



Detailed Outline of Topics in the National Health Interview Survey (NHIS) Core Sample Adult Questionnaire

This document presents the topics included in the NHIS sample adult interview, including annual content and content that rotates on and off the questionnaire with a pre-established periodicity.

One “sample adult” aged 18 years or more and one “sample child” aged 17 years or less (if any children live in the household) is randomly selected from each household following a brief household roster that identifies the age, sex, Hispanic ethnicity, and race of everyone who usually lives or stays in the household. The roster section also asks questions about the highest educational attainment of all adults and whether any adults are currently active duty military. Only civilian adults are eligible to be the sample adult.

Questions are asked to identify the parents of all children in the household and the members of the sample adult’s and sample child’s family. For NHIS, a family is defined as two or more persons residing together who are related by birth, marriage, or adoption, as well as any unrelated children who are cared for by the family (such as foster children) and any unmarried cohabiting partners and their children. Family members include adults who are temporarily away at school if they are living in on-campus housing. Adults living alone are considered single-person families.

Information about the sample adult is collected from the sample adult him/herself unless he/she is physically or mentally unable to do so, in which case a knowledgeable proxy is allowed to answer for the sample adult. Information about the sample child is collected from the sample child’s parent or a knowledgeable adult. The respondent for the sample child may or may not also be the sample adult.

The order of the sample adult and sample child interviews varies by household depending on the availability of the respondents. When the sample adult and sample child are in the same family, content areas that refer to the family are captured only once, in whichever interview comes first.

ANNUAL CORE CONTENT FOR HOUSEHOLDS

Household roster

- Name or alias of all persons living in household
- Age, sex, Hispanic ethnicity, race, and usual residence for all persons
- Educational attainment for all adults
- Identification of parents (biological/step/adoptive) for each child in household
For children without parents in the household:
 - Whether child is in foster care
If any children are in foster care:
 - Identification of foster parents
- Identification of adults who are currently serving on active duty in the military

Selection of sample adult and sample child

One civilian adult and one child (if any) are randomly selected from each household

- Identification of all persons in sample adult's family
If sample child is not in sample adult's family:
 - Identification of all persons in sample child's family
- Identification of possible knowledgeable respondents for sample child interview

ANNUAL CORE CONTENT FOR SAMPLE ADULTS

Demographic characteristics (VFY)

- Verification of age, sex, Hispanic ethnicity, and race
If Hispanic, Asian, and/or Native Hawaiian or Pacific Islander:
 - Specific ancestry (e.g., Mexican, Puerto Rican, Chinese, Filipino, Chamorro, Samoan)
- Date of birth

Current health status (HIS)

- General health status: excellent, very good, good, fair, poor

Hypertension (HYP)

- Ever told by doctor or other health professional that you had hypertension or high blood pressure
If yes:
 - Told you have hypertension or high blood pressure on 2 or more different visits
If yes:
 - (Past 12 months) Had hypertension or high blood pressure
 - (Currently) Taking prescription medication for high blood pressure

High cholesterol (CHL)

- Ever told by doctor or other health professional that you had high cholesterol
If yes:
 - (Past 12 months) Had high cholesterol
 - (Currently) Taking prescription medication for high cholesterol

Cardiovascular chronic conditions (CVC)

- Ever told by doctor or other health professional that you had coronary heart disease
- Ever told by doctor or other health professional that you had angina
- Ever told by doctor or other health professional that you had a heart attack
- Ever told by doctor or other health professional that you had a stroke

Asthma (AST)

- Ever told by doctor or other health professional that you had asthma
If yes:
 - Still have asthma
 - (Past 12 months) Had an episode of asthma or an asthma attack
 - (Past 12 months) Had an ER or urgent care visit due to asthma

Cancer (CAN)

- Ever told by doctor or other health professional that you had cancer or a malignancy of any kind
 - If yes:*
 - Type(s) of cancer/location(s) (up to 3 types/locations)
 - Age(s) when each type of cancer first diagnosed (up to 3 types/locations)

Diabetes (DIB)

