGHT?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → <i>Q.526</i> <input type="checkbox"/> 2</p>			
Empty space for 520 and 521	<p>524. <i>Interviewer: Show Prompt Card 19</i></p> <p>WHAT SIGHT PROBLEMS DO GLASSES OR CONTACT LENSES CORRECT, OR PARTIALLY CORRECT?</p> <p>Astigmatism <i>a</i> <input type="checkbox"/> 1</p> <p>Short-sightedness/Myopia <i>b</i> <input type="checkbox"/> 2</p> <p>Long-sightedness/Hyperopia <i>c</i> <input type="checkbox"/> 3</p> <p>Other (<i>Specify</i>) <i>d</i> <input type="checkbox"/> 4</p> <p>Don't know <i>e</i> <input type="checkbox"/> 5</p> <div style="border: 1px solid black; padding: 2px; margin-top: 5px; text-align: center;"> <p>OFFICE USE ONLY</p> <p>525.</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> </div>			
Empty space for 520 and 521	<p>526. DOES HAVE <u>ANY</u> (OTHER) PROBLEMS WITH (HIS/HER) SIGHT?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → <i>Q.533</i> <input type="checkbox"/> 2</p> <p>Don't know → <i>Q.533</i> <input type="checkbox"/> 3</p>			
Empty space for 520 and 521	<p>527. CAN ANY OF THESE (OTHER) PROBLEMS BE CORRECTED, OR PARTIALLY CORRECTED, BY GLASSES OR CONTACT LENSES?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → <i>Q.531</i> <input type="checkbox"/> 2</p> <p>Don't know → <i>Q.531</i> <input type="checkbox"/> 3</p>			

528. *Interviewer: Show Prompt Card 19*

WHAT (OTHER) SIGHT PROBLEMS DOES HAVE THAT CAN BE CORRECTED, OR PARTIALLY CORRECTED, BY GLASSES OR CONTACT LENSES?

- Astigmatism a 1
- Short-sightedness/Myopia b 2
- Long-sightedness/Hyperopia ... c 3
- Other (*Specify*)
- d 4
- Don't know e 5

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529.

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530. DOES HAVE ANY (OTHER) SIGHT PROBLEMS?

- Yes 1
- No → Q.533 2
- Don't know → Q.533 3

531. WHAT (OTHER) SIGHT PROBLEMS DOES HAVE?

- Totally blind in both eyes a 01
- Totally blind in 1 eye only b 02
- Partially blind in both eyes c 03
- Partially blind in 1 eye only d 04
- Glaucoma e 05
- Cataracts f 06
- Trachoma g 07
- Lazy eye/Strabismus h 08
- Other (*Specify*)
- i 09
- Don't know j 10

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532.

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533. *Sequence Guide:*

- . *If currently has diabetes/high sugar levels (code '1') in Q.506* ... → Q.534 1
- . *Otherwise* ... → Q.542 2

534. *Sequence Guide:*

- . *If sight problems reported (code '1') in Q.523 or Q.526* → Q.535 1
- . *Otherwise* ... → Q.541 2

535. ARE ANY OF SIGHT PROBLEMS DUE TO (HIS/HER) (DIABETES/HIGH SUGAR LEVELS)?

- Yes 1
- No → Q.541 2
- Don't know → Q.541 3

536. *Interviewer:*

- . *If only 1 sight problem reported in Q.524, Q.528 or Q.531, mark problem in Q.537 and ask Q.539* ... → Q.537 1
- . *Otherwise* ... → Q.537 2

537. OF THE SIGHT PROBLEMS YOU HAVE TOLD ME ABOUT, WHICH ONES ARE DUE TO (DIABETES/HIGH SUGAR LEVELS)?

- Astigmatism a 01
- Short-sightedness/Myopia b 02
- Long-sightedness/Hyperopia ... c 03
- Totally blind in both eyes d 04
- Totally blind in 1 eye only e 05
- Partially blind in both eyes f 06
- Partially blind in 1 eye only ... g 07
- Glaucoma h 08
- Cataracts i 09
- Trachoma j 10
- Lazy eye/Strabismus k 11
- Other (*Specify*)
- l 12
- Don't know m 13

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538.

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539. HOW LONG AGO SINCE LAST CONSULTED AN EYE SPECIALIST OR OPTOMETRIST ABOUT ANY OF THESE CONDITIONS?

Interviewer: If has visited both an optometrist and an eye specialist, record the most recent visit

- Less than 1 year ... 1
1 to less than 2 years ... 2
2 to less than 5 years ... 3
5 years or more ... 4
Never ... 5
Don't know ... 6

540. -> Q.542

541. HOW LONG AGO SINCE LAST CONSULTED AN EYE SPECIALIST OR OPTOMETRIST?

Interviewer: If has visited both an optometrist and an eye specialist, record the most recent visit

- Less than 1 year ... 1
1 to less than 2 years ... 2
2 to less than 5 years ... 3
5 years or more ... 4
Never ... 5
Don't know ... 6

542. DOES HAVE ANY HEARING PROBLEMS OR PROBLEMS WITH (HIS/HER) EARS THAT HAVE LASTED, OR ARE EXPECTED TO LAST, FOR 6 MONTHS OR MORE?

- Yes ... 1
No ... -> Q.545 2

543. WHAT HEARING OR EAR PROBLEMS DOES HAVE?

- Total deafness ... a 1
Deaf in 1 ear ... b 2
Hearing loss/partially deaf ... c 3
Tinnitus ... d 4
Meniere's Disease/Syndrome ... e 5
Otitis media ... f 6
Other (Specify) ... g 7
Don't know ... h 8

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544.

Three empty boxes for recording data.

545. DOES CURRENTLY HAVE -

- OSTEOARTHRITIS? ... a 1
RHEUMATOID ARTHRITIS? ... b 2
GOUT? ... c 3
RHEUMATISM? ... d 4
OTHER TYPE OF ARTHRITIS? (Specify)
Arthritis - type unknown ... f 6
None of these -> Q.550 g 7

OFFICE USE ONLY

546.

Three empty boxes for recording data.

