

Illinois Health Survey

IHS Youth Core Instrument
Ages 0-17
Version 9
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Child Health Data Lab
Children's Memorial Hospital
Chicago, IL



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Section A-Demographic and Overall Health Status

- CA1 Is (child) male or female?
1 Male
2 Female
7 Don't know
9 Refused
- CA2 What is the child's year of birth?
_____ Year
77 Don't know
99 Refused
- CA3 [IF DOB OK, GO TO CA4] How old is he/she?
_____ Years
77 Don't know
88 Skipped
99 Refused
- CA4 In general, would you say your child's health is...
1 Excellent
2 Very good
3 Good
4 Fair
5 Poor
7 Don't know
9 Refused
- CA5 How much did he/she weigh at birth? [IF NEEDED SAY: "Your best guess is fine."]
_____ Pounds _____ Ounces OR
_____ Grams
7777 Don't know
9999 Refused
- CA6 Was (child) born prematurely, that is, was he/she born more than 4 weeks early?
1 Yes
2 No
7 Don't know
9 Refused
- CA7 Did he/she receive any newborn care in an intensive care unit, premature nursery, or any other type of special care facility?
1 Yes
2 No
7 Don't know
9 Refused
- CA8 About how tall is your child now without shoes? [IF NEEDED SAY: "Your best guess is fine."]
_____ Feet _____ Inches OR
_____ Centimeters
777 Don't know
999 Refused

Section A-Demographic and Overall Health Status, continued

- CA9 Would you say your child is taller, shorter or about the same height as other children his/her age?
- 1 Taller
 - 2 About the same height
 - 3 Shorter
 - 7 Don't know
 - 9 Refused
- CA10 About how much does your child weigh without shoes? **[IF NEEDED SAY: "Your best guess is fine."]**
- _____ Pounds OR
 - _____ Kilograms
 - 777 Don't know
 - 999 Refused
- CA11 Would you say your child is very underweight, slightly underweight, about the right weight, slightly overweight or very overweight?...
- 1 Very Overweight
 - 2 Slightly overweight
 - 3 About the right weight
 - 4 Slightly underweight
 - 5 Very Underweight
 - 7 Don't know
 - 9 Refused

Section B-Health Care Access and utilization

- CB1 Is there a place that you usually take him/her to when he/she needs a checkup, is sick or you need advice about health?
- 1 Yes
 - 2 No [GO TO CB2]
 - 7 Don't know [GO TO CB2]
 - 9 Refused [GO TO CB2]
- CB1A Is the place a private doctor's office, a clinic, an emergency room, or some other place?
- 1 Private doctor's office
 - 2 Clinic
 - 3 Emergency Room
 - 4 Other, specify _____
 - 7 Don't know
 - 9 Refused
- CB2 About how long has it been since he/she last saw a medical doctor (for any reason)?
- 1 One year or less
 - 2 > 1 year, but < 2 years [GO TO CB5]
 - 3 > 2 years, but < 3 years [GO TO CB5]
 - 4 More than 2 years [GO TO CB5]
 - 5 Never [GO TO CB5]
 - 7 Don't know
 - 9 Refused [GO TO CB5]
- CB3 During the past 12 months, how many times has (child) ever seen any kind of medical doctor?
- _____ Times
 - 777 Don't know
 - 999 Refused
- CB4 During the past 12 months, did (child) get a physical exam or general check-up when he/she was not sick or hurt?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 9 Refused
- CB5 The last time you saw a doctor for (child), did you have a hard time understanding the doctor?
- 1 Yes
 - 2 No [GO TO CB6]
 - 7 Don't know [GO TO CB6]
 - 9 Refused [GO TO CB6]
- CB5A Was this because you and the doctor spoke a different language?
- 1 Yes
 - 2 No [GO TO CB6]
 - 7 Don't know [GO TO CB6]
 - 8 Skipped
 - 9 Refused [GO TO CB6]

Section B-Health Care Access and utilization, continued

CB5A.1 Did you need someone else to help you understand the doctor?

- 1 Yes
- 2 No [GO TO CB6]
- 7 Don't know [GO TO CB6]
- 8 Skipped
- 9 Refused [GO TO CB6]

CB5A.1A Who was this person who helped you understand the doctor?

- 01 Minor child (under 18 years old)
- 02 Adult family member or friend
- 03 Doctor, nurse or other medical staff
- 04 Other office staff
- 05 Professional interpreter (in person or on phone)
- 06 Other (other patients, someone else)
- 07 Did not have someone to help
- 77 Don't know
- 88 Skipped
- 99 Refused

CB6 During the past 12 months, did (child) visit a hospital emergency room?

- 1 Yes
- 2 No [GO TO CBDENT1]
- 7 Don't know [GO TO CDENT1]
- 9 Refused [GO TO CDENT1]

CB6A What was the problem? [DO NOT READ RESPONSES]

- 01 Asthma attack
- 02 Dehydration
- 03 Diarrhea
- 04 Ear ache
- 05 Fever
- 06 Headache
- 07 Injury
- 08 Other (non-Asthma) respiratory illness
- 09 Stomach ache
- 10 Vomiting
- 11 Other, specify_____
- 77 Don't know
- 88 Skipped
- 99 Refused

CBDENT1 [If age <2, GO TO CB7] During the past 12 months, did (child) visit a dentist?

- 1 Yes
- 2 No [GO TO CB7]
- 7 Don't know [GO TO CB7]
- 9 Refused [GO TO CB7]

CBDENT2 Was it for a routine checkup or cleaning, or was it for a specific problem?

- 1 Routine checkup or cleaning
- 2 Specific problem
- 3 Both
- 7 Don't know
- 8 Skipped
- 9 Refused

Section B-Health Care Access and utilization, continued

- CB7 Does your child currently have health insurance, for example KidCare or Blue Cross/Blue Shield?
- 1 Yes
 - 2 No [GO TO CB8A]
 - 7 Don't know [GO TO CB8A]
 - 9 Refused [GO TO CB8A]
- CB7A What type of health insurance does your child have?
- 01 Through a current or former employer/union
 - 02 Through school, professional association, trade group or other organization
 - 03 Purchased directly from health plan (by R or anyone else)
 - 04 AllKids or KidCare
 - 05 Medicaid
 - 06 Medicare
 - 07 Champus
 - 08 Other government health plan, Specify _____
 - 09 Other non-government health plan, specify _____
 - 77 Don't know
 - 88 Skipped
 - 99 Refused
- CB8 During the past 12 months, was there any time when (child) had no insurance at all?
- 1 Yes
 - 2 No [GO TO CB9]
 - 7 Don't know [GO TO CB9]
 - 9 Refused [GO TO CB9]
- CB8A About how long was your child not covered by health insurance?
- _____ Months
 - 77 Don't know
 - 88 Skipped
 - 99 Refused
- CB9 During the past 12 months, did you delay or not get medicine, medical or dental care for your child because of cost or lack of insurance?
- 1 Yes
 - 2 No [GO TO CB10]
 - 7 Don't know [GO TO CB10]
 - 9 Refused [GO TO CB10]
- CB9A What was delayed? {Select all that apply}
- 1 Getting Medicine
 - 2 Seeing a doctor
 - 3 Seeing a specialist or other health care professional recommended by doctor
 - 4 Mental health services
 - 5 Dental services
 - 6 Other, specify _____
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

Section B-Health Care Access and utilization, continued

CB9B Did your child have health insurance at the time that he/she needed these services?