- Ever told by doctor or other health professional that you had prediabetes
 - If female:*
 - Ever told by doctor or other health professional that you had gestational diabetes
- (Other than prediabetes/gestational diabetes) Ever told by doctor or health professional you had diabetes
 - If ever diagnosed with diabetes:*
 - Age when first told you had diabetes (not including prediabetes or gestational diabetes)
 - If ever diagnosed with diabetes or prediabetes:*
 - (Currently) Taking diabetic pills
 - (Currently) Taking insulin
 - If ever diagnosed with diabetes:*
 - Diabetes type according to doctor or other health professional: type 1, type 2, other, don't know

Other chronic conditions (CON)

- Ever told by doctor or other health professional that you had...
 - COPD, emphysema, or chronic bronchitis
 - Arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia
 - Dementia, including Alzheimer's
 - Any type of anxiety disorder
 - Any type of depression

Body measurements (BMI)

- If female and age 18-49, or female and age not given:*
 - (Currently) pregnant
- Self-reported height (without shoes)
- Self-reported weight (if currently pregnant, pre-pregnancy weight)

Vision (VIS)

- Use of eyeglasses or contact lenses
- Level of difficulty seeing (even with glasses or contact lenses)

Hearing (HEA)

- Use of hearing aid
 - If yes:*
 - Frequency of hearing aid use
- Level of difficulty hearing (even with hearing aid)

Mobility (MOB)

- Level of difficulty walking or climbing steps
- Use equipment or receive help for getting around
 - If does not use equipment or receive help for getting around:*
 - Level of difficulty walking 100 yards
 - If able to walk 100 yards:*
 - Level of difficulty walking one-third mile
 - Level of difficulty walking up or down 12 steps
 - If uses equipment or receives help for getting around:*
 - Use of cane or walker
 - Use of wheelchair or scooter
 - Use of someone's assistance
 - Without the use of your aid, level of difficulty walking 100 yards
 - If able to walk 100 yards without using aid(s):*
 - Without the use of your aid, level of difficulty walking one-third mile
 - Without the use of your aid, level of difficulty walking up or down 12 steps
 - If uses equipment or receives help getting around and does not use a wheelchair or scooter:*
 - When using your aid, level of difficulty walking 100 yards
 - If able to walk 100 yards when using aid(s):*
 - When using your aid, level of difficulty walking one-third mile
 - When using your aid, level of difficulty walking up or down 12 steps

Communication (COM)

- Level of difficulty communicating in usual language (e.g., understanding or being understood)

Cognition (COG)

- Level of difficulty remembering or concentrating
 - If any difficulty:*
 - Difficulty remembering, concentrating or both
 - If difficulty includes remembering:*
 - How often do you have difficulty remembering (sometimes, often, all the time)
 - Do you have difficulty remembering a few things, a lot of things, or almost everything?

Self-care and upper body (UPP)

- Level of difficulty with self-care such as washing or dressing
- Level of difficulty raising a 2-liter bottle
- Level of difficulty using hands and fingers

Social functioning (SOC)

- Level of difficulty doing errands alone due to a physical, mental, or emotional condition
- Level of difficulty participating in social activities due to a physical, mental, or emotional condition
- Does a physical, mental, or emotional problem limit kind or amount of work?

Health insurance coverage (INS)

- Any health insurance coverage or health care plan?
If yes:
 - Type of health insurance
- If 65 or older and does not report Medicare:
 - Confirm no Medicare
- If under 65 and no insurance coverage reported:
 - Confirm no Medicaid
- Do you have separate plan for dental services?
- Do you have separate plan for vision services?
- Do you have separate plan for prescriptions?
- Confirm no insurance or confirm all types of insurance coverage are recorded

Specifics about current insurance coverage

If enrolled in Medicare:

- Enrollment in Part A, Part B, or both
- Medicare Advantage plan enrollment
- Medicare managed care arrangement
- If enrolled in Advantage or managed care:
 - Name of Advantage or Medicare HMO plan (*open-ended*)
- Part D enrollment

If enrolled in Medicaid:

- Name of plan (*open-ended*)
- Was the plan obtained through healthcare.gov or Marketplace?
- Are you required to pay a premium?
- Is there a deductible?
If yes:
 - Is it a high deductible health plan?