547. Sequence Guide:

- If osteoarthritis only (code '1') in Q.545 ... -> Q.550 1
Otherwise ... -> Q.548 2

548. (HAS THIS/HAVE ANY OF THESE) CONDITION(S) LASTED, OR (IS IT/ARE THEY) EXPECTED TO LAST, FOR 6 MONTHS OR MORE?

- Yes ... 1
No ... -> Q.550 2
Don't know ... -> Q.550 3

549. Interviewer: If more than 1 condition marked in Q.545, ask WHICH ONES?

- Rheumatoid arthritis ... a 1
Gout ... b 2
Rheumatism ... c 3
Other type of arthritis ... d 4
Arthritis - type unknown ... e 5

550. THE NEXT FEW QUESTIONS ARE ABOUT OTHER LONG TERM CONDITIONS, THAT IS, CONDITIONS WHICH HAVE LASTED, OR ARE EXPECTED TO LAST, FOR 6 MONTHS OR MORE.

DOES HAVE ANY OF THESE CONDITIONS?

Interviewer: Show Prompt Card 20

- Yes 1
- No → **Q.552** 2

551. WHICH OF THESE DOES HAVE?

- Hayfever a 01
- Sinusitis or sinus allergy b 02
- Other allergy c 03
- Anaemia d 04
- Bronchitis e 05
- Cystic fibrosis f 06
- Emphysema g 07
- Epilepsy h 08
- Fluid problems/fluid retention/
oedema (not due to heart or
circulatory problems) i 09
- Hernias j 10
- Kidney stones k 11
- Migraine l 12
- Osteoporosis m 13
- Psoriasis n 14
- Stomach ulcers or other
gastrointestinal ulcers o 15
- Thyroid trouble/goitre p 16
- Tuberculosis q 17

552. (APART FROM THE CONDITION(S) YOU HAVE ALREADY TOLD ME ABOUT,)

DOES HAVE ANY OTHER CONDITIONS THAT HAVE LASTED, OR ARE EXPECTED TO LAST, FOR 6 MONTHS OR MORE. FOR EXAMPLE:

Interviewer: Show Prompt Card 21

- Yes 1
- No → **Q.558** 2

553. WHICH CONDITIONS DOES HAVE?

- (a)
 - (b)
 - (c)
 - (d) 1
 2
 3
 4
- Interviewer: Mark number of conditions reported in a-d*

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554. <input type="text"/>	555. <input type="text"/>
556. <input type="text"/>	557. <input type="text"/>

558. (APART FROM THE CONDITION(S) YOU HAVE ALREADY TOLD ME ABOUT,)

DOES HAVE ANY (OTHER) LONG TERM CONDITIONS SUCH AS THESE:

Interviewer: Show Prompt Card 22

- Yes 1
- No → **Q.564** 2

559. WHICH CONDITIONS DOES HAVE?

- (a)
 - (b)
 - (c)
 - (d) 1
 2
 3
 4
- Interviewer: Mark number of conditions reported in a-d*

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560. <input type="text"/>	561. <input type="text"/>
562. <input type="text"/>	563. <input type="text"/>

600. (INJURIES ARE A MAJOR HEALTH PROBLEM. IN ORDER TO DEVELOP NEW WAYS TO HELP PREVENT BOTH ACCIDENTAL AND INTENTIONAL INJURIES, WE NEED TO KNOW MORE ABOUT THEM.)

(SOME PEOPLE REMEMBER THEIR INJURIES BY THINKING ABOUT THE TYPES OF INJURY RECEIVED, WHILE OTHERS FIND IT EASIER TO RECALL INJURIES BY REMEMBERING HOW THE INJURY HAPPENED.)

Interviewer: Show Prompt Card 23

IN THE LAST 4 WEEKS, HAVE ANY OF THESE HAPPENED TO?

- Yes 1
- No → **Q.700A** 2

601. *Interviewer:* Show Prompt Card 24

DID ANY OF THESE EVENTS RESULT IN ANY OF THE FOLLOWING ACTIONS?

- Yes 1
- No → **Q.700A** 2

602. WHICH EVENTS WERE THESE ACTIONS TAKEN FOR?

Interviewer: Show Prompt Card 25
Record the number of each type of event
Do not collect details about food poisoning

Type of event	No. of events					
	1	2	3	4	5+	
Vehicle accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a
Low fall (1 metre or less)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b
High fall (more than 1 metre)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c
Hitting something or being hit by something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d
Attack by another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e
Near drowning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f
Exposure to fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g
Exposure to chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h
Bite or sting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i
Other event requiring some action	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	j

603. *Interviewer:*

- . If only food poisoning reported → **Q.700A** 1
- . If only 1 event reported in Q.602, mark the appropriate box in Q.604 and ask Q.605 2
- . Otherwise → **Q.604** 3

604. (NOT INCLUDING FOOD POISONING,) (OF THOSE), WHICH EVENT(S) HAPPENED (MOST RECENTLY/ SECOND MOST RECENTLY/THIRD MOST RECENTLY)?

Type of event	Most recent	2nd most recent	3rd most recent	
	a	b	c	
Vehicle accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	01
Low fall (1 metre or less)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	02
High fall (more than 1 metre)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	03
Hitting something or being hit by something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	04
Attack by another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	05
Near drowning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	06
Exposure to fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	07
Exposure to chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	08
Bite or sting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	09
Other event	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10

605. I WOULD NOW LIKE TO ASK YOU ABOUT THE MOST RECENT EVENT, THAT IS, THE *(Specify most recent event marked in Q.604).*

Interviewer: Show Prompt Card 26

WHICH OF THESE BEST DESCRIBES THE INJURY(IES) RECEIVED AS A RESULT OF *(Specify most recent event recorded in Q.604)?* (WHICH PART OR PARTS OF (HIS/HER) BODY WERE INJURED?)