- 1 Yes
- 2 No [GO TO CB10]
- 7 Don't know [GO TO CB10]
- 8 Skipped [GO TO CB10]
- 9 Refused [GO TO CB10]

CBMedicaid [If insurance does not equal Medicaid or All Kids, GO TO CB10] Were you able to find a provider that accepts Medicaid?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CB10 During the past 12 months, did you delay or not get medicine, medical or dental care for your child because it was too difficult to travel to the doctor, pharmacy or health care provider?

- 1 Yes
- 2 No [GO TO CB11]
- 7 Don't know [GO TO CB11]
- 9 Refused [GO TO CB11]

CB10A What was delayed?

- 1 Getting Medicine
- 2 Seeing a doctor
- 3 Seeing a specialist or other health care professional recommended by doctor
- 4 Mental health services
- 5 Dental services
- 6 Other, specify _____
- 7 Don't know
- 8 Skipped
- 9 Refused

CB11 During the past 12 months, did you delay or not get medicine, medical or dental care for your child because you do not have a doctor that speaks your language?

- 1 Yes
- 2 No
- 7 Don't know
- 9 Refused

CB12 During the past 12 months, have you chosen a doctor or other health care professional for your child because he/she could speak your language?

- 1 Yes
- 2 No [GO TO CB13]
- 7 Don't know [GO TO CB13]
- 9 Refused [GO TO CB13]

CB12A Do you feel that you were able to get the best medical care for the child's problem?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

Section B-Health Care Access and utilization, continued

CB13 Is (child) now on TANF? **[IF NEEDED, SAY: "TANF means 'Temporary Assistance to Needy Families'."]**

- 1 Yes
- 2 No
- 7 Don't know
- 9 Refused

CB14 Is (child) receiving food stamp benefits? **[IF NEEDED, SAY: "You may receive benefits as stamps or through an EBT card." "EBT stands for Electric Benefit Transfer card."]**

- 1 Yes
- 2 No
- 7 Don't know
- 9 Refused

CB15 [IF AGE >5, GO TO CB16] Is (child) on WIC now? **[IF NEEDED, SAY: "WIC means 'Supplemental Food Program for Women, Infants, and Children.'"]**

- 1 Yes
- 2 No
- 7 Don't know
- 9 Refused

CB16 [IF AGE <5, GO TO CC1] Does (child) receive free or reduced fee lunches at school?

- 1 Yes
- 2 No
- 7 Don't know
- 9 Refused

Section C-Screening and Immunizations

- CC1 Is your child up to date with his/her routine immunizations?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 9 Refused
- CC2 Have you ever delayed or not gotten your child a shot because it was too expensive?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 9 Refused
- CC3 Have you ever refused permission or consent to have your child immunized for something when your child's doctor recommended the immunization?
- 1 Yes
 - 2 No [GO TO CC3]
 - 7 Don't know [GO TO CC3]
 - 9 Refused [GO TO CC3]
- CC3A What were the immunizations for? [DO NOT READ RESPONSES] [CODE ALL THAT APPLY]
- 01 Diphtheria, Tetanus, Pertussis (DTaP)
 - 02 Haemophilus influenza type b (Hib)
 - 03 Hepatitis A
 - 04 Hepatitis B
 - 05 Inactivated Poliovirus
 - 06 Measles
 - 07 Meningococcal
 - 08 Mumps
 - 09 Pneumococcal
 - 10 Rotavirus
 - 11 Rubella
 - 12 Varicella
 - 13 Other, specify _____
 - 77 Don't know
 - 88 Skipped
 - 99 Refused
- CC3B Why did you refuse the immunization?
- 1 Did not seem necessary [GO TO CC4]
 - 2 My religion prohibits immunizations [GO TO CC4]
 - 3 I'm concerned about long term effects, like autism
 - 4 I was worried about reactions
 - 5 Other, specify _____ [GO TO CC4]
 - 7 Don't know [GO TO CC4]
 - 8 Skipped
 - 9 Refused [GO TO CC4]
- CC3B.1 Has your child had previous reactions?
- 1 Yes [GO TO CC4]
 - 2 No
 - 7 Don't know [GO TO CC4]
 - 8 Skipped
 - 9 Refused [GO TO CC4]

Section C-Screening and Immunizations, continued

- CC3B.1A Do you personally know a child who has had a reaction to an immunization?
- 1 Yes, another child of mine
 - 2 Yes, someone else
 - 3 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused
- CC4 Has your child ever had a blood test to detect a high level of lead in his/her blood?
- 1 Yes
 - 2 No [GO TO CD1]
 - 7 Don't know [GO TO CD1]
 - 9 Refused [GO TO CD1]
- CC4A Was the lead level in your child's blood high?
- 1 Yes
 - 2 No [GO TO CD1]
 - 7 Don't know [GO TO CD1]
 - 8 Skipped
 - 9 Refused [GO TO CD1]
- CC4A.1 Did you receive medical care to reduce your child's lead level?
- 1 Yes
 - 2 No [GO TO CD1]
 - 7 Don't know [GO TO CD1]
 - 8 Skipped
 - 9 Refused [GO TO CD1]
- CC4A.2 Were there problems identified in your home?
- 1 Yes
 - 2 No [GO TO CD1]
 - 7 Don't know [GO TO CD1]
 - 8 Skipped
 - 9 Refused [GO TO CD1]
- CC4A.2A Did you do anything to reduce your child's lead exposure? For example, repair your home or move.
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

Section D-Nutrition and Physical Activity

- CD1 [IF AGE <1, GO TO CE1] About how physically active is (child) compared to other children his/her age? Would you say...
- 1 About the same
 - 2 A lot less
 - 3 A little less
 - 4 A little more
 - 5 A lot more
 - 7 Don't know
 - 9 Refused
- CD2 In the past week, how many days did he/she play actively enough to make him/her breathe hard, or to make his/her heart beat fast?
- _____ Days
 - 77 Don't know
 - 99 Refused
- CD3 Yesterday, how many glasses or small cartons of milk did he/she drink?
- _____ Times
 - 77 Don't know
 - 99 Refused
- CD4 Yesterday, how many glasses or cans of soda (such as Coke) or other sweetened drinks (such as fruit punch or Sunny Delight) did he/she drink? Do not count diet or sugar free drinks. [NOTE: This also includes drinks such as Tampico, Hawaiian Punch, Cranberry Cocktail, Hi-C, Snapple, Sugar Cane Juice, Gatorade and other sports drinks with added sugar.]
- _____ Times
 - 77 Don't know
 - 99 Refused
- CD5 Yesterday, how many glasses or small cartons of 100% juice (such as apple or orange) did he/she drink? Do not count the drinks you counted before. **[If needed say, "Only include 100% fruit juices."]** **[NOTE: Part of a glass counts as 1 glass, ask R to estimate number of glasses if drinking from a bottle, can or carton.]**
- _____ Times
 - 77 Don't know
 - 99 Refused
- CD6 Yesterday, how many servings of fruit, such as an apple or a banana, did he/she have? **[IF NEEDED, SAY: "Servings' are self-defined. A serving is the child's regular portion of this food."]**
- _____ Times
 - 77 Don't know
 - 99 Refused
- CD7 Yesterday, how many servings of vegetables like green beans, green salad, corn, or other vegetables did he/she have?
- _____ Times
 - 77 Don't know
 - 99 Refused

Section D-Nutrition and Physical Activity, continued

CD8 Yesterday, how many times did he/she eat fast food? Include fast food meals eaten at school, at home, at fast food restaurants, carryout or drive-thru. [IF NEEDED, SAY:

"Such as food you get at McDonald's, Burger King, or Taco Bell."]