If enrolled in a private plan:

(Repeated for each private plan (up to two) in which sample adult is enrolled)

(If sample child questionnaire is complete, adult and child are in same family, and sample child was enrolled in a private plan, ask if adult has same plan as child. If so, skip this section.)

- Name of plan (*open-ended*)
- Any additional private plans?
If yes:
 - Name of second plan (*open-ended*)
The private plan questions are repeated for second plan
- Are you the policyholder?
If yes:
 - Does the plan cover self-only or family?
- If no:
 - Relationship to policyholder
- How plan was obtained (employer, union, association, direct purchase, etc.)
If plan was purchased directly or obtained through state/local government or community program:
 - Was plan obtained through healthcare.gov or Marketplace?

- o Who pays for plan? (self/family, employer, person outside household, government program, etc.)

If self/family in household pays for the plan:

- Out-of-pocket premium amount
- o Is there a deductible?
 - If yes:*
 - Is it a high deductible health plan?
 - If yes:*
 - Does it include a health savings account?
- o Does it include prescription drug coverage?
- o Does it include dental coverage?
- o Does it include vision coverage?

If enrolled in CHIP, state-sponsored, and/or other government plan:

(Repeated for each type of CHIP, state-sponsored, and/or other government plan in which sample adult is enrolled)

- o Name of plan (*open-ended*)
- o Was the plan obtained through healthcare.gov or Marketplace?
- o Are you required to pay a premium?
- o Is there a deductible?
 - If yes:*
 - Is it a high deductible health plan?

If military health care:

- o Type of plan (TRICARE, VA, CHAMP-VA, other)

Health insurance continuity

If currently uninsured:

- o Length of time since last insured
 - If less than 12 months:*
 - (Past 12 months) Number of months without health insurance
 - If uninsured less than 3 years:*
 - What were the reason(s) you are no longer enrolled? Was it because...
 - You retired, lost a job, or changed employers
 - Missed a deadline to sign up
 - Ineligible for coverage because of age or leaving school
 - Cost increases
 - No longer eligible for Medicaid, CHIP, or other public coverage
- o What are the reason(s) for not having health insurance? Was it because...
 - Coverage is unaffordable
 - Do not need or want coverage
 - Ineligible for coverage
 - Signing up is too difficult or confusing
 - Cannot find a plan that meets needs
 - Applied for coverage that has not started yet
 - Other reason (*open-ended*)

If currently insured:

- o (Past 12 months) Any time without health insurance
 - If yes:*

- (Past 12 months) Number of months without health insurance

Financial burden of medical care (PAY)

Skip first question and follow-up if sample child questionnaire is complete and if adult and child are in same family.

- (Past 12 months) Anyone in family have problems paying or unable to pay medical bills
If yes:
 - (Currently) Anyone in family have medical bills unable to pay at all
- Level of worry about ability to pay medical bills if sick or injured

Health care utilization and access (UTZ)

- Time since last seen doctor or health professional about your health
If not never:
 - Was most recent visit a wellness visit, physical, or general purpose check-up
If no:
 - Time since last wellness visit, physical, or general purpose check-up
- Has a usual place for care when sick
If yes or more than one place:
 - Type of place (or type of place visited most often)
- (Past 12 months) Number of retail clinic visits
- (Past 12 months) Number of urgent care center visits
- (Past 12 months) Number of hospital ER visits
- (Past 12 months) Any overnight hospital stay
- (Past 12 months) Delayed getting medical care because of cost
- (Past 12 months) Did not get medical care because of cost

Telehealth (TLH)

- (Past 12 months) Virtual medical appointment

Prescription medications (PMD)

- (Past 12 months) Took any prescribed medication
If yes:
 - (Past 12 months) Skipped medication doses to save money
 - (Past 12 months) Took less medicine to save money
 - (Past 12 months) Delayed filling a prescription to save money
- (Past 12 months) Any medication needed that you didn't get due to cost

Immunizations (IMS)

- (Past 12 months) Flu vaccination
If yes:
 - Month and year of most recent flu vaccination
- (Ever) Pneumonia shot
 - Number of pneumonia shots

Anxiety (ANX)

- Frequency of feeling worried, nervous, or anxious
- (Currently) Taking prescription medication for these feelings
If worried at least a few times per year and/or taking medication for anxiety:
 - (Last time felt anxious) How anxious did you feel?