Interviewer:

1. Mark the injury type, e.g. fractures, (down the left hand side)
2. Mark the body part that was injured as a result of EACH of the types of injuries, e.g. arms, (along the top)

		a	b	c	d	e	f	g	h	i	j	k	l
			Eyes	Head (ex. eyes)	Neck (ex. spine)	Shoulder (incl. collar bone)	Arms (incl. wrists)	Hands/ fingers	Back/ spine	Trunk (incl. chest, internal organs, groin & buttocks (bottom))	Hip	Legs/ feet	Whole body
606	Fractures	<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"/>
607	Dislocations, sprains, strains, torn muscles/ligaments	<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"/>
608	Internal injury	<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"/>
609	Open wounds	<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"/>
610	Bruising	<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"/>
611	Burns and scalds	<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"/>
612	Concussion	<input type="checkbox"/>											
613	Choking	<input type="checkbox"/>											
614	Poisoning	<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"/>
615	Other	<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"/>
616	No injury sustained	<input type="checkbox"/> → Q.628											

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<p>617. <i>Sequence Guide:</i></p> <p>. If child aged 15 or more ... → Q.618 <input type="checkbox"/> 1</p> <p>. Otherwise ... → Q.620 <input type="checkbox"/> 2</p>	<p>622. DID ATTEND HOSPITAL FOR THE INJURY(IES) RECEIVED IN (<i>Specify most recent event recorded in Q.604</i>)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.624 <input type="checkbox"/> 2</p> <p>Don't know → Q.624 <input type="checkbox"/> 3</p>
<p>618. DID RECEIVE THE INJURY(IES) WHILE -</p> <p>WORKING FOR INCOME? <input type="checkbox"/> 1</p> <p>WORKING AS A VOLUNTEER? → Q.621 <input type="checkbox"/> 2</p> <p>Neither → Q.620 <input type="checkbox"/> 3</p>	<p>623. <i>Interviewer: Show Prompt Card 31</i></p> <p>WHICH OF THESE DID ATTEND AT THE HOSPITAL?</p> <p>Inpatient stay in hospital a <input type="checkbox"/> 1</p> <p>Emergency/casualty department b <input type="checkbox"/> 2</p> <p>Outpatient clinic at hospital c <input type="checkbox"/> 3</p>
<p>619. WAS THIS THE SAME JOB YOU TOLD ME ABOUT EARLIER?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p>	<p>624. <i>Interviewer: Show Prompt Card 32</i></p> <p>DID VISIT ANY OF THESE FOR THE INJURY(IES) (HE/SHE) RECEIVED IN (<i>Specify most recent event recorded in 604</i>)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.626 <input type="checkbox"/> 2</p> <p>Don't know → Q.626 <input type="checkbox"/> 3</p>
<p>619A. → Q.621</p> <p>620. <i>Interviewer: Show Prompt Card 28</i></p> <p>WHICH OF THESE BEST DESCRIBES THE ACTIVITY WAS DOING WHEN (HE/SHE) RECEIVED THE INJURY(IES) SUSTAINED IN (<i>Specify most recent event recorded in Q.604</i>)?</p> <p>Sports activities <input type="checkbox"/> 1</p> <p>Leisure activities <input type="checkbox"/> 2</p> <p>Resting, sleeping, eating or other personal activities <input type="checkbox"/> 3</p> <p>Being nursed or cared for <input type="checkbox"/> 4</p> <p>Attending pre-school/school/college/university <input type="checkbox"/> 5</p> <p>Domestic activities <input type="checkbox"/> 6</p> <p>Other <input type="checkbox"/> 7</p>	<p>625. WHICH ONES?</p> <p>Doctor, General Practitioner ... a <input type="checkbox"/> 1</p> <p>Other health professional ... b <input type="checkbox"/> 2</p> <p>626. DID HAVE ANY TIME OFF (WORK/SCHOOL/ (HIS/HER) PLACE OF STUDY) DUE TO THE INJURY(IES)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No/not applicable <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p>
<p>621. <i>Interviewer: Show Prompt Card 30</i></p> <p>IN WHICH OF THESE LOCATIONS WAS WHEN (HE/SHE) RECEIVED THE INJURY(IES) FROM THE (<i>Specify most recent event recorded in Q.604</i>)?</p> <p>Inside own/someone else's home <input type="checkbox"/> 01</p> <p>Outside own/someone else's home <input type="checkbox"/> 02</p> <p>At pre-school/school/college/university <input type="checkbox"/> 03</p> <p>Residential institution <input type="checkbox"/> 04</p> <p>Health care facility <input type="checkbox"/> 05</p> <p>Sports facility/athletics field/park ... <input type="checkbox"/> 06</p> <p>Street/highway <input type="checkbox"/> 07</p> <p>Commercial place <input type="checkbox"/> 08</p> <p>Industrial place <input type="checkbox"/> 09</p> <p>Farm <input type="checkbox"/> 10</p> <p>Other <input type="checkbox"/> 11</p>	<p>627. ON ANY OTHER DAYS, DID CUT DOWN ON ANYTHING (HE/SHE) USUALLY DOES BECAUSE OF THE INJURY(IES)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p> <p>628. <i>Sequence Guide:</i></p> <p>. If <i>only 1</i> event recorded in Q.604 → Q.700A <input type="checkbox"/> 1</p> <p>. If <i>more than 1</i> event recorded in Q.604 → Q.629 <input type="checkbox"/> 2</p>

629. I WOULD NOW LIKE TO ASK YOU ABOUT THE SECOND MOST RECENT EVENT, THAT IS, THE (Specify 2nd most recent event recorded in Q.604).

Interviewer: Show Prompt Card 26

WHICH OF THESE BEST DESCRIBES THE INJURY(IES) RECEIVED AS A RESULT OF (Specify 2nd most recent event recorded in Q.604)? (WHICH PART OR PARTS OF (HIS/HER) BODY WERE INJURED?)