_____ Times
77 Don't know
99 Refused

CD9 Yesterday, how many servings of high sugar foods, such as cookies, candy, doughnuts, pastries, cake or popsicles did he/she have? [IF NEEDED, SAY: **"Do not include sugar-free kinds but include low-fat kinds."**]

_____ Times
77 Don't know
99 Refused

Section E-Child care

CE1 [IF AGE > 11, GO TO CF1] The next questions are about childcare. By childcare we mean any arrangement where someone other than the parents, legal guardian or stepparents takes care of (child). {This includes preschool and nursery school, but not kindergarten} Do you currently have any kind of regular childcare arrangements for (child) for 10 or more hours per week?

- 1 Yes
- 2 No [GO TO CF1]
- 7 Don't know [GO TO CF1]
- 9 Refused [GO TO CF1]

CE1A In what kind of setting is your child usually cared for?

- 1 Group setting, outside someone's home, eg daycare center, Head Start, preschool
- 2 Group setting in someone's house
- 3 Non-group setting in someone's house
- 4 In your own home, daycare provider comes to your house
- 5 Other, specify _____-
- 7 Don't know
- 8 Skipped
- 9 Refused

CE1B Do you or someone else usually pay for this childcare?

- 1 Yes
- 2 No [GO TO CF1]
- 7 Don't know [GO TO CF1]
- 8 Skipped
- 9 Refused [GO TO CF1]

CE1B.1 In the past month have you had any trouble paying for the child care?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CE1B.2 Does anyone help you pay for all or part of the cost of child care? By this, I mean a government social service agency, an employer, a charity, a relative, or a friend?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

Section F-Child Emotional Functioning

- CF1 During the past 30 days, how often has your child acted restless or edgy?
- 1 Never
 - 2 Sometimes
 - 3 Often
 - 4 Very often
 - 7 Don't know
 - 9 Refused
- CF2 During the past 30 days, how often has your child been irritable most of the day?
- 1 Never
 - 2 Sometimes
 - 3 Often
 - 4 Very often
 - 7 Don't know
 - 9 Refused
- CF3 During the past 30 days, how often has your child been extremely tense or unable to relax?
- 1 Never
 - 2 Sometimes
 - 3 Often
 - 4 Very often
 - 7 Don't know
 - 9 Refused
- CF4 During the past 30 days, how often has you child had difficulties controlling worries?
- 1 Never
 - 2 Sometimes
 - 3 Often
 - 4 Very often
 - 7 Don't know
 - 9 Refused
- CF5 During the past 30 days, how often has your child worried that his/her parents will be hurt or leave home and not come back?
- 1 Never
 - 2 Sometimes
 - 3 Often
 - 4 Very often
 - 7 Don't know
 - 9 Refused
- CF6 During the past 30 days, how often has your child worried that some disaster will separate child from parents?
- 1 Never
 - 2 Sometimes
 - 3 Often
 - 4 Very often
 - 7 Don't know
 - 9 Refused

Section F-Child Emotional Functioning, continued

- CF7 During the past 30 days, how often has your child been very upset when he/she expects to be separated from their home or parents?
- 1 Never
 - 2 Sometimes
 - 3 Often
 - 4 Very often
 - 7 Don't know
 - 9 Refused
- CF8 During the past 30 days, how often has your child been excessively shy with peers?
- 1 Never
 - 2 Sometimes
 - 3 Often
 - 4 Very often
 - 7 Don't know
 - 9 Refused
- CF9 During the past 30 days, when your child was been put in an uncomfortable social situation how often did he/she cry, freeze or withdraw from interacting?
- 1 Never
 - 2 Sometimes
 - 3 Often
 - 4 Very often
 - 7 Don't know
 - 9 Refused
- CF10 During the past 30 days, how often has your child been depressed or sad for most of the day?
- 1 Never
 - 2 Sometimes
 - 3 Often
 - 4 Very often
 - 7 Don't know
 - 9 Refused
- CF11 During the past 30 days, how often has your child shown little interest in (or enjoyment of) pleasurable activities?
- 1 Never
 - 2 Sometimes
 - 3 Often
 - 4 Very often
 - 7 Don't know
 - 9 Refused
- CF12 During the past 30 days, how often has your child had a low energy level or is tired for no apparent reason?
- 1 Never
 - 2 Sometimes
 - 3 Often
 - 4 Very often
 - 7 Don't know
 - 9 Refused

Section F-Child Emotional Functioning, continued

- CF13 During the past 30 days, how often has your child had little confidence or has been very self conscious?
- 1 Never
 - 2 Sometimes
 - 3 Often
 - 4 Very often
 - 7 Don't know
 - 9 Refused

Section G-Acute Conditions

- CG1 Turning to injuries, including violent injuries, during the past 12 months, was (child) injured seriously enough that he/she got medical advice or treatment?
- 1 Yes
 - 2 No [GO TO CG5]
 - 7 Don't know [GO TO CG5]
 - 9 Refused [GO TO CG5]
- CG2 How many times did this happen in the past 12 months? That (child) was injured seriously enough that he/she got medical advice or treatment?
- _____ Times
- 7 Don't know
 - 8 Skipped
 - 9 Refused
- CG3 What was the cause of the (most serious) injury?
- 01 Auto accident-child was in car
 - 02 Auto accident-child was walking
 - 03 Auto accident-child was biking
 - 04 Other bicycle-related
 - 05 Serious fall
 - 06 Sports-related
 - 07 Burn/scald/fire
 - 08 Violence
 - 09 Other, specify _____
 - 77 Don't know
 - 88 Skipped
 - 99 Refused
- CG4 Did (child) reduce his/her physical activity for some period of time because of this injury?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused
- CG5 [IF AGE <2, GO TO CG6] Has (child) ridden a bike in the past year?
- 1 Yes
 - 2 No [GO TO CG6]
 - 7 Don't know [GO TO CG6]
 - 9 Refused [GO TO CG6]
- CG5A How often does he/she wear a helmet when riding a bike? Would you say...
- 1 Always
 - 2 Usually
 - 3 Sometimes
 - 4 Never
 - 7 Don't know
 - 8 Skipped

Section G-Acute Conditions, continued

CG6 [IF CG3=01, GO TO CG6A] **[IF AGE >15, ASK "Has (child) taken a ride or driven a car or other motor vehicle in the past year?"** Has (child) taken a ride in a car or other motor vehicle in the past year?

- 1 Yes
- 2 No[GO TO CG7]
- 7 Don't know [GO TO CG6]
- 8 Skipped
- 9 Refused [GO TO CG6]

CG6A How often does your child ride in the front seat?

