



Please return your completed Life History Survey in the pre-addressed postage paid envelope to University of Michigan.

If you have any questions about the survey, please feel free to call us at 866-611-6476

THANK YOU!

Conducted by:

The Survey Research Center  
The University of Michigan

Sponsored by:

The National Institute on Aging with co-funding  
by the Social Security Administration

HRS

HEALTH AND RETIREMENT STUDY  
A Longitudinal Study of Health, Retirement, and Aging  
Sponsored by the National Institute on Aging

# Life History Survey 2019

## Supplemental Questionnaire

It is very important that the questions in this survey be answered by the person to whom the survey is addressed.

**If the addressee is unable to complete the survey alone:**

It can be filled out by someone who knows this person well enough to answer the questions.

**If neither the addressee nor another person is able to complete the survey:**

Please return the survey, with a short note of explanation, in the enclosed, prepaid envelope.

{First Name} – FPO  
123456A (barcode)

<M. ID>



Conducted by: The Survey Research Center at the University of Michigan.  
Sponsored by: The National Institute on Aging with co-funding by the Social Security Administration.

**SEE FRONT  
COVER  
LAYOUT ON  
SEPARATE PDF**

## ABOUT THIS SURVEY

This Life History Survey covers different topics than the one you completed in 2015. Together the 2015 and this survey will provide information about important things that happened earlier in your life and help us to understand better how you are doing now.

**This survey is not meant to be a test of your memory.**

**However, we would like you to try to be as accurate as possible.**

**You may find it useful to consult your spouse, another family member, or some personal files, photos, or notes as you go through the questions.**

We hope that you will find this survey interesting to complete. As always, your answers are extremely important to us. Please remember that your participation is voluntary and that you may skip over any questions that you would prefer not to answer.

Please return your completed Life History Survey in the pre-addressed postage paid envelope. If you have any questions, please feel free to call us at 1-866-611-6476.

## HOW TO FILL IN THIS SURVEY

Please answer the questions by:

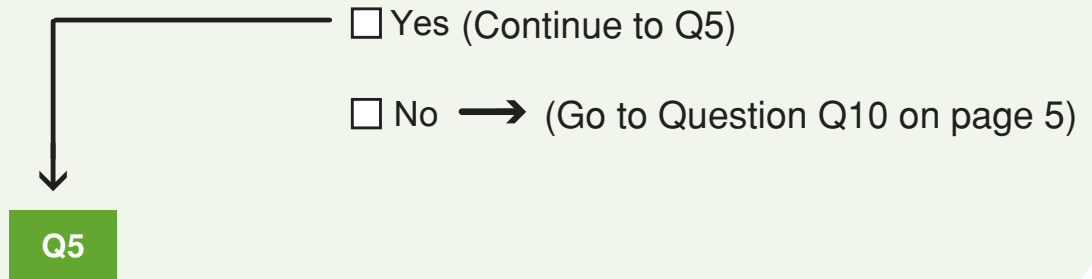
Marking a box like this:

Or writing in a box like this:

		2	5	Answer
--	--	---	---	--------

Please use a #2 pencil or a blue/black ink ballpoint pen. DO NOT use a felt tip pen.

Sometimes you may find instructions telling you which questions to answer like this:



Some of the questions spread across two facing pages like this.

#	Type of employer or business	Job Title	Start Year	End Year
1	Office Furniture Ltd	QC Inspector	1985	1999
2	Auto Parts Factory	Production Manager	2000	2008
3				
4				

Did you work full-time or part-time?	What did you do after leaving this job? [Check all that apply]		
<input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Started next job	<input type="checkbox"/> Worked short-term job(s)	<input type="checkbox"/> Cared for/started a family
<input type="checkbox"/> Full-time <input checked="" type="checkbox"/> Part-time	<input checked="" type="checkbox"/> Unemployed	<input checked="" type="checkbox"/> Medical leave/disability	<input type="checkbox"/> Other _____
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input checked="" type="checkbox"/> Started next job	<input type="checkbox"/> Worked short-term job(s)	<input type="checkbox"/> Cared for/started a family
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Medical leave/disability	<input type="checkbox"/> Other _____
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Started next job	<input type="checkbox"/> Worked short-term job(s)	<input type="checkbox"/> Cared for/started a family
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Medical leave/disability	<input type="checkbox"/> Other _____

Please complete one row across both pages before moving to the next row.



**Before you begin, please take a few minutes to think back over your life.**

Please write a few notes for yourself in the table below. They will be helpful in filling out the survey. Each row is for a different 10-year period of your life. You do not need to write something in each line for all of the questions. This table is meant to outline just a few things in your life. We will ask for more details later.