Interviewer:

1. Mark the injury type, e.g. fractures, (down the left hand side)
2. Mark the body part that was injured as a result of EACH of the types of injuries, e.g. arms, (along the top)

		a	b	c	d	e	f	g	h	i	j	k	l
		Eyes	Head (ex. eyes)	Neck (ex. spine)	Shoulder (incl. collar bone)	Arms (incl. wrists)	Hands/ fingers	Back/ spine	Trunk (incl. chest, internal organs, groin & buttocks (bottom))	Hip	Legs/ feet	Whole body	
630	Fractures	<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"/>
631	Dislocations, sprains, strains, torn muscles/ ligaments	<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"/>
632	Internal injury	<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"/>
633	Open wounds	<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"/>
634	Bruising	<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"/>
635	Burns and scalds	<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"/>
636	Concussion	<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"/>
637	Choking	<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"/>
638	Poisoning	<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"/>
639	Other	<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"/>
640	No injury sustained	<input type="checkbox"/> → Q.652											

COMMENTS

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<p>641. <i>Sequence Guide:</i></p> <p>. If child aged 15 or more ... → Q.642 <input type="checkbox"/> 1</p> <p>. Otherwise ... → Q.644 <input type="checkbox"/> 2</p>	<p>646. DID ATTEND HOSPITAL FOR THE INJURY(IES) RECEIVED IN (Specify 2nd most recent event recorded in Q.604)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.648 <input type="checkbox"/> 2</p> <p>Don't know → Q.648 <input type="checkbox"/> 3</p>
<p>642. DID RECEIVE THE INJURY(IES) WHILE -</p> <p>WORKING FOR INCOME? <input type="checkbox"/> 1</p> <p>WORKING AS A VOLUNTEER? → Q.645 <input type="checkbox"/> 2</p> <p>Neither → Q.644 <input type="checkbox"/> 3</p>	<p>647. <i>Interviewer: Show Prompt Card 31</i></p> <p>WHICH OF THESE DID ATTEND AT THE HOSPITAL?</p> <p>Inpatient stay in hospital a <input type="checkbox"/> 1</p> <p>Emergency/casualty department b <input type="checkbox"/> 2</p> <p>Outpatient clinic at hospital c <input type="checkbox"/> 3</p>
<p>643. WAS THIS THE SAME JOB YOU TOLD ME ABOUT EARLIER?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p>	<p>648. <i>Interviewer: Show Prompt Card 32</i></p> <p>DID VISIT ANY OF THESE FOR THE INJURY(IES) (HE/SHE) RECEIVED IN (Specify 2nd most recent event recorded in Q.604)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.650 <input type="checkbox"/> 2</p> <p>Don't know → Q.650 <input type="checkbox"/> 3</p>
<p>643A. → Q.645</p>	<p>649. WHICH ONES?</p> <p>Doctor, General Practitioner ... a <input type="checkbox"/> 1</p> <p>Other health professional ... b <input type="checkbox"/> 2</p>
<p>644. <i>Interviewer: Show Prompt Card 28</i></p> <p>WHICH OF THESE BEST DESCRIBES THE ACTIVITY WAS DOING WHEN (HE/SHE) RECEIVED THE INJURY(IES) SUSTAINED IN (Specify 2nd most recent event recorded in Q.604)?</p> <p>Sports activities <input type="checkbox"/> 1</p> <p>Leisure activities <input type="checkbox"/> 2</p> <p>Resting, sleeping, eating or other personal activities <input type="checkbox"/> 3</p> <p>Being nursed or cared for <input type="checkbox"/> 4</p> <p>Attending pre-school/school/college/university <input type="checkbox"/> 5</p> <p>Domestic activities <input type="checkbox"/> 6</p> <p>Other <input type="checkbox"/> 7</p>	<p>650. DID HAVE ANY TIME OFF (WORK/SCHOOL/ (HIS/HER) PLACE OF STUDY) DUE TO THE INJURY(IES)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No/not applicable <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p>
<p>645. <i>Interviewer: Show Prompt Card 30</i></p> <p>IN WHICH OF THESE LOCATIONS WAS WHEN (HE/SHE) RECEIVED THE INJURY(IES) FROM THE (Specify 2nd most recent event recorded in Q.604)?</p> <p>Inside own/someone else's home <input type="checkbox"/> 01</p> <p>Outside own/someone else's home <input type="checkbox"/> 02</p> <p>At pre-school/school/college/university <input type="checkbox"/> 03</p> <p>Residential institution <input type="checkbox"/> 04</p> <p>Health care facility <input type="checkbox"/> 05</p> <p>Sports facility/athletics field/park ... <input type="checkbox"/> 06</p> <p>Street/highway <input type="checkbox"/> 07</p> <p>Commercial place <input type="checkbox"/> 08</p> <p>Industrial place <input type="checkbox"/> 09</p> <p>Farm <input type="checkbox"/> 10</p> <p>Other <input type="checkbox"/> 11</p>	<p>651. ON ANY OTHER DAYS, DID CUT DOWN ON ANYTHING (HE/SHE) USUALLY DOES BECAUSE OF THE INJURY(IES)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p>
	<p>652. <i>Sequence Guide:</i></p> <p>. If <i>only</i> 2 events recorded in Q.604 → Q.700A <input type="checkbox"/> 1</p> <p>. If <i>more than</i> 2 events recorded in Q.604 → Q.653 <input type="checkbox"/> 2</p>

653. I WOULD NOW LIKE TO ASK YOU ABOUT THE THIRD MOST RECENT EVENT, THAT IS, THE (Specify 3rd most recent event recorded in Q.604).

Interviewer: Show Prompt Card 26

WHICH OF THESE BEST DESCRIBES THE INJURY(IES) RECEIVED AS A RESULT OF (Specify 3rd most recent event recorded in Q.604)? (WHICH PART OR PARTS OF (HIS/HER) BODY WERE INJURED?)

Interviewer:

1. Mark the injury type, e.g. fractures, (down the left hand side)
2. Mark the body part that was injured as a result of EACH of the types of injuries, e.g. arms, (along the top)

		a	b	c	d	e	f	g	h	i	j	k	l
		Eyes	Head (ex. eyes)	Neck (ex. spine)	Shoulder (incl. collar bone)	Arms (incl. wrists)	Hands/ fingers	Back/ spine	Trunk (incl. chest, internal organs, groin & buttocks (bottom))	Hip	Legs/ feet	Whole body	
654	Fractures	<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"/>	
655	Dislocations, sprains, strains, torn muscles/ ligaments	<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"/>	
656	Internal injury	<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"/>	
657	Open wounds	<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"/>	
658	Bruising	<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"/>	
659	Burns and scalds	<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"/>	
660	Concussion	<input type="checkbox"/>											
661	Choking	<input type="checkbox"/>											
662	Poisoning	<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"/>	
663	Other	<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"/>	
664	No injury sustained	<input type="checkbox"/> → Q.700A											