Depression (DEP)

- Frequency of feeling depressed
- (Currently) Taking prescription medication for depression
 - If depressed at least a few times per year and/or taking medication for depression:*
 - (Last time felt depressed) How depressed did you feel?

Mental health care (MHC)

- If does not take medication for anxiety or depression:*
 - (Past 12 months) Any prescription medication taken to help with other emotions, concentration, behavior, or mental health
- (Past 12 months) Received counseling or therapy from a mental health professional
 - If yes:*
 - (Currently) Receiving counseling or therapy
- (Past 12 months) Any counseling or therapy delayed due to cost
- (Past 12 months) Any counseling or therapy needed that you didn't get due to cost

Cigarette smoking and e-cigarettes (CIG)

- (Lifetime) Smoked 100 or more cigarettes
 - If yes:*
 - (Currently) Smoke every day, some days, or not at all
 - If smoking everyday:*
 - Average number of cigarettes NOW smoked per day
 - If smoking some days:*
 - (Past 30 days) Number of days smoked cigarettes
 - (Past 30 days) Average number of cigarettes on days smoked any cigarettes
- (Ever) Used e-cigarette, even one time
 - If yes:*
 - (Currently) Use e-cigarette every day, some days, or not at all

Sexual orientation (ORN)

- Sexual orientation

Marital status (MAR)

Skip section if marital status of sample adult was already collected from sample adult during sample child interview.

- Married, living with partner as unmarried couple, or neither
 - If married:*
 - Is your spouse living in the same household?
 - If yes:*
 - Identification of spouse
 - Confirmation of sex of spouse
 - If no:*
 - Are you and spouse legally separated?
 - If living with a partner:*
 - Identification of partner
 - Confirmation of sex of partner
 - Ever been married
 - If yes:*

- Legal marital status (married, widowed, divorced, separated)

If neither:

- Ever been married

If yes:

- Legal marital status (widowed, divorced, or separated)

Veteran status (VET)

- Ever serve on active duty in US Armed Forces, military reserves, or National Guard

If yes:

- Was this only for training in Reserves or National Guard?

If no:

- Ever served in a foreign country during armed conflict or on humanitarian mission?

- Do you have a VA service-connected disability rating?

- (Past 12 months) Received any care at Veteran's Health Administration facility or received any other health care paid for by the VA

If no and did not specify VA health care in INS section:

- Ever enrolled in or used VA health care

Nativity and acculturation (NAT)

- Were you born in the United States or a US territory?

If yes:

- State or US territory of birth

If no:

- What year did you come to the United States to stay?

- Are you a citizen of the United States?

If yes:

- Born abroad to an American parent, born abroad and adopted by an American parent, or naturalized

Schooling (SCH)

- (Currently) attending or enrolled in school

If yes:

- (Past 12 months) Number of school days missed due to illness/injury/disability

Employment (EMP)

- (Last week) Work for pay at a job or business

If no:

- (Last week) Have a job or business, but temporarily absent due to illness, vacation, family or maternity leave, or some other reason

If yes:

- How many hours usually work in total at all jobs/businesses?

If don't know or refused

- Usually work 35 hours or more per week in total in all jobs/businesses?

If no:

- (Last week) Main reason not working

If not working for any reason besides working in a family business not for pay or does seasonal/contract work.