- 1 Always
- 2 Usually
- 3 Sometimes
- 4 Never
- 7 Don't know
- 8 Skipped
- 9 Refused

CG6B [IF AGE >9, GO TO CG6C] How often does he/she use a car seat or a booster seat when riding in a car?

- 1 Always
- 2 Usually
- 3 Sometimes
- 4 Never
- 7 Don't know
- 8 Skipped
- 9 Refused

CG6C [IF AGE <9, GO TO CG7] How often does he/she use a seatbelt?

- 1 Always
- 2 Usually
- 3 Sometimes
- 4 Never
- 7 Don't know
- 8 Skipped
- 9 Refused

CG7 In the past 12 months, was your child ever sick enough with an infectious disease, for example a cold, the flu or some "bug", that you called or went to visit a doctor?

- 1 Yes
- 2 No [GO TO CG8]
- 7 Don't know [GO TO CG8]
- 9 Refused [GO TO CG8]

CG7A What was wrong?

- 01 Cold or flu
- 02 Stomach virus
- 03 Diarrhea

- 04 Ear infection
- 05 Bronchitis
- 06 Chicken pox
- 07 Other, specify _____
- 77 Don't know
- 88 Skipped
- 99 Refused

Section G-Acute Conditions, continued

CG8 Does your child usually snore?

- 1 Yes
- 2 No
- 7 Don't know
- 9 Refused

CG9 When does (child) usually go to bed on a normal school night? **[IF AGE >3, ASK "When does (child) usually go to bed on a normal week night?"]**

- _____ Hour
- _____ Minute
- 1 AM
- 2 PM
- 7 Don't know
- 9 Refused

CG10 When does (child) usually get up to go to school on a normal morning? **[IF AGE >3, ASK "When does (child) usually get up on a normal weekday morning?"]**

- _____ Hour
- _____ Minute
- 1 AM
- 2 PM
- 7 Don't know
- 9 Refused

CG11 How often does (child) take naps? Would you say...

- 1 Everyday
- 2 1 or 2 times a week
- 3 1 or 2 times a month
- 4 Never [GO TO CH1]
- 7 Don't know [GO TO CH1]
- 9 Refused [GO TO CH1]

CG12 How long are his/her naps?

- _____ Hours
- _____ Minutes
- 77 Don't know
- 88 Skipped
- 99 Refused

Section H-Chronic Conditions

- CH1 Has your doctor, a health care professional or a staff member at your child's school ever told you that [subject child] had hearing problems?
- 1 Yes
 - 2 No [GO TO CH1E]
 - 7 Don't know [GO TO CH1E]
 - 9 Refused [GO TO CH1E]
- CH1A What did the doctor, health care professional or school staff call his/her problem? [DO NOT READ RESPONSES]
- 01 Chronic ear infections
 - 02 Deaf
 - 03 Hearing impaired
 - 04 Injury to ear/head
 - 05 Non cancerous growth
 - 06 Otosclerosis
 - 07 Other, specify _____
 - 77 Don't know
 - 88 Skipped
 - 99 Refused
- CH1B Does he/she still have this problem?
- 1 Yes
 - 2 No [GO TO CH2]
 - 7 Don't know [GO TO CH2]
 - 8 Skipped
 - 9 Refused [GO TO CH2]
- CH1C Is he/she currently getting any treatment or services to help with this problem?
- 1 Yes
 - 2 No [GO TO CH1D.1]
 - 7 Don't know [GO TO CH1D.1]
 - 8 Skipped
 - 9 Refused [GO TO CH1D.1]
- CH1C.1 Are these treatments or services received from either a doctor or other health care professional?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused
- CH1C.2 Are these treatments or services received from a school?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped

Section H-Chronic Conditions, continued

- CH1C.3 Do these treatments involve medication prescribed by a doctor or equipment, such as a hearing aid?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused
- CH1C.4 Are these treatments home or alternative treatments, such as herbs or acupuncture?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused
- CH1D.1 [IF AGE <4, GO TO CH1D.2] Does the problem negatively affect or interfere with his/her school work?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused
- CH1D.2 Does the problem negatively affect or interfere with his/her play or sports activities?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused
- CH1D.3 [IF AGE <2, GO TO CH1D.4] Does the problem negatively affect or interfere with his/her friendships or social activities?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused
- CH1D.4 Does the problem negatively affect or interfere with your family life?
- 1 Yes [GO TO CH2]
 - 2 No [GO TO CH2]
 - 7 Don't know [GO TO CH2]
 - 8 Skipped
 - 9 Refused [GO TO CH2]

- CH1E Has your child ever been screened for hearing problems?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

Section H-Chronic Conditions, continued

- CH2 Has your doctor, a health care professional or a staff member from your child's school ever told you that [subject child] had vision problems?
- 1 Yes
 - 2 No [GO TO CH2D]
 - 7 Don't know [GO TO CH2D]
 - 9 Refused [GO TO CH2D]

- CH2A What did the doctor, health care professional or school staff call his/her problem? [DO NOT READ RESPONSES]
- 01 Astigmatism
 - 02 Blind
 - 03 Cataracts
 - 04 Color blindness
 - 05 Cross-eyed (Strabismus)
 - 06 Far-sighted
 - 07 Glaucoma
 - 08 Lazy Eye (Amblyopia)
 - 09 Near-sighted
 - 10 Retinal detachment
 - 11 Retinopathy of prematurity
 - 12 Other, specify _____
 - 77 Don't know
 - 88 Skipped
 - 99 Refused

- CH2B Is he/she currently getting any treatment or services to help with this problem?
- 1 Yes
 - 2 No [GO TO CH2C.1]
 - 7 Don't know [GO TO CH2C.1]
 - 8 Skipped
 - 9 Refused [GO TO CH2C.1]

- CH2B.1 Are any of these treatments or services received from a doctor or other health care professional?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH2B.2 Are any of these treatments or services received from a school?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped

9 Refused

CH2B.3 Do these treatments involve equipment or medications prescribed by a doctor, such as glasses?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

Section H-Chronic Conditions, continued

CH2B.4 Are any of these treatments home or alternative treatments, such as herbs or acupuncture?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH2C.1 [IF AGE <4, GO TO CH2C.2] Does the problem negatively affect or interfere with his/her school work?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH2C.2 Does the problem negatively affect or interfere with his/her play or sports activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH2C.3 [IF AGE <2, GO TO CH2C.4] Does the problem negatively affect or interfere with his/her friendships or social activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH2C.4 Does the problem negatively affect or interfere with your family life?

- 1 Yes [GO TO CH3]
- 2 No [GO TO CH3]
- 7 Don't know [GO TO CH3]
- 8 Skipped
- 9 Refused [GO TO CH3]

CH2D Has your child ever been screened for vision problems?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH3 [IF AGE <3, GO TO CH5] Has your doctor, a health care professional, including psychiatrist, psychologist, social worker or counselor, or a staff member from your child's school ever

told you that [subject child] had Attention Deficit Disorder (ADD or ADHD)?

- 1 Yes
- 2 No [GO TO CH3D]
- 7 Don't know [GO TO CH3D]
- 9 Refused [GO TO CH3D]

Section H-Chronic Conditions, continued

CH3A Does he/she still have ADD/ADHD?