<b>Age</b>	<b>Where did you live? (e.g., Ann Arbor, MI)</b>	<b>What were you doing? (e.g., in school, work)</b>	<b>What important things happened? (e.g., births, deaths, marriages)</b>
<b>0-9</b>			
<b>10-19</b>			
<b>20-29</b>			
<b>30-39</b>			
<b>40-49</b>			
<b>50-59</b>			
<b>60-69</b>			
<b>70-79</b>			



## Partnership History

In this section, we would like to find out more about all of your long-term partners (e.g., lasting for at least one year). This includes spouses, as well as girlfriends/boyfriends, fiancés, or partners with whom you lived for a year or more.

**Q1** Have you ever been married?

Yes

No → Go to Q2 on page 5



**Q1a**

In the table below, please fill out the information for each of your marriages. If you have been married more than five times, please list the first five, beginning with your first marriage.

#	Initials of Spouse	Gender of Spouse	Did you live together before marriage?	Year Married	Are you still together? If not, how did this marriage end?	Year Marriage Ended (If applies)
1		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Still together <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Separated	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Still together <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Separated	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Still together <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Separated	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Still together <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Separated	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
5		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Still together <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Separated	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



**Q2**

**Other than your spouse(s)**, have you ever lived together with someone else as a couple for at least a year or more?

Yes

No → Go to Q3 on page 6

**Q2a**

In the table below, please fill out the information for the partner(s), other than your spouse(s), with whom you lived together as a couple for at least a year or more. If you had more than five partners, please list the first five.

#	Initials of Partner	Gender of Partner	Year Began Living Together	Are you still together? If not, how did this relationship end?	Year Relationship Ended (If applies)
1		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	<input type="checkbox"/> Split up <input type="checkbox"/> Partner died <input type="checkbox"/> Still together	<input type="text"/>
2		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	<input type="checkbox"/> Split up <input type="checkbox"/> Partner died <input type="checkbox"/> Still together	<input type="text"/>
3		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	<input type="checkbox"/> Split up <input type="checkbox"/> Partner died <input type="checkbox"/> Still together	<input type="text"/>
4		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	<input type="checkbox"/> Split up <input type="checkbox"/> Partner died <input type="checkbox"/> Still together	<input type="text"/>
5		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	<input type="checkbox"/> Split up <input type="checkbox"/> Partner died <input type="checkbox"/> Still together	<input type="text"/>



## Your Work History

The next section asks about work you may have done during your life. This may include paid work for an employer or unpaid care for others.

**Q3** Since you left full-time education, have you **ever** done any **paid work** which lasted for a **period of one year or more**? (Paid work includes both full-time and part-time work)

Yes → Go to Q4 on the next page

No (Continue to Q3a) ↓

**Q3a** What was the reason(s) you **never** worked for pay for one year or more?  
[Check all that apply]

- Stayed at home to raise children or care for family
- Physical disability or injury
- Mental or emotional disability
- Could not find work
- Was not interested in working
- Other (please specify):

↓ → Go to Q5 on page 7



**Q4**Did **you ever...**

[Check one box for each line]

- a. stop working at a job to stay home and care for your children?  Yes  No  Does not apply
- b. cut back on the number of hours worked at a job to care for your children?  Yes  No  Does not apply
- c. work longer hours to meet the added expenses of having children?  Yes  No  Does not apply
- d. switch to a different job that was less demanding or more flexible to be more available to your children?  Yes  No  Does not apply

**Q5**Did **your spouse or partner ever...**

[Check one box for each line]

- a. stop working at a job to stay home and care for your children?  Yes  No  Does not apply
- b. cut back on the number of hours worked at a job to care for your children?  Yes  No  Does not apply
- c. work longer hours to meet the added expenses of having children?  Yes  No  Does not apply
- d. switch to a different job that was less demanding or more flexible to be more available to your children?  Yes  No  Does not apply

**Q6** through **Q15** ask about paid work.

If you **NEVER** worked for pay for one year or more, **go to Q16 on page 12.**





**Q6**

In the table below, please fill out the information for all the places you have **worked for one year or more after you finished full-time education**. If you worked at more than ten places, fill out the information for the first ten places you worked. If you are still working for an employer, write the current year in the END YEAR column. If you changed jobs (or job title) but stayed with the same employer, please list the first and last title you held with that employer in the same line.

TABLE COLUMNS SPAN ACROSS BOTH PAGES. ►

#	Type of employer or business	Job Title	Start Year	End Year
1			<input type="text"/>	<input type="text"/>
2			<input type="text"/>	<input type="text"/>
3			<input type="text"/>	<input type="text"/>
4			<input type="text"/>	<input type="text"/>
5			<input type="text"/>	<input type="text"/>
6			<input type="text"/>	<input type="text"/>
7			<input type="text"/>	<input type="text"/>
8			<input type="text"/>	<input type="text"/>
9			<input type="text"/>	<input type="text"/>
10			<input type="text"/>	<input type="text"/>

TABLE COLUMNS SPAN ACROSS BOTH PAGES. ►



◀ TABLE COLUMNS SPAN ACROSS BOTH PAGES.