- Length of time since last held a job or worked at a business

If yes:

(When working) how many hours do you usually work in total at all jobs or business

If yes:

- (Last week) Number of hours worked in total at all jobs/businesses

If worked less than 35 hours in past week or don't know or refused to say how many hours worked:

- Usually work 35 hours or more per week in total in all jobs/businesses?

If working at or had a paid job or business last week, if working in a family business not for pay, or if not working because does seasonal/contract work:

- Is paid sick leave available if you need it?
- Was health insurance offered to you through workplace?

If working at or had a paid job or business last week, if working in a family business not for pay, if not working because does seasonal/contract work, or if not currently working but had a paid job or business in past 12 months:

- (Past 12 months) Number of work days missed due to illness/injury/disability

Employment of all adult family members (FEM)

Skip section if sample child questionnaire is complete and if adult and child are in same family, or if there is only one adult in the family.

Ask for each adult family member other than sample adult:

- (Currently) Work for pay at a job or business

If yes:

- Usually work 35 hours or more per week in total in all jobs/businesses?

Family income and source(s) of income (INC)

Skip section if sample child questionnaire is complete and if adult and child are in same family. If family size is one (sample adult is living alone or with unrelated roommates), then questions are asked only about the sample adult's income and sources.

(Last calendar year) Did you or any adult family members living here receive:

- Income from wages, salaries, commissions, bonuses, tips, or self-employment?
- Income from interest, dividends, rent, royalties, or income from estates or trusts?
- Social Security or Railroad Retirement?
- Supplemental Security Income (SSI) or Social Security Disability?

If yes:

- Was it SSI, SSDI or both?
- Was this a disability benefit?

If more than one person in the family:

- Who in the family received SSI and/or SSDI?
- Any public assistance or welfare payments?
- Retirement, survivor, or disability pensions?
- Other income, such as VA payments, unemployment, child support, or alimony?
- (Last calendar year) Total family income

If unknown or refused:

- Cascading questions to categorize income relative to federal poverty thresholds

Family participation in food-related programs (FOO)

Skip section if sample child questionnaire is complete and if adult and child are in same family.

- (Past 12 months) Anyone in family receive SNAP/food stamp benefits

If family includes females 12-55 or children 0-5:

- (Past 12 months) Anyone in family receive food through the WIC program

If family includes children 5-17:

- (Past 12 months) Any children in the family receive free or reduced-cost lunches at school

Housing (HOU)

Skip second question and follow-up if sample child questionnaire is complete and if adult and child are in same family.

- Length of time you have lived in this house/apartment
- Owned, rented, or occupied by some other arrangement

If rented:

- Paying lower rent because a government program is paying part of the cost

Recontact information (REC)

- Full name

Telephone use (TEL)

- Is there a working telephone in your home that is not a cell phone? *(if not already known from sample child interview)*
- Do you have a working cell phone (wireless/mobile telephone)?

If no:

- Do you live with anyone who has a working cell phone? *(if not already known from sample child interview)*

If adult has cell phone and home has a landline telephone:

- Frequency of your landline/wireless use (landline mostly, wireless mostly, equal use)

Linkage with vital statistics and health-related records of other government agencies (LNK)

- Linkage intro, providing explanation for why SSN and Medicare number are being sought
- Last 4 digits of social security number

If Medicare was reported in INS section:

- Last 4 digits and any letters of Medicare number

If no SSN or SSN refused or unknown and/or Medicare number refused or unknown:

- Consent to link without SSN and/or Medicare number

ROTATING CORE CONTENT: UTILIZATION OF SERVICES

Years: 2025, 2026, 2028, 2029

Dental care (DNC)

- Time since most recent dental exam or cleaning
- (Past 12 months) Any dental care delayed because of cost
- (Past 12 months) Any dental care needed that you didn't get due to cost

Other care received (PTC)

- (Past 12 months) Received an eye exam from an eye specialist
- (Past 12 months) Received physical, speech, rehabilitative, or occupational therapy
- (Past 12 months) Received care at home from nurse or other health professional

ROTATING CORE CONTENT: CHRONIC PAIN

Years: 2025, 2027, 2029

Frequency, severity, and impact of pain (PAI)