- 1 Yes
- 2 No [GO TO CH4]
- 7 Don't know [GO TO CH4]
- 8 Skipped
- 9 Refused [GO TO CH4]

CH3B Is he/she currently getting any treatment or services to help with this problem?

- 1 Yes
- 2 No [GO TO CH3C.1]
- 7 Don't know [GO TO CH3C.1]
- 8 Skipped
- 9 Refused [GO TO CH3C.1]

CH3B.1 Are any of these treatments or services received from a doctor or other health care professional?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH3B.2 Are any of these treatments or services received from a school?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH3B.3 Do these treatments involve medications prescribed by a doctor?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH3B.4 Are any of these treatments home or alternative treatments, such as herbs or acupuncture?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

- CH3C.1 [IF AGE <4, GO TO CH3C.2] Does the problem negatively affect or interfere with his/her school work?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

Section H-Chronic Conditions, continued

- CH3C.2 Does the problem negatively affect or interfere with his/her play or sports activities?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH3C.3 Does the problem negatively affect or interfere with his/her friendships or social activities?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH3C.4 Does the problem negatively affect or interfere with your family life?
- 1 Yes [GO TO CH4]
 - 2 No [GO TO CH4]
 - 7 Don't know [GO TO CH4]
 - 8 Skipped
 - 9 Refused [GO TO CH4]

- CH3D Has your child ever been screened for ADD/ADHD?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH4 Has your doctor or any health care professional, psychiatrist, psychologist, social worker or counselor ever told you that [subject child] had depression or anxiety problems?
- 1 Yes
 - 2 No [GO TO CH5]
 - 7 Don't know [GO TO CH5]
 - 9 Refused [GO TO CH5]

- CH4A What did the doctor or health care professional call his/her problem?
-
- 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH4B Does he/she still have this problem?
- 1 Yes

- 2 No [GO TO CH5]
- 7 Don't know [GO TO CH5]
- 8 Skipped
- 9 Refused [GO TO CH5]

CH4C Is he/she currently getting any treatment or services to help with this problem?

- 1 Yes
- 2 No [GO TO CH4D.1]
- 7 Don't know [GO TO CH4D.1]
- 8 Skipped
- 9 Refused [GO TO CH4D.1]

Section H-Chronic Conditions, continued

CH4C.1 Are any of these treatments or services received from either a doctor or other health care professional?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH4C.2 Are these treatments or services received from a school?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH4C.3 Do these treatments involve medications prescribed by a doctor?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH4C.4 Are any of these treatments home or alternative treatments, such as herbs or acupuncture?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH4D.1 [IF AGE <4, GO TO CH4D.2] Does the problem negatively affect or interfere with his/her school work?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH4D.2 Does the problem negatively affect or interfere with his/her play or sports activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

- CH4D.3 [IF AGE <2, GO TO CH4D.4] Does the problem negatively affect or interfere with his/her friendships or social activities?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

Section H-Chronic Conditions, continued

- CH4D.4 Does the problem negatively affect or interfere with your family life?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH5 [IF AGE <1, GO TO CH6] Has your doctor, a health care professional, psychiatrist, psychologist, social worker or counselor or a staff member from your child's school ever told you that [subject child] had behavioral or conduct problems?
- 1 Yes
 - 2 No [GO TO CH6]
 - 7 Don't know [GO TO CH6]
 - 9 Refused [GO TO CH6]

- CH5A What did the doctor, health care professional or school staff call his/her problem?
-
- 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH5B Does he/she still have this problem?
- 1 Yes
 - 2 No [GO TO CH6]
 - 7 Don't know [GO TO CH6]
 - 8 Skipped
 - 9 Refused [GO TO CH6]

- CH5C Is he/she currently getting any treatment or services to help with this problem?
- 1 Yes
 - 2 No [GO TO CH5D.1]
 - 7 Don't know [GO TO CH5D.1]
 - 8 Skipped
 - 9 Refused [GO TO CH5D.1]

- CH5C.1 Are any of these treatments or services received from either a doctor or other health care professional?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH5C.2 Are any of these treatments or services received from a school?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

Section H-Chronic Conditions, continued

- CH5C.3 Do these treatments involve medications prescribed by a doctor?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH5C.4 Are any of these treatments home or alternative treatments, such as herbs or acupuncture?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH5D.1 [IF AGE < 4, GO TO CH5D.2] Does the problem negatively affect or interfere with his/her school work?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH5D.2 Does the problem negatively affect or interfere with his/her play or sports activities?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH5D.3 [IF AGE < 2, GO TO CH5D.4] Does the problem negatively affect or interfere with his/her friendships or social activities?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH5D.4 Does the problem negatively affect or interfere with your family life?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped

9 Refused

- CH6 [IF AGE <5, GO TO CH7] Has your doctor, health care professional or a staff member from your child's school ever told you that [subject child] had learning problems, like dyslexia, reading delays or other problems keeping up at school?
- 1 Yes
 - 2 No [GO TO CH7]
 - 7 Don't know [GO TO CH7]
 - 9 Refused [GO TO CH7]

Section H-Chronic Conditions, continued

- CH6A What did the doctor, health care professional or school staff call his/her problem? [DO NOT READ RESPONSES]
- 1 Dyscalculia (math disability)
 - 2 Dysgraphia (written language disability)
 - 3 Dyslexia (reading disability)
 - 4 Other, specify _____
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH6B Does he/she still have this problem?
- 1 Yes
 - 2 No [GO TO CH7]
 - 7 Don't know [GO TO CH7]
 - 8 Skipped
 - 9 Refused [GO TO CH7]

- CH6C Is he/she currently getting any treatment or services to help with this problem?
- 1 Yes
 - 2 No [GO TO CH6D.1]
 - 7 Don't know [GO TO CH6D.1]
 - 8 Skipped
 - 9 Refused [GO TO CH6D.1]

- CH6C.1 Are any of these treatments or services received from a doctor or other health care professional?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH6C.2 Are any of these treatments or services received from a school?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH6C.3 Do these treatments involve medications prescribed by a doctor?
- 1 Yes

- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH6C.4 Are any of these treatments home or alternative treatments, such as herbs or acupuncture?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

Section H-Chronic Conditions, continued

CH6D.1 Does the problem negatively affect or interfere with his/her school work?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH6D.2 Does the problem negatively affect or interfere with his/her play or sports activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH6D.3 Does the problem negatively affect or interfere with his/her friendships or social activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH6D.4 Does the problem negatively affect or interfere with your family life?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH7 [IF AGE < 1, GO TO CH8] Has your doctor, a health care professional, psychiatrist, psychologist, social worker or counselor or a staff member from your child's school ever told you that [subject child] had Pervasive Developmental Delay, autism or Asperger's Syndrome? [If necessary, say: sometimes Pervasive Developmental Delay is called PDD]

- 1 Yes
- 2 No [GO TO CH8]
- 7 Don't know [GO TO CH8]
- 9 Refused [GO TO CH8]

CH7A Is he/she currently getting any treatment or services to help with this problem?

