SECTION F: MATERNAL AND CHILD HEALTH

F1. And now I have some questions about health issues. How would you rate your overall physical health--excellent, very good, good, fair, or poor?

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

F2. Compared to one year ago, how would you rate your health in general now? Is it much better, somewhat better, about the same, somewhat worse, or much worse?

1. MUCH BETTER	2. SOMEWHAT BETTER	3. ABOUT THE SAME	4. SOMEWHAT WORSE	5. MUCH WORSE

F2a. Are you pregnant now?

1. YES	5. NO	8. DK

F3. (RB, P. 14) The following items are about activities you might do during a typical day. How much does your health limit you in...

	A LOT (1)	A LITTLE (2)	NOT AT ALL (3)
a. vigorous activities, such as running or lifting heavy objects--a lot, a little, or not at all?			GO TO F3c
b. moderate activities, such as moving a table or pushing a vacuum cleaner?			
c. lifting or carrying groceries?			
d. climbing several flights of stairs (a lot, a little, or not at all)?			GO TO F3f
e. climbing one flight of stairs?			
f. bending, kneeling, or stooping?			
g. walking more than one mile?			NEXT PAGE, F4
h. walking several blocks?			

F4. During the past four weeks have you had to cut back on the amount of time you spent at work or in a training program, or looking for work because of a physical or mental health problem?

1. YES	5. NO

F5. Have you ever received treatment for a mental health problem?

1. YES	5. NO

F6. Do you feel that you need treatment now for a mental health problem?

1. YES	5. NO	8. DK

F7. Have you ever applied for disability benefits from the Social Security Disability program, SSI program, Veteran's Administration, Worker's Compensation, State Disability Assistance, or another program for yourself or your children?

1. YES	5. NO → NEXT PAGE, F8

↓

F7a. In what month and year did you last apply for benefits?

_____ / _____

MONTH YEAR

F8. Do you have any chronic health or medical conditions that prevent you from attending work, affect your work performance, or prevent you from doing regular activities?

1. YES

5. NO → NEXT PAGE, F9

F8a. What are these conditions? (DO NOT READ; CHECK ALL THAT APPLY)

A. ARTHRITIS/BONE PAIN

B. ASTHMA/EMPHYSEMA

C. BACK PROBLEMS; "BAD BACK"

D. CANCER

E. DIABETES; "SUGAR"

F. FATIGUE/TIRED

G. LEARNING DISABILITY

H. HEADACHES

J. HEART CONDITION

K. HEPATITIS/CIRRHOSIS (LIVER PROBLEMS)

M. HIGH BLOOD PRESSURE

N. NERVES/ANXIETY/STRESS

P. OBESITY

Q. SEIZURES

R. ULCERS; "STOMACH PROBLEMS"

Z. OTHER (SPECIFY): _____

_____

_____

F9. INTERVIEWER CHECKPOINT

SEE COVERSHEET

☐ 1. R HAS OWN OR "CAREGIVEN" CHILD(REN) UNDER 18 IN HH

☐ 2. ALL OTHERS → TURN TO P. 54, SECTION G

F9a. Now let's talk about the health of your own (child/children) living with you (and any children living with you for whom you are the primary caregiver). (Does this child/do any of these children) have a physical, learning, or mental health condition that limits their regular activities?

1. YES

5. NO → TURN TO P. 53, F10

F9b. How many of the children have these problems?

1. ONE

2. TWO

3. THREE

4. FOUR OR MORE

F9c. What kinds of problems are those? (DO NOT READ; CHECK ALL THAT APPLY)

- [ ] A. ASTHMA
- [ ] B. ATTENTION DEFICIT DISORDER (ADD)
- [ ] C. AUTISM
- [ ] D. BLINDNESS/IMPAIRED VISION
- [ ] E. CANCER
- [ ] F. CEREBRAL PALSY
- [ ] G. CYSTIC FIBROSIS
- [ ] H. DEAFNESS/IMPAIRED HEARING
- [ ] J. DEVELOPMENTAL DELAYS
- [ ] K. DIABETES
- [ ] M. EPILEPSY
- [ ] N. HEART PROBLEMS
- [ ] P. HYPERACTIVITY
- [ ] Q. LEARNING/BEHAVIORAL PROBLEMS
- [ ] R. MENTAL RETARDATION
- [ ] S. MENTAL/EMOTIONAL ILLNESS
- [ ] T. SPEECH IMPAIRMENT
- [ ] U. OBESITY

- [ ] Z. OTHER (SPECIFY): _____
_____

F9d. (Does this child's/do the children's) physical, learning or mental health conditions interfere with your work or regular activities?

1. YES	5. NO

F10. INTERVIEWER CHECKPOINT

SEE COVERSHEET, ITEM 15

☐ 1. ONE CHILD UNDER 2 IN HH

☐ 2. TWO OR MORE CHILDREN UNDER 2 IN HH

☐ 3. ALL OTHERS → TURN TO NEXT PAGE, SECTION G

F11. Please think about the (child/children) in your household who (is/are) less than 2 years old...

	YES (1)	NO (5)
a. Does anything about (this child's/these children's) sleeping patterns bother you?		
b. Does anything about their sleep affect the time or energy you have for household tasks or for working?		
c. Does anything about (this child's/these children's) crying bother or concern you?		
d. Does their crying affect the time or energy you have for household tasks or for working?		
e. Does anything about (this child's/these children's) feeding patterns bother you?		
f. Does anything about their feeding affect the time or energy you have for household tasks or for working?		
g. (Is this child/are any of these children) difficult, fussy, or demanding?		NEXT PAGE, SECTION G
h. Does this affect the time or energy you have for household tasks or for working?		