- (Past 3 months) Frequency of pain
 - If at least some days:*
 - (Last time had pain) Severity of pain: a lot, a little, somewhere in between
 - (Past 3 months) Frequency of interference with life or work activities
 - (Past 3 months) Frequency that your pain affected your family and significant others

Pain locations

If experienced pain at least some days in past 3 months:

- (Past 3 months) How much have you been bothered by...back pain
- (Past 3 months) How much have you been bothered by...pain in hands, arms, or shoulders
- (Past 3 months) How much have you been bothered by...pain in hips, knees, or feet
- (Past 3 months) How much have you been bothered by...headaches or migraines
- (Past 3 months) How much have you been bothered by...abdominal, pelvic, or genital pain
- (Past 3 months) How much have you been bothered by...toothache or jaw pain

ROTATING CORE CONTENT: PREVENTIVE SERVICES

Years: 2025, 2027, 2029

Aspirin use for prevention (ASP)

If age 40+:

- (Ever) Doctor or other health professional advised taking low-dose aspirin every day

If yes:

- o (Currently) Following this advice?

If no:

- Did doctor advise you to stop taking low-dose aspirin?

If no:

- o (Currently) Taking low-dose aspirin every day on your own

Preventive screening for adults (PRV)

- Time since blood pressure was last checked
- Time since cholesterol was last checked

If never been told by a doctor have diabetes

- o Time since blood sugar test for diabetes

If age 40+:

- o (Ever) Colonoscopy or sigmoidoscopy

If yes:

- Have had colonoscopy, sigmoidoscopy, or both?

If colonoscopy or both:

- Time since most recent colonoscopy

If sigmoidoscopy or both:

- Time since most recent sigmoidoscopy

If don't know which:

- Time since most recent colonoscopy or sigmoidoscopy

- o (Ever) CT colonography or virtual colonoscopy

If yes:

- Time since most recent CT colonography or virtual colonoscopy

- o (Ever) had blood stool or FIT test using at home kit

If yes:

- Time since most recent home-based blood stool or FIT test

If female:

- o (Ever) have Pap or HPV test to check for cervical cancer

If yes:

- Time since most recent test for cervical cancer

- o (Ever) Hysterectomy

If female and age 30+:

- o (Ever) Mammogram

If yes:

- Time since most recent mammogram



ROTATING CORE CONTENT: MENTAL HEALTH ASSESSMENT

Years: 2025, 2028

PHQ-8 diagnostic tool for depression (PHQ)

See <http://www.phqscreeners.com> for more information on the Patient Health Questionnaire.

- (Past 2 weeks) Frequency of...little interest or pleasure in doing things
- (Past 2 weeks) Frequency of...feeling down, depressed, hopeless
- (Past 2 weeks) Frequency of...trouble falling or staying asleep, or sleeping too much
- (Past 2 weeks) Frequency of...feeling tired or having little energy
- (Past 2 weeks) Frequency of...poor appetite or overeating
- (Past 2 weeks) Frequency of...feeling bad about self, or that you are a failure, or have let yourself or family down
- (Past 2 weeks) Frequency of...trouble concentrating
- (Past 2 weeks) Frequency of...moving/speaking slowly or fidgety/restless

GAD-7 diagnostic tool for anxiety (GAD)

See <http://www.phqscreeners.com> for more information on the GAD-7.

- (Past 2 weeks) Frequency of...feeling nervous, anxious, or on edge
- (Past 2 weeks) Frequency of...not being able to stop or control worrying
- (Past 2 weeks) Frequency of...worrying too much about different things
- (Past 2 weeks) Frequency of...trouble relaxing
- (Past 2 weeks) Frequency of...being so restless that it is hard to sit still
- (Past 2 weeks) Frequency of...becoming easily annoyed or irritable
- (Past 2 weeks) Frequency of...feeling afraid that something awful might happen

ROTATING CORE CONTENT: EMPLOYMENT

Years: 2024, 2026, 2027, 2029, 2030

Detailed adult employment (EMD)

If working at or had a paid job or business last week, if working in a family business not for pay, if doing seasonal/contract work, or if not currently working but had a paid job or business in past 12 months:

- For whom do/did you work at your main job/business? (name of company, employer, etc.)
- Industry (kind of business) (*open-ended*)
- Occupation (kind of work) (*open-ended*)
- Most important activities on the job (*open-ended*)
- Supervisory status
- Work category of main job (private sector, government employee, self-employed, etc.)