- 1 Yes
- 2 No [GO TO CH7B.1]
- 7 Don't know [GO TO CH7B.1]
- 8 Skipped

9 Refused [GO TO CH7B.1]

CH7A.1 Are any of these treatments or services received from a doctor or other health care professional?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

Section H-Chronic Conditions, continued

CH7A.2 Are any of these treatments or services received from a school?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH7A.3 Do these treatments involve medications prescribed by a doctor?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH7A.4 Are any of these treatments home or alternative treatments, such as herbs or acupuncture?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH7B.1 [IF AGE <4, GO TO CH7B.2] Does the problem negatively affect or interfere with his/her school work?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH7B.2 Does the problem negatively affect or interfere with his/her play or sports activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH7B.3 [IF AGE <2, GO TO CH7B.4] Does the problem negatively affect or interfere with his/her friendships or social activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped

9 Refused

CH7B.4 Does the problem negatively affect or interfere with your family life?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH8 Has your doctor or any health care professional ever told you that [subject child] had a delay in physical development, like difficulty learning to walk?

- 1 Yes
- 2 No [GO TO CH9]
- 7 Don't know [GO TO CH9]
- 9 Refused [GO TO CH9]

Section H-Chronic Conditions, continued

CH8A What did the doctor call his/her problem? [DO NOT READ RESPONSES]

- 01 Ataxia
- 02 Cerebral Palsy
- 03 Developmental delay
- 04 Down's Syndrome
- 05 Fetal Alcohol Syndrome
- 06 Fragile X Syndrome
- 07 Mental retardation
- 08 Myopathy
- 09 Spina Bifida
- 10 Other, specify _____
- 77 Don't know
- 88 Skipped
- 99 Refused

CH8B Does he/she still have this problem?

- 1 Yes
- 2 No [GO TO CH9]
- 7 Don't know [GO TO CH9]
- 8 Skipped
- 9 Refused [GO TO CH9]

CH8C Is he/she currently getting any treatment or services to help with this problem?

- 1 Yes
- 2 No [GO TO CH8E.1]
- 7 Don't know [GO TO CH8E.1]
- 8 Skipped
- 9 Refused [GO TO CH8E.1]

CH8C.1 Are any of these treatments or services received from either a doctor or other health care professional?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH8C.2 Are any of these treatments or services received from a school?

- 1 Yes
- 2 No

- 7 Don't know
- 8 Skipped
- 9 Refused

- CH8C.3 Do these treatments involve medications prescribed by a doctor or equipment?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

Section H-Chronic Conditions, continued

- CH8C.4 Are any of these treatments home or alternative treatments, such as herbs or acupuncture?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH8D.1 How many different doctors does your child see because of his/her conditions?
- _____ doctors
- 777 Don't know
 - 888 Skipped
 - 999 Refused

- CH8D.2 In the past 12 months, how many times had your child gone to the doctor?
- _____ Times
- 777 Don't know
 - 888 Skipped
 - 999 Refused

- CH8D.3 Is your child dependent on machines or equipment to do daily activities?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH8E.1 [IF AGE <4, GO TO CH8E.2] Does the problem negatively affect or interfere with his/her school work?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH8E.2 Does the problem negatively affect or interfere with his/her play or sports activities?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH8E.3 [IF AGE <2, GO TO CH8E.4] Does the problem negatively affect or interfere with his/her friendships or social activities?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

Section H-Chronic Conditions, continued

- CH8E.4 Does the problem negatively affect or interfere with your family life?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH9 [IF AGE <2, GOTO CH10] Has your doctor or any health care professional ever told you that [subject child] had a speech delay?
- 1 Yes
 - 2 No [GO TO CH10]
 - 7 Don't know [GO TO CH10]
 - 9 Refused [GO TO CH10]

- CH9A What did the doctor or health care professional call his/her problem? [DO NOT READ RESPONSES]
- 1 Autism Spectrum Disorder
 - 2 Dysarthria
 - 3 Hearing loss
 - 4 Learning disability
 - 5 Other, specify _____
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH9B Does he/she still have this problem?
- 1 Yes
 - 2 No [GO TO CH10]
 - 7 Don't know [GO TO CH10]
 - 8 Skipped
 - 9 Refused [GO TO CH10]

- CH9C Is he/she currently getting any treatment or services to help with this problem?
- 1 Yes
 - 2 No [GO TO CH9D.1]
 - 7 Don't know [GO TO CH9D.1]
 - 8 Skipped
 - 9 Refused [GO TO CH9D.1]

CH9C.1 Are any of these treatments or services received from either a doctor or other health care professional?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH9C.2 Are any of these treatments or services received from a school?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

Section H-Chronic Conditions, continued

CH9C.3 Do these treatments involve medications prescribed by a doctor or equipment?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH9C.4 Are any of these treatments home or alternative treatments, such as herbs or acupuncture?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH9D.1 [IF AGE < 4, GO TO CH9D.2] Does the problem negatively affect or interfere with his/her school work?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH9D.2 Does the problem negatively affect or interfere with his/her play or sports activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH9D.3 Does the problem negatively affect or interfere with his/her friendships or social activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH9D.4 Does the problem negatively affect or interfere with your family life?

- 1 Yes

- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

- CH10 Has your child ever had a seizure?
- 1 Yes
 - 2 No [GO TO CH11]
 - 7 Don't know [GO TO CH11]
 - 9 Refused [GO TO CH11]

Section H-Chronic Conditions, continued

- CH10A What did the doctor or health professional call his/her problem? [DO NOT READ RESPONSES]
- 1 Epilepsy
 - 2 Fever/febrile seizures/fever convulsions
 - 3 Other, specify _____
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH10B Does he/she still have this problem?
- 1 Yes
 - 2 No [GO TO CH11]
 - 7 Don't know [GO TO CH11]
 - 8 Skipped
 - 9 Refused [GO TO CH11]

- CH10C Is he/she currently getting any treatment or services to help with this problem?
- 1 Yes
 - 2 No [GO TO CH10D.1]
 - 7 Don't know [GO TO CH10D.1]
 - 8 Skipped
 - 9 Refused [GO TO CH10D.1]

- CH10C.1 Are any of these treatments or services received from either a doctor or other health care professional?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH10C.2 Are any of these treatments or services received from a school?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

- CH10C.3 Do these treatments involve medications prescribed by a doctor or equipment?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused
- CH10C.4 Are any of these treatments home or alternative treatments, such as herbs or acupuncture?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

Section H-Chronic Conditions, continued

- CH10D.1 [IF AGE <4, GO TO CH10D.2] Does the problem negatively affect or interfere with his/her school work?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused
- CH10D.2 Does the problem negatively affect or interfere with his/her play or sports activities?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused
- CH10D.3 [IF AGE <2, GO TO CH10D.4] Does the problem negatively affect or interfere with his/her friendships or social activities?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused
- CH10D.4 Does the problem negatively affect or interfere with your family life?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused
- CH11 [IF AGE <2, GO TO CH12] Has your doctor or any health care professional ever told you that [subject child] had asthma?
- 1 Yes
 - 2 No [GO TO CH12]
 - 7 Don't know [GO TO CH12]

9 Refused [GO TO CH12]

CH11A Does he/she still have asthma?
1 Yes
2 No [GO TO CH12]
7 Don't know [GO TO CH12]
8 Skipped
9 Refused [GO TO CH12]

CH11B Is he/she currently getting any treatment or services to help with this problem?
1 Yes
2 No [GO TO CH11C.1]
7 Don't know [GO TO CH11C.1]
8 Skipped
9 Refused [GO TO CH11C.1]

Section H-Chronic Conditions, continued

CH11B.1 Are any of these treatments or services received from either a doctor or other health care professional?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

CH11B.2 Are any of these treatments or services received from a school?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

CH11B.3 Do these treatments involve medications prescribed by a doctor?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

CH11B.4 Are any of these treatments home or alternative treatments, such as herbs or acupuncture?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

CH11C.1 [IF AGE < 4, GO TO CH11C.2] Does the problem negatively affect or interfere with his/her school work?
1 Yes
2 No
7 Don't know
8 Skipped

9 Refused

CH11C.2 Does the problem negatively affect or interfere with his/her play or sports activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH11C.3 Does the problem negatively affect or interfere with his/her friendships or social activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

Section H-Chronic Conditions, continued

CH11C.4 Does the problem negatively affect or interfere with your family life?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH12 Has your doctor or any health care professional ever told you that [subject child] had diabetes?