COMMENTS

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<p>665. <i>Sequence Guide:</i></p> <p>. If child aged 15 or more ... → Q.666 <input type="checkbox"/> 1</p> <p>. Otherwise ... → Q.668 <input type="checkbox"/> 2</p>	<p>670. DID ATTEND HOSPITAL FOR THE INJURY(IES) RECEIVED IN (<i>Specify 3rd most recent event recorded in Q.604</i>)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.672 <input type="checkbox"/> 2</p> <p>Don't know → Q.672 <input type="checkbox"/> 3</p>
<p>666. DID RECEIVE THE INJURY(IES) WHILE -</p> <p>WORKING FOR INCOME? <input type="checkbox"/> 1</p> <p>WORKING AS A VOLUNTEER? → Q.669 <input type="checkbox"/> 2</p> <p>Neither → Q.668 <input type="checkbox"/> 3</p>	<p>671. <i>Interviewer: Show Prompt Card 31</i></p> <p>WHICH OF THESE DID ATTEND AT THE HOSPITAL?</p> <p>Inpatient stay in hospital a <input type="checkbox"/> 1</p> <p>Emergency/casualty department b <input type="checkbox"/> 2</p> <p>Outpatient clinic at hospital c <input type="checkbox"/> 3</p>
<p>667. WAS THIS THE SAME OCCUPATION YOU TOLD ME ABOUT EARLIER?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p>	<p>672. <i>Interviewer: Show Prompt Card 32</i></p> <p>DID VISIT ANY OF THESE FOR THE INJURY(IES) (HE/SHE) RECEIVED IN (<i>Specify 3rd most recent event recorded in Q.604</i>)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.674 <input type="checkbox"/> 2</p> <p>Don't know → Q.674 <input type="checkbox"/> 3</p>
<p>667A. → Q.669</p>	<p>673. WHICH ONES?</p> <p>Doctor, General Practitioner ... a <input type="checkbox"/> 1</p> <p>Other health professional ... b <input type="checkbox"/> 2</p>
<p>668. <i>Interviewer: Show Prompt Card 28</i></p> <p>WHICH OF THESE BEST DESCRIBES THE ACTIVITY WAS DOING WHEN (HE/SHE) RECEIVED THE INJURY(IES) SUSTAINED IN (<i>Specify 3rd most recent event recorded in Q.604</i>)?</p> <p>Sports activities <input type="checkbox"/> 1</p> <p>Leisure activities <input type="checkbox"/> 2</p> <p>Resting, sleeping, eating or other personal activities <input type="checkbox"/> 3</p> <p>Being nursed or cared for <input type="checkbox"/> 4</p> <p>Attending pre-school/school/college/university <input type="checkbox"/> 5</p> <p>Domestic activities <input type="checkbox"/> 6</p> <p>Other <input type="checkbox"/> 7</p>	<p>674. DID HAVE ANY TIME OFF (WORK/SCHOOL/ (HIS/HER) PLACE OF STUDY) DUE TO THE INJURY(IES)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No/not applicable <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p>
<p>669. <i>Interviewer: Show Prompt Card 30</i></p> <p>IN WHICH OF THESE LOCATIONS WAS WHEN (HE/SHE) RECEIVED THE INJURY(IES) FROM THE (<i>Specify 3rd most recent event recorded in Q.604</i>)?</p> <p>Inside own/someone else's home <input type="checkbox"/> 01</p> <p>Outside own/someone else's home <input type="checkbox"/> 02</p> <p>At pre-school/school/college/university <input type="checkbox"/> 03</p> <p>Residential institution <input type="checkbox"/> 04</p> <p>Health care facility <input type="checkbox"/> 05</p> <p>Sports facility/athletics field/park ... <input type="checkbox"/> 06</p> <p>Street/highway <input type="checkbox"/> 07</p> <p>Commercial place <input type="checkbox"/> 08</p> <p>Industrial place <input type="checkbox"/> 09</p> <p>Farm <input type="checkbox"/> 10</p> <p>Other <input type="checkbox"/> 11</p>	<p>675. ON ANY OTHER DAYS, DID CUT DOWN ON ANYTHING (HE/SHE) USUALLY DOES BECAUSE OF THE INJURY(IES)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p>

<p>700A. Sequence Guide:</p> <ul style="list-style-type: none"> . If child aged less than 5 years → Q.710 <input type="checkbox"/> 1 . If child aged less than 15 years → Q.701 <input type="checkbox"/> 2 . If child aged 15-17 years <u>and</u> is a student (column G on HF) ... → Q.701 <input type="checkbox"/> 3 . If child had a job last week (code '1' or '2') in Q.63 ... → Q.701 <input type="checkbox"/> 4 . Otherwise ... → Q.707 <input type="checkbox"/> 5 	<p>707. I NOW WANT YOU TO THINK ABOUT <u>ANY ILLNESS OR INJURY</u> HAD, AND THE EFFECTS THIS MAY HAVE HAD ON (HIM/HER) IN THE <u>LAST 2 WEEKS</u>.</p>
<p>701. I NOW WANT YOU TO THINK ABOUT <u>ANY ILLNESS OR INJURY</u> HAD, AND THE EFFECTS THIS MAY HAVE HAD ON (HIM/HER) IN THE <u>LAST 2 WEEKS</u>.</p> <p>IN THE <u>LAST 2 WEEKS</u>, HAS STAYED AWAY FROM (HIS/HER) (WORK/SCHOOL/PLACE OF STUDY) FOR MORE THAN HALF THE DAY BECAUSE OF ANY ILLNESS OR INJURY (<u>HE/SHE</u>) HAD?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.703 <input type="checkbox"/> 2</p>	<p>708. (APART FROM WHEN WAS AWAY FROM (WORK/SCHOOL/(HIS/HER) PLACE OF STUDY),) ON ANY (<u>OTHER</u>) DAYS IN THE <u>LAST 2 WEEKS</u>, HAS HAD TO CUT DOWN ON ANYTHING (HE/SHE) USUALLY DOES BECAUSE OF THESE ILLNESSES OR INJURIES?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.710 <input type="checkbox"/> 2</p>
<p>702. ON HOW MANY DAYS IN THE <u>LAST 2 WEEKS</u> HAS STAYED AWAY FROM (HIS/HER) (WORK/SCHOOL/PLACE OF STUDY)?</p> <p><i>Interviewer: Record number</i></p> <p>Number <input type="text"/> <input type="text"/></p> <p>14 days → Q.710 <input type="checkbox"/> 14</p>	<p>709. ON HOW MANY DAYS IN THE <u>LAST 2 WEEKS</u>, HAS CUT DOWN ON (HIS/HER) USUAL ACTIVITIES?</p> <p><i>Interviewer: Record number</i></p> <p>Number <input type="text"/> <input type="text"/></p> <p>14 days <input type="checkbox"/> 14</p>
<p>703. Sequence Guide:</p> <ul style="list-style-type: none"> . If child aged less than 10 years → Q.708 <input type="checkbox"/> 1 . Otherwise ... → Q.704 <input type="checkbox"/> 2 	<div style="text-align: right;"> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 </div>
<p>704. IN THE <u>LAST 2 WEEKS</u>, DID HAVE ANY DAYS OFF (WORK/SCHOOL/STUDY) TO LOOK AFTER OR CARE FOR SOMEONE ELSE BECAUSE <u>THEY</u> WERE SICK OR INJURED?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.708 <input type="checkbox"/> 2</p>	
<p>705. ON HOW MANY DAYS IN THE <u>LAST 2 WEEKS</u>, HAS STAYED AWAY FROM (HIS/HER) (WORK/SCHOOL/PLACE OF STUDY) TO LOOK AFTER SOMEONE ELSE?</p> <p><i>Interviewer: Record number</i></p> <p>Number <input type="text"/> <input type="text"/></p> <p>14 days → Q.710 <input type="checkbox"/> 14</p>	
<p>706. → Q.708</p>	