Did you work full-time or part-time?	What did you do after leaving this job? [Check all that apply]		
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Started next job <input type="checkbox"/> Unemployed	<input type="checkbox"/> Worked short-term job(s) <input type="checkbox"/> Medical leave/disability	<input type="checkbox"/> Cared for/started a family <input type="checkbox"/> Other _____
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Started next job <input type="checkbox"/> Unemployed	<input type="checkbox"/> Worked short-term job(s) <input type="checkbox"/> Medical leave/disability	<input type="checkbox"/> Cared for/started a family <input type="checkbox"/> Other _____
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Started next job <input type="checkbox"/> Unemployed	<input type="checkbox"/> Worked short-term job(s) <input type="checkbox"/> Medical leave/disability	<input type="checkbox"/> Cared for/started a family <input type="checkbox"/> Other _____
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Started next job <input type="checkbox"/> Unemployed	<input type="checkbox"/> Worked short-term job(s) <input type="checkbox"/> Medical leave/disability	<input type="checkbox"/> Cared for/started a family <input type="checkbox"/> Other _____
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Started next job <input type="checkbox"/> Unemployed	<input type="checkbox"/> Worked short-term job(s) <input type="checkbox"/> Medical leave/disability	<input type="checkbox"/> Cared for/started a family <input type="checkbox"/> Other _____
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Started next job <input type="checkbox"/> Unemployed	<input type="checkbox"/> Worked short-term job(s) <input type="checkbox"/> Medical leave/disability	<input type="checkbox"/> Cared for/started a family <input type="checkbox"/> Other _____
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Started next job <input type="checkbox"/> Unemployed	<input type="checkbox"/> Worked short-term job(s) <input type="checkbox"/> Medical leave/disability	<input type="checkbox"/> Cared for/started a family <input type="checkbox"/> Other _____
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Started next job <input type="checkbox"/> Unemployed	<input type="checkbox"/> Worked short-term job(s) <input type="checkbox"/> Medical leave/disability	<input type="checkbox"/> Cared for/started a family <input type="checkbox"/> Other _____
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Started next job <input type="checkbox"/> Unemployed	<input type="checkbox"/> Worked short-term job(s) <input type="checkbox"/> Medical leave/disability	<input type="checkbox"/> Cared for/started a family <input type="checkbox"/> Other _____
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Started next job <input type="checkbox"/> Unemployed	<input type="checkbox"/> Worked short-term job(s) <input type="checkbox"/> Medical leave/disability	<input type="checkbox"/> Cared for/started a family <input type="checkbox"/> Other _____

◀ TABLE COLUMNS SPAN ACROSS BOTH PAGES.



Now we'd like to learn a little more about the job you held **between the ages of 30 and 40** that you consider to be **most important** (e.g., longest duration, best paying, most satisfying).

**Q7** Which employer or business was that?

Not relevant/did not work for pay between the ages of 30 and 40

↳ Go to Q16 on page 12

**Q8** Did you work for someone else on that job, or were you self-employed or a partner in a business?

Someone else

Self-employed

Partner in business

**Q9** In what city and state or country did you work for this employer or business?

City	State (or Country)
<input type="text"/>	<input type="text"/>

**Q10** What was your job title? What were your most important activities or duties?

**Q11** What kind of business or industry did you work in – that is, what did they make or do at the place where you worked?

**Q12** How much did you earn before taxes and other deductions when you started that job?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>
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per hour

per month

per week

per year

**Q13** Were you covered on that job by a union or employee-association contract?

Yes

No



**Q14** Do you still work for this employer or business?

Yes → Go to Q15 below

No ↓

**Q14a** Why did you leave or stop working for this employer? [Check all that apply]

- |   |  |
|---|--|
| <input type="checkbox"/> Moved to a higher paying job                 | <input type="checkbox"/> I had poor health/a disability      |
| <input type="checkbox"/> Moved to a job with a better future          | <input type="checkbox"/> I was laid off, let go, or replaced |
| <input type="checkbox"/> Moved to a more satisfying job               | <input type="checkbox"/> I retired                           |
| <input type="checkbox"/> Moved to a job that better matched my skills | <input type="checkbox"/> Other (please specify):             |
| <input type="checkbox"/> Moved or relocated                           |  |
| <input type="checkbox"/> To take care of or start a family            |  |
| <input type="checkbox"/> To continue education                        |  |