ROTATING CORE CONTENT: INJURIES

Years: 2024, 2026, 2027, 2029, 2030

Repetitive strain injuries (REP)

- (Past 3 months) Any injuries due to repetitive strain

If yes:

- Any repetitive strain injuries serious enough to limit usual activities for 24 hours

If yes:

- (Past 3 months) talk to or see doctor or health professional about these repetitive strain injuries
- (Past 3 months) How many days of work missed because of repetitive strain injuries

If 1-90 days missed:

- Do you expect to miss any more work because of repetitive strain injuries

If less than 91 days missed:

- (Past 3 months) Stop working or change jobs because of repetitive strain injuries
- (Past 3 months) Make major changes in work activities because of repetitive strain injuries
- Ever told by doctor or health professional that any repetitive strain injuries were likely work related

Sudden accidents and injuries (INJ)

- (Past 3 months) [Not including repetitive strain injuries] any accident or injury where any part of your body was hurt

If yes:

- Any injuries serious enough to limit activities for 24 hours

If yes:

- (Past 3 months) Number of significant injuries
- (Past 3 months) Any injury while you were at home

If no or if yes and had more than one injury:

- (Past 3 months) Any injury while you were working at a job or business
- (Past 3 months) Any injury while you were playing sports or exercising
- (Past 3 months) Any injury result of fall or falling

If yes, had at least 2 injuries, and any injury while home

- Did any fall occur while you were at home

If yes, had at least 2 injuries, and any injury while working at job or business

- Did any fall occur while you were working at job or business

- (Past 3 months) Any injury a result of a collision involving a motor vehicle

If yes:

- Were you a driver, passenger, bicyclist, pedestrian, or doing something else when this occurred

- (Past 3 months) Any injury while you were doing household activities

- (Past 3 months) See or talk to doctor or health professional about any injuries

If yes and reported going to emergency room:

- (Past 3 months) Go to emergency room because of any injury

If yes and reported being hospitalized overnight:

- (Past 3 months) Hospitalized overnight because of any injury
- If yes:*
- (Past 3 months) Any broken bones as a result of any injury
 - (Past 3 months) Any stitches or staples because of any injury
- (Past 3 months) Number of days of work missed because of injuries
- If 1-90 days missed:*
- Do you expect to miss any more days of work because of injuries that occurred during past 3 months?
- If less than 91 days missed:*
- (Past 3 months) Stopped working or changed jobs because of an injury
 - (Past 3 months) Made a major change in work activities because of an injury

ROTATING CORE CONTENT: HEALTH BEHAVIORS

Years: 2020, 2022, 2024, 2026, 2028, 2030

Fatigue (FGE)

- (Past 30 days) Frequency of feeling very tired or exhausted
- If at least some days:*
- (Last time) Duration of feeling very tired or exhausted (some/most/all of the day)
 - (Last time) Level of tiredness: a lot, a little, somewhere in between

Smoking history and cessation (CIH)

If ever smoked 100 cigarettes:

- Age when first started smoking regularly

If currently an everyday smoker or someday smoker:

- (Past 12 months) Stopped smoking for more than 1 day because trying to quit

If former smoker:

- Length of time since quit smoking cigarettes

If everyday smoker, someday smoker, or quit smoking in the past 12 months, and if seen doctor in past 12 months:

- (Past 12 months) Doctor advised you about ways to quit smoking or prescribed medicine to help you quit smoking

Alcohol use (ALC)

- (Lifetime) Had at least one drink of any alcoholic beverage

If yes:

- (Past 12 months) Number of days per week/month/year that alcohol was consumed

If none:

- (In any one year) Had at least 12 drinks of any alcoholic beverage

If any:

- (Past 12 months) Average number of drinks on days consumed any alcohol
- If average is less than 5 (if male) or 4 (if female):*

- (Past 12 months) Did you ever have 5/4 or more drinks in a day?