710. THE FOLLOWING QUESTIONS ARE ABOUT USE OF HEALTH SERVICES IN THE LAST 2 WEEKS.

IN THE LAST 2 WEEKS, HAS VISITED THE OUTPATIENTS SECTION OF A HOSPITAL FOR (HIS/HER) OWN HEALTH?

Yes 1
No → *Q.713* 2

711. HOW MANY TIMES IN THE LAST 2 WEEKS, DID ATTEND THE OUTPATIENTS SECTION?

Interviewer: Record number

Number 0 0
 1 1
 2 2
 3 3
 4 4
 5 5
 6 6
 7 7
 8 8
 9 9

712. (I WANT TO ASK ABOUT THE MOST RECENT OF THESE VISITS.)

WAS THIS VISIT RELATED TO -
A PREVIOUS ADMISSION TO HOSPITAL? 1
AN EXPECTED ADMISSION TO HOSPITAL? 2
Neither 3
Don't know 4

713. IN THE LAST 2 WEEKS, HAS VISITED A CASUALTY OR EMERGENCY WARD FOR (HIS/HER) OWN HEALTH?

Yes 1
No → *Q.715* 2

714. HOW MANY TIMES IN THE LAST 2 WEEKS, DID ATTEND A CASUALTY OR EMERGENCY WARD?

Interviewer: Record number

Number 0 0
 1 1
 2 2
 3 3
 4 4
 5 5
 6 6
 7 7
 8 8
 9 9

715. (APART FROM VISIT(S) TO (OUTPATIENTS/(OR) CASUALTY OR EMERGENCY),)

IN THE LAST 2 WEEKS, HAS BEEN TO A DAY CLINIC FOR MINOR SURGERY OR DIAGNOSTIC TESTS, OTHER THAN AN X-RAY, FOR (HIS/HER) OWN HEALTH?

Yes 1
No → *Q.717* 2

716. HOW MANY TIMES IN THE LAST 2 WEEKS, DID VISIT A DAY CLINIC?

Interviewer: Record number

Number 0 0
 1 1
 2 2
 3 3
 4 4
 5 5
 6 6
 7 7
 8 8
 9 9

717. I WOULD NOW LIKE TO ASK YOU ABOUT ALL OF THE TIMES HAS BEEN ADMITTED TO HOSPITAL IN THE LAST 12 MONTHS.

(APART FROM VISIT(S) TO (OUTPATIENTS/(OR) CASUALTY OR EMERGENCY/(OR) A DAY CLINIC),)

DURING THE LAST 12 MONTHS, HAS BEEN ADMITTED TO HOSPITAL?

Yes 1
No → *Q.722* 2

718. (APART FROM VISIT(S) TO (OUTPATIENTS/(OR) CASUALTY OR EMERGENCY/(OR) A DAY CLINIC),)

HOW MANY TIMES HAS BEEN ADMITTED TO HOSPITAL IN THE LAST 12 MONTHS?

Interviewer: Record number

Number 0 0
 1 1
 2 2
 3 3
 4 4
 5 5
 6 6
 7 7
 8 8
 9 9

Don't know 98

719. I WOULD LIKE TO TALK ABOUT (THIS/..... MOST RECENT) ADMISSION TO HOSPITAL.

HOW MANY NIGHTS DID STAY IN HOSPITAL?