- 1 Yes
- 2 No [GO TO CH13]
- 7 Don't know [GO TO CH13]
- 9 Refused [GO TO CH13]

CH12A Is he/she currently getting any treatment or services to help with this problem?

- 1 Yes
- 2 No [GO TO CH12B.1]
- 7 Don't know [GO TO CH12B.1]
- 8 Skipped
- 9 Refused [GO TO CH12B.1]

CH12A.1 Are any of these treatments or services received from a doctor or other health care professional?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH12A.2 Are any of these treatments or services received from a school?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped

9 Refused

CH12A.3 Do these treatments involve medications prescribed by a doctor?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH12A.4 Are any of these treatments home or alternative treatments, such as herbs or acupuncture?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

Section H-Chronic Conditions, continued

CH12B.1 [IF AGE < 4, GO TO CH12B.2] Does the problem negatively affect or interfere with his/her school work?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH12B.2 Does the problem negatively affect or interfere with his/her play or sports activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH12B.3 [IF AGE < 2, GO TO CH12B.4] Does the problem negatively affect or interfere with his/her friendships or social activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH12B.4 Does the problem negatively affect or interfere with your family life?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH13 [IF AGE < 2, GO TO CH14] Has your doctor or any health care professional ever told you that [subject child] had hay fever or other kinds of allergies that affect breathing?

- 1 Yes
- 2 No [GO TO CH14]
- 7 Don't know [GO TO CH14]

9 Refused [GO TO CH14]

CH13A Does he/she still have this problem?
1 Yes
2 No [GO TO CH14]
7 Don't know [GO TO CH14]
8 Skipped [GO TO CH14]
9 Refused [GO TO CH14]

CH13B Is he/she currently getting any treatment or services to help with this problem?
1 Yes
2 No [GO TO CH13C.1]
7 Don't know [GO TO CH13C.1]
8 Skipped
9 Refused [GO TO CH13C.1]

Section H-Chronic Conditions, continued

CH13B.1 Are any of these treatments or services received from either a doctor or other health care professional?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

CH13B.2 Are any of these treatments or services received from a school?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

CH13B.3 Do these treatments involve medications prescribed by a doctor?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

CH13B.4 Are any of these treatments home or alternative treatments, such as herbs or acupuncture?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

CH13C.1 [IF AGE < 4, GO TO CH13C.2] Does the problem negatively affect or interfere with his/her school work?
1 Yes
2 No
7 Don't know
8 Skipped

9 Refused

CH13C.2 Does the problem negatively affect or interfere with his/her play or sports activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH13C.3 Does the problem negatively affect or interfere with his/her friendships or social activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

Section H-Chronic Conditions, continued

CH13C.4 Does the problem negatively affect or interfere with your family life?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH14 Has your doctor or any health care professional ever told you that [subject child] had an allergy that affects the skin, like eczema or hives?

- 1 Yes
- 2 No [GO TO CH15]
- 7 Don't know [GO TO CH15]
- 9 Refused [GO TO CH15]

CH14A Does he/she still have this problem?

- 1 Yes
- 2 No [GO TO CH15]
- 7 Don't know [GO TO CH15]
- 8 Skipped
- 9 Refused [GO TO CH15]

CH14B Is he/she currently getting any treatment or services to help with this problem?

- 1 Yes
- 2 No [GO TO CH14C.1]
- 7 Don't know [GO TO CH14C.1]
- 8 Skipped
- 9 Refused [GO TO CH14C.1]

CH14B.1 Are any of these treatments or services received from either a doctor or other health care professional?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH14B.2 Are any of these treatments or services received from a school?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

CH14B.3 Do these treatments involve medications prescribed by a doctor?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

Section H-Chronic Conditions, continued

CH14B.4 Are any of these treatments home or alternative treatments, such as herbs or acupuncture?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

CH14C.1 [IF AGE <4, GO TO CH14C.2] Does the problem negatively affect or interfere with his/her school work?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

CH14C.2 Does the problem negatively affect or interfere with his/her play or sports activities?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

CH14C.3 [IF AGE <2, GO TO C14C.4] Does the problem negatively affect or interfere with his/her friendships or social activities?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

CH14C.4 Does the problem negatively affect or interfere with your family life?
1 Yes
2 No

- 7 Don't know
- 8 Skipped
- 9 Refused

CH15 Has your doctor or any health care professional ever told you that [subject child] had allergies from food?

- 1 Yes
- 2 No [GO TO CH16]
- 7 Don't know [GO TO CH16]
- 9 Refused [GO TO CH16]

CH15A What food(s)?

-
- 7 Don't know
 - 8 Skipped
 - 9 Refused

Section H-Chronic Conditions, continued

CH15B Does he/she still have this problem?

- 1 Yes
- 2 No [GO TO CH16]
- 7 Don't know [GO TO CH16]
- 8 Skipped
- 9 Refused [GO TO CH16]

CH15C Is he/she currently getting any treatment or services to help with this problem?

- 1 Yes
- 2 No [GO TO CH15D.1]
- 7 Don't know [GO TO CH15D.1]
- 8 Skipped
- 9 Refused [GO TO CH15D.1]

CH15C.1 Are any of these treatments or services received from either a doctor or other health care professional?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH15C.2 Are any of these treatments or services received from a school?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH15C.3 Do these treatments involve medications prescribed by a doctor?

- 1 Yes
- 2 No
- 7 Don't know

- 8 Skipped
- 9 Refused

CH15C.4 Are any of these treatments home or alternative treatments, such as herbs or acupuncture?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH15D.1 [IF AGE <4, GO TO CH15D.2] Does the problem negatively affect or interfere with his/her school work?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

Section H-Chronic Conditions, continued

CH15D.2 Does the problem negatively affect or interfere with his/her play or sports activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH15D.3 [IF AGE <2, GO TO C15D.4] Does the problem negatively affect or interfere with his/her friendships or social activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH15D.4 Does the problem negatively affect or interfere with your family life?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH16 [IF AGE <3, GO TO CH17] In the past 12 months, has child complained to you of frequent headaches?

- 1 Yes
- 2 No [GO TO CH17]
- 7 Don't know [GO TO CH17]
- 9 Refused [GO TO CH17]

CH16A Have you talked to his/her doctor or any health care professional about headaches?