If average is greater than or equal to 5 (if male) or 4 (if female), or if yes, had 5/4 or more drinks in one day in past 12 months:

- (Past 30 days) Had at least one drink

If yes:

- o (Past 30 days) Number of times had 5/4 or more drinks on an occasion

If any and seen doctor in past 12 months:

- (Past 12 months) Doctor advised you to stop or cut down on your drinking

Physical activity (PHY)

- Frequency of moderate-intensity leisure-time activities (# times per day/week/month/year)
If at least once per year:
 - o Number of hours/minutes each time
- Frequency of vigorous-intensity leisure-time activities (# times per day/week/month/year)
If at least once per year:
 - o Number of hours/minutes each time
- Frequency of leisure-time muscle-strengthening activities (# times per day/week/month/year)

Walking for transportation and leisure (WLK)

Skip to last question if sample adult reported being unable to walk or climb steps in MOB section

- (Past 7 days) Walked for transportation
If yes:
 - o (Past 7 days) Number of times walked for transportation
 - o Average length of walk(s), in minutes/hours
- (Past 7 days) Walked for fun, relaxation, exercise, or to walk the dog
If yes:
 - o (Past 7 days) Number of times walked for fun, relaxation, exercise, or to walk the dog
 - o Average length of walk(s), in minutes/hours

If seen doctor in past 12 months:

- o (Past 12 months) Doctor advised you to exercise more

Sleep (SLP)

- Average hours of sleep in 24-hour period
- (Past 30 days) Frequency waking up well-rested
- (Past 30 days) Frequency having trouble falling asleep
- (Past 30 days) Frequency having trouble staying asleep
- (Past 30 days) How often take medication prescribed by doctor to help sleep or fall asleep
- (Past 30 days) How often take OTC medications or supplements to fall asleep or stay asleep
- (Past 30 days) How often use marijuana or CBD to fall asleep or stay asleep

ROTATING CORE CONTENT: ROTATING CONDITIONS SECTION

Years: 2021, 2024, 2027

Rotating hearing detail (HEA)

- Level of difficulty hearing a conversation in a quiet room (even with hearing aid)
If able to hear at all in a quiet room:
 - Level of difficulty hearing a conversation in a noisier room (even with hearing aid)

Rotating communication detail (COM)

- Use of sign language

Rotating conditions list (RCN)

- Ever told by doctor or other health professional that you had weak or failing kidneys
- Ever told by doctor or other health professional that you had hepatitis
- Ever told by doctor or other health professional that you had cirrhosis or any other kind of long-term liver condition

Allergies (ALG)

- Get symptoms such as sneezing, runny nose, or itchy or watery eyes due to hay fever, seasonal or year-round allergies
If yes:
 - Ever told by doctor or other health professional that you had hay fever, seasonal or year-round allergies
- Have an allergy to one or more foods
If yes:
 - Ever told by doctor or other health professional that you had an allergy to one or more foods
- Get an itchy rash due to eczema or atopic dermatitis
 - Ever told by doctor or other health professional that you had eczema or atopic dermatitis

ROTATING CORE CONTENT: PSYCHOLOGICAL DISTRESS

Years: 2021, 2024, 2027

Serious psychological distress (SPD)

See https://www.hcp.med.harvard.edu/ncs/k6_scales.php for more information on the K6 scale.

- (Past 30 days) Frequency of feeling ... so sad that nothing could cheer you up
- (Past 30 days) Frequency of feeling ... nervous
- (Past 30 days) Frequency of feeling ... restless or fidgety
- (Past 30 days) Frequency of feeling ... hopeless
- (Past 30 days) Frequency of feeling ... that everything was an effort
- (Past 30 days) Frequency of feeling ... worthless