Interviewer: Record number

Number 0 0
 1 1
 2 2
 3 3
 4 4
 5 5
 6 6
 7 7
 8 8
 9 9

Don't know 98

720. WAS DISCHARGED FROM HOSPITAL IN THE LAST 2 WEEKS?

Yes 1
No 2

721. DURING (THIS/..... MOST RECENT) ADMISSION TO HOSPITAL, WAS (HE/SHE) ADMITTED AS A -

MEDICARE PATIENT? 1
PRIVATE PATIENT? 2
Don't know 3

<p>722. IN THE LAST 2 WEEKS, HAS CONSULTED A DENTIST OR DENTAL PROFESSIONAL ABOUT (HIS/HER) TEETH, DENTURES OR GUMS?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.724 <input type="checkbox"/> 2</p>	<p>726. HOW MANY TIMES IN THE LAST 2 WEEKS, DID CONSULT A GENERAL PRACTITIONER?</p> <p><i>Interviewer: Record number</i></p> <p>Number <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> <input type="checkbox"/> 0 <input type="checkbox"/> 0</p> <p style="text-align: right;"> <input type="checkbox"/> 1 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 9 </p>
<p>723. HOW MANY CONSULTATIONS HAS HAD IN THE LAST 2 WEEKS?</p> <p><i>Interviewer: Record number</i></p> <p>Number ... <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> → Q.725</p> <p style="text-align: right;"> <input type="checkbox"/> 0 <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 9 </p>	<p>727. (APART FROM CONSULTATIONS DURING ANY HOSPITAL OR DAY CLINIC VISITS,)</p> <p>IN THE LAST 2 WEEKS, HAS CONSULTED A SPECIALIST?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.729 <input type="checkbox"/> 2</p>
<p>724. WHEN WAS THE LAST TIME CONSULTED A DENTIST OR DENTAL PROFESSIONAL?</p> <p>Less than 3 months ago <input type="checkbox"/> 1</p> <p>3 months to less than 6 months ago <input type="checkbox"/> 2</p> <p>6 months to less than 12 months ago <input type="checkbox"/> 3</p> <p>12 months to less than 2 years ago <input type="checkbox"/> 4</p> <p>2 years ago or more <input type="checkbox"/> 5</p> <p>Never <input type="checkbox"/> 6</p> <p>Don't know <input type="checkbox"/> 7</p>	<p>728. HOW MANY TIMES IN THE LAST 2 WEEKS, DID CONSULT A SPECIALIST?</p> <p><i>Interviewer: Record number</i></p> <p>Number ... <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> → Q.731</p> <p style="text-align: right;"> <input type="checkbox"/> 0 <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 9 </p>
<p>725. THE NEXT FEW QUESTIONS ARE ABOUT VISITS TO DOCTORS OR SPECIALISTS.</p> <p>(APART FROM CONSULTATIONS DURING ANY HOSPITAL OR DAY CLINIC VISITS,)</p> <p>IN THE LAST 2 WEEKS, HAS CONSULTED A GENERAL PRACTITIONER?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.727 <input type="checkbox"/> 2</p>	<p>729. <i>Sequence Guide:</i></p> <p>. If consulted a General Practitioner in last 2 weeks (code '1') in Q.725 → Q.731 <input type="checkbox"/> 1</p> <p>. Otherwise → Q.730 <input type="checkbox"/> 2</p>
<p>730. (APART FROM CONSULTATIONS DURING ANY HOSPITAL OR DAY CLINIC VISITS,)</p> <p>WHEN WAS THE LAST TIME CONSULTED A DOCTOR ABOUT (HIS/HER) OWN HEALTH?</p> <p>Less than 3 months ago <input type="checkbox"/> 1</p> <p>3 months to less than 6 months ago <input type="checkbox"/> 2</p> <p>6 months to less than 12 months ago <input type="checkbox"/> 3</p> <p>12 months ago or more <input type="checkbox"/> 4</p> <p>Never <input type="checkbox"/> 5</p> <p>Don't know <input type="checkbox"/> 6</p>	<p>731. <i>Interviewer: Show Prompt Card 33</i></p> <p>(APART FROM CONSULTATIONS DURING ANY HOSPITAL OR DAY CLINIC VISITS,)</p> <p>IN THE LAST 2 WEEKS, HAS CONSULTED ANY OF THESE (FOR (HIS/HER) OWN HEALTH)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.750 <input type="checkbox"/> 2</p> <p>Don't know → Q.750 <input type="checkbox"/> 3</p>

732. WHICH OF THESE HAS CONSULTED IN THE LAST 2 WEEKS ABOUT (HIS/HER) OWN HEALTH?

- Aboriginal health worker (nec) a 01
- Accredited counsellor b 02
- Acupuncturist c 03
- Alcohol and drug worker (nec) d 04
- Audiologist/Audiometrist e 05
- Chemist (for advice only) f 06
- Chiropodist/Podiatrist g 07
- Chiropractor h 08
- Dietitian/Nutritionist i 09
- Herbalist j 10
- Hypnotherapist k 11
- Naturopath l 12
- Nurse m 13
- Occupational Therapist n 14
- Optician/Optomtrist o 15
- Osteopath p 16
- Physiotherapist/Hydrotherapist q 17
- Psychologist r 18
- Social worker/Welfare Officer s 19
- Speech Therapist/Pathologist t 20

733. Sequence Guide:
 . If only 1 OHP marked in Q.732 ... → **Q.735** 1
 . Otherwise ... → **Q.734** 2

734. Interviewer: Show Prompt Card 33
 IN THE LAST 2 WEEKS, WHICH OF THESE DID VISIT MOST RECENTLY?
 Interviewer: Transcribe code from Q.732

735. HOW MANY TIMES IN THE LAST 2 WEEKS, DID CONSULT A (Specify only OHP in Q.732 OR most recent OHP in Q.734)?

Interviewer: Record number

Number

736. Sequence Guide:
 . If only 1 OHP in Q.732 ... → **Q.750** 1
 . If only 2 OHPs in Q.732 ... → **Q.738** 2
 . If more than 2 OHPs in Q.732 → **Q.737** 3