- 1 Yes
- 2 No [GO TO CH16C.1]
- 7 Don't know [GO TO CH16C.1]
- 8 Skipped

9 Refused [GO TO CH16C.1]

CH16B Is he/she currently getting any treatment or services to help with this problem?

- 1 Yes
- 2 No [GO TO CH16C.1]
- 7 Don't know [GO TO CH16C.1]
- 8 Skipped
- 9 Refused [GO TO CH16C.1]

CH16B.1 Are any of these treatments or services received from a doctor or other health care professional?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

Section H-Chronic Conditions, continued

CH16B.2 Are any of these treatments or services received from a school?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH16B.3 Do these treatments involve medications prescribed by a doctor?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH16B.4 Are any of these treatments home or alternative treatments, such as herbs or acupuncture?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH16C.1 [IF AGE <2, GO TO CH16C.2] Does the problem negatively affect or interfere with his/her school work?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH16C.2 Does the problem negatively affect or interfere with his/her play or sports activities?

- 1 Yes
- 2 No

- 7 Don't know
- 8 Skipped
- 9 Refused

CH16C.3 Does the problem negatively affect or interfere with his/her friendships or social activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH16C.4 Does the problem negatively affect or interfere with your family life?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

Section H-Chronic Conditions, continued

CH17 [IF AGE <3, GO TO CH18] In the past 12 months, has your child complained to you of frequent stomach pains?

- 1 Yes
- 2 No [GO TO CH18]
- 7 Don't know [GO TO CH18]
- 9 Refused [GO TO CH18]

CH17A Have you talked to his/her doctor or any health care professional about stomach pains?

- 1 Yes
- 2 No [GO TO CH17C.1]
- 7 Don't know [GO TO CH17C.1]
- 8 Skipped
- 9 Refused [GO TO CH17C.1]

CH17B Is he/she currently getting any treatment or services to help with this problem?

- 1 Yes
- 2 No [GO TO CH17C.1]
- 7 Don't know [GO TO CH17C.1]
- 8 Skipped
- 9 Refused [GO TO CH17C.1]

CH17B.1 Are any of these treatments or services received from a doctor or other health care professional?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH17B.2 Are any of these treatments or services received from a school?

- 1 Yes

- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH17B.3 Do these treatments involve medications prescribed by a doctor?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH17B.4 Are any of these treatments home or alternative treatments, such as herbs or acupuncture?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

Section H-Chronic Conditions, continued

CH17C.1 [IF AGE <4, GO TO CH17C.2] Does the problem negatively affect or interfere with his/her school work?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH17C.2 Does the problem negatively affect or interfere with his/her play or sports activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH17C.3 Does the problem negatively affect or interfere with his/her friendships or social activities?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH17C.4 Does the problem negatively affect or interfere with your family life?

- 1 Yes
- 2 No
- 7 Don't know
- 8 Skipped
- 9 Refused

CH18 [IF AGE <3, GO TO CH19] In the past 12 months, has your child complained to you of frequent pain in his or her legs, arms, or bones?
1 Yes
2 No [GO TO CH19]
7 Don't know [GO TO CH19]
9 Refused [GO TO CH19]

CH18A Have you talked to his/her doctor or any health care professional about the pains?
1 Yes
2 No [GO TO CH18C.1]
7 Don't know [GO TO CH18C.1]
8 Skipped
9 Refused [GO TO CH18C.1]

CH18B Is he/she currently getting any treatment or services to help with this problem?
1 Yes
2 No [GO TO CH18C.1]
7 Don't know [GO TO CH18C.1]
8 Skipped
9 Refused [GO TO CH18C.1]

Section H-Chronic Conditions, continued

CH18B.1 Are any of these treatments or services received from a doctor or other health care professional?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

CH18B.2 Are any of these treatments or services received from a school?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

CH18B.3 Do these treatments involve medications prescribed by a doctor?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

CH18B.4 Are any of these treatments home or alternative treatments, such as herbs or acupuncture?
1 Yes
2 No
7 Don't know
8 Skipped
9 Refused

- CH18C.1 [IF AGE <4, GO TO CH18C.2] Does the problem negatively affect or interfere with his/her school work?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused
- CH18C.2 Does the problem negatively affect or interfere with his/her play or sports activities?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused
- CH18C.3 Does the problem negatively affect or interfere with his/her friendships or social activities?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused

Section H-Chronic Conditions, continued

- CH18C.4 Does the problem negatively affect or interfere with your family life?
- 1 Yes
 - 2 No
 - 7 Don't know
 - 8 Skipped
 - 9 Refused
- CH19 Does your child have any other medical, behavioral or emotional problems?
- 1 Yes
 - 2 No [END OF SURVEY]
 - 7 Don't know [END OF SURVEY]
 - 9 Refused [END OF SURVEY]
- CH19A What problems does he/she have? [DO NOT READ RESPONSES]
- 01 Aortic Stenosis
 - 02 Atrial Septal Defect
 - 03 Atrioventricular Canal Defect
 - 04 Auditory Processing Disorder
 - 05 Bronchopulmonary Dysplasia (Chronic Lung Disease)
 - 06 Cancer
 - 07 Celiac Disease
 - 08 Cerebral Palsy
 - 09 Chronic Kidney Disease
 - 10 Coarctation of the Aorta
 - 11 Cystic Fibrosis
 - 12 Depression
 - 13 Down's Syndrome

- 14 Dwarfism
- 15 Eating disorders
- 16 Fetal Alcohol Syndrome
- 17 G6PD Deficiency
- 18 Gastroesophageal Reflux Disease (GERD)
- 19 Glomerulonephritis
- 20 Heart problems
- 21 Hemophilia
- 22 Hepatitis
- 23 Hereditary hemochromatosis
- 24 High blood pressure
- 25 HIV/AIDS
- 26 Hypoplastic Left Heart Syndrome
- 27 Juvenile Rheumatoid Arthritis
- 28 Lupus
- 29 Lyme Disease
- 30 Marfan Syndrome
- 31 Mitral Value Prolapse
- 32 Multicystic Kidney disease
- 33 Muscular Dystrophy
- 34 Nephrotic Syndrome
- 35 Neurocutaneous Syndromes
- 36 Noonan's Syndrome
- 37 Osgood-Schlatter Disease
- 38 Patent Ductus Arteriosus (PDA)
- 39 Peptic ulcers
- 40 Polycystic Kidney Disease
- 41 Polycystic Ovary Syndrome (PCOS)
- 42 Pulmonary Atresia
- 43 Pulmonary Stenosis
- 44 Renal Tubular Acidosis
- 45 Scoliosis
- 46 Shaken baby/Shaken Impact Syndrome
- 47 Sickle Cell Disease
- 48 Spina Bifida
- 49 Stuttering
- 50 Tay-Sachs Disease
- 51 Tetralogy of Fallot (TOF)
- 52 Thalassemia
- 53 Total Anomalous Pulmonary Venous Connection
- 54 Tourette's Syndrome
- 55 Transposition of the Great Arteries
- 56 Tricuspid Atresia
- 57 Truncus Arteriosus
- 58 Tuberculosis
- 59 Turner Syndrome
- 60 Ventricular Septal Defect (VSD)
- 61 Von Willebrand Disease
- 62 Other, specify _____
- 77 Don't know
- 88 Skipped
- 99 Refused