737. OTHER THAN THE (Specify OHP in Q.734) WHICH OF THESE DID VISIT SECOND MOST RECENTLY?

Interviewer: Transcribe code from Q.732

738. HOW MANY TIMES IN THE LAST 2 WEEKS, DID CONSULT A (Specify second OHP in Q.732 or specify OHP in Q.737)?

Interviewer: Record number

Number

<p>750. <i>Sequence Guide:</i></p> <p>. If child aged 15 years or more → Q.751 1</p> <p>. Otherwise ... → Q.800 2</p>	<p>755. HOW LONG HAS BEEN COVERED BY PRIVATE HEALTH INSURANCE?</p> <p>Less than 1 year ... 1</p> <p>1 year to less than 2 years ... 2</p> <p>2 years to less than 5 years ... 3</p> <p>5 years or more ... 4</p>
<p>751. THE NEXT FEW QUESTIONS ARE ABOUT PRIVATE HEALTH INSURANCE.</p> <p>APART FROM MEDICARE, IS CURRENTLY COVERED BY <u>PRIVATE</u> HEALTH INSURANCE?</p> <p>Yes ... 1</p> <p>No ... → Q.756 2</p> <p>Don't know ... → Q.757 3</p>	<p>755A. → Q.757</p>
<p>752. IS COVERED BY FAMILY, COUPLE, SOLE PARENT OR SINGLE MEMBERSHIP?</p> <p>Family membership ... 1</p> <p>Couple membership ... 2</p> <p>Sole parent membership ... 3</p> <p>Single membership ... 4</p>	<p>756. WHAT ARE <u>ALL</u> THE REASONS IS <u>NOT</u> COVERED BY PRIVATE HEALTH INSURANCE?</p> <p>Can't afford it/too expensive ... <i>a</i> 01</p> <p>High risk category ... <i>b</i> 02</p> <p>Lack of value for money/not worth it ... <i>c</i> 03</p> <p>Medicare cover sufficient ... <i>d</i> 04</p> <p>Don't need medical care/in good health/have no dependents ... <i>e</i> 05</p> <p>Won't pay Medicare levy <u>and</u> private health insurance premium ... <i>f</i> 06</p> <p>Disillusionment about having to pay "out of pocket" costs/Gap fees ... <i>g</i> 07</p> <p>Prepared to pay cost of private treatment from own resources ... <i>h</i> 08</p> <p>Pensioner/Veterans' Affairs/health concession card ... <i>i</i> 09</p> <p>Not high priority/previously included in parents' cover ... <i>j</i> 10</p> <p>Other ... <i>k</i> 11</p>
<p>753. <i>Interviewer: Show Prompt Card 34</i></p> <p>WHICH OF THESE BEST DESCRIBES WHAT PRIVATE HEALTH INSURANCE COVERS?</p> <p>Hospital only ... 1</p> <p>Ancillary only ... 2</p> <p>Both hospital and ancillary ... 3</p> <p>Don't know ... 4</p>	<p>757. DOES HAVE A DEPARTMENT OF VETERANS' AFFAIRS TREATMENT ENTITLEMENT CARD?</p> <p>Yes ... 1</p> <p>No ... → Q.759 2</p> <p>Don't know ... → Q.759 3</p>
<p>754. WHAT ARE <u>ALL</u> THE REASONS IS COVERED BY PRIVATE HEALTH INSURANCE?</p> <p>Security/protection/peace of mind <i>a</i> 01</p> <p>Lifetime cover/avoid age surcharge <i>b</i> 02</p> <p>Choice of doctor ... <i>c</i> 03</p> <p>Allows treatment as private patient in hospital ... <i>d</i> 04</p> <p>Provides benefits for ancillary services/"extras" ... <i>e</i> 05</p> <p>Shorter wait for treatment/concern over public hospital waiting lists <i>f</i> 06</p> <p>Always had it/parents pay it/condition of job ... <i>g</i> 07</p> <p>To gain government benefits/avoid extra Medicare levy ... <i>h</i> 08</p> <p>Other financial reasons ... <i>i</i> 09</p> <p>Has illness/condition that requires treatment ... <i>j</i> 10</p> <p>Elderly/getting older/likely to need treatment ... <i>k</i> 11</p> <p>Other ... <i>l</i> 12</p>	<p>758. WHAT COLOUR IS THAT CARD?</p> <p>White ... 1</p> <p>Gold ... 2</p> <p>Other ... 3</p>
	<p>759. <i>Interviewer: Show Prompt Card 35</i></p> <p>IS COVERED BY ANY OF THESE GOVERNMENT CONCESSION CARDS?</p> <p>Health care card ... <i>a</i> 1</p> <p>Pensioner concession card ... <i>b</i> 2</p> <p>Commonwealth seniors health card ... <i>c</i> 3</p> <p>None of the above ... <i>d</i> 4</p>

800. Sequence Guide:

- . If child proxy is selected adult, no more questions ◀ 1
- . If child proxy is partner of selected adult, no more questions ◀ 2
- . If first child's schedule → Q.804 3
- . Otherwise, no more questions ◀ 4

804. I WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT INCOME.

INCOME IS VERY IMPORTANT IN UNDERSTANDING HEALTH, AS IT INFLUENCES THE HEALTH SERVICES SOMEONE HAS ACCESS TO.

DO YOU CURRENTLY RECEIVE INCOME FROM ANY OF THESE SOURCES?

Interviewer: Show Prompt Card 41

- Wages or salary a 1
- Profit or loss from a business or rental property b 2
- Any government pension, benefit or allowance c 3
- Any other regular source d 4
- No/none of the above → Q.807 e 5

805. BEFORE INCOME TAX IS TAKEN OUT, HOW MUCH DO YOU USUALLY RECEIVE FROM (THIS/THESE) SOURCE(S) IN TOTAL?

Interviewer: If respondent unable to answer, prompt for best estimate

(a) \$

Don't know → Q.807 999998

-
-
-
-
-
-
-
-
-

- (b) Profit 1
- Loss 2

806. WHAT PERIOD DOES THAT COVER?

Interviewer: Record period

- Weeks 1
- Months 2

807. Sequence Guide:

- . If child proxy has spouse/partner → Q.815 1
- . Otherwise, no more questions ◀ 2

815. DOES YOUR (SPOUSE/PARTNER) CURRENTLY RECEIVE INCOME FROM ANY OF THESE SOURCES?

Interviewer: Show Prompt Card 41

- Wages or salary a 1
- Profit or loss from a business or rental property b 2
- Any government pension, benefit or allowance c 3
- Any other regular source d 4
- No/none of the above, no more questions ◀ e 5

816. BEFORE INCOME TAX IS TAKEN OUT, HOW MUCH DOES YOUR (SPOUSE/PARTNER) USUALLY RECEIVE FROM (THIS/THESE) SOURCE(S) IN TOTAL?

Interviewer: If respondent unable to answer, prompt for best estimate

(a) \$

Don't know → Q.819 999998

-
-
-
-
-
-
-
-
-

- (b) Profit 1
- Loss 2

817. WHAT PERIOD DOES THAT COVER?

Interviewer: Record period

- Weeks 1
- Months 2

819. No more questions ◀

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Sample only



Sample only