**Q15** Please say how much you agree or disagree with each of the following statements regarding this job. [Check one box for each line]

	Strongly Disagree	Disagree	Agree	Strongly Agree	Does not apply
a. The job was physically demanding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I had very little freedom to decide how I did my work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. At work, I felt I had control over what happened in most situations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I had a lot to say about what happened on my job.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. The people I worked with could be relied on when I needed help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I learned useful skills in this job.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. My skills were not a good match for this job.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. The job was interesting and enjoyable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**Q16**

Have you ever provided **unpaid** care to a relative or friend with some sort of special need to help them take care of themselves for a **period of 6 months or more?**

**NOTE:** Raising children without special needs does not apply here.

A special need could be an illness, disability, or mental health problem.

Helping them take care of themselves may include personal needs or household chores, managing a person's finances, arranging for outside services, or visiting regularly to see how they are doing. This person need not live with you.

Yes (Continue to Q16a)       No **—————>** Go to Q17 on the next page

**Q16a**

In the table below, **please list the people for whom you have provided unpaid care.** If you have provided unpaid care for more than five people, please list the five that you consider to be the most important. If you are currently caring for someone, please write the current year in the END YEAR column.

#	Initial of Person	Relationship to the Person	Start Year	End Year
1		<input type="checkbox"/> Parent / Parent-in-law <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Biological, adopted, or step child  <input type="checkbox"/> Other (please specify): _____	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-between; padding: 2px;"> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> </div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-between; padding: 2px;"> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> </div>
2		<input type="checkbox"/> Parent / Parent-in-law <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Biological, adopted, or step child  <input type="checkbox"/> Other (please specify): _____	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-between; padding: 2px;"> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> </div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-between; padding: 2px;"> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> </div>
3		<input type="checkbox"/> Parent / Parent-in-law <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Biological, adopted, or step child  <input type="checkbox"/> Other (please specify): _____	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-between; padding: 2px;"> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> </div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-between; padding: 2px;"> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> </div>
4		<input type="checkbox"/> Parent / Parent-in-law <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Biological, adopted, or step child  <input type="checkbox"/> Other (please specify): _____	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-between; padding: 2px;"> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> </div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-between; padding: 2px;"> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> </div>
5		<input type="checkbox"/> Parent / Parent-in-law <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Biological, adopted, or step child  <input type="checkbox"/> Other (please specify): _____	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-between; padding: 2px;"> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> </div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-between; padding: 2px;"> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> <span style="width: 10px;"></span> </div>



## Your Health History

The following questions ask about your health including medically diagnosed conditions, exercise, and health habits throughout your life.

**Q17** Have you **ever** had any of the following serious conditions or diseases?

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. Chronic breathing problems/asthma   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Chronic hepatitis or other liver disease  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. HIV or AIDS   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Inflammatory bowel disease (e.g., Crohn's disease)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Kidney disease or failure   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Meningitis or encephalitis  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Mononucleosis (commonly referred to as mono)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Multiple sclerosis (commonly referred to as MS)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Neurological disorders (e.g., seizure, brain, or spinal cord disorders)                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Thyroid disease   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k. Rheumatoid arthritis  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l. Gynecological issues [Females only] (e.g., fibroids or other problems with uterus or ovaries) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Q18** Have you ever had a pregnancy (or experienced a partner's pregnancy) that ended in a miscarriage, an induced abortion, or a stillbirth?

- Yes  
 No

**Q19** Have you ever had a major surgery or operation? (e.g., Caesarian section, heart surgery, hysterectomy, joint replacement, organ transplant, tumor removal, etc.)

- Yes → If yes, please specify the surgery or surgeries:  
 No



**Q20**

Have you ever received any professional counseling, treatment, or therapy because of your use of alcohol or drugs?

Yes

No

**Q21**

Have you ever been involved in a major car or vehicle crash or other accident that resulted in serious injury?

Yes



If yes, in what year did this accident occur?

--	--	--	--

No

**Q22**

**After age 16**, how many periods of ill health or disability (physical or mental) have you had that lasted for more than a year that kept you from doing usual activities?

None



Go to Q23 on the next page

One

Two

Three

More than three

Have been ill or had a disability for all or most of my life

Continue to Q22a



**Q22a**

For each of the periods of ill health or disability, write the year the period began, what year the period ended, and the condition which accounted for the period of ill health or disability. If you marked "More than three" in Q22, refer to the three worst periods of ill health or disability. If this period of ill health is still ongoing, please write the current year in the END YEAR column.

#	Start Year	End Year	Health condition(s)								
1	<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>					<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>					
2	<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>					<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>					
3	<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>					<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>					



We have asked about many things in your life from the time you were born up to now, but there may be something especially important that we have missed.

**Q23**

Please use the space below to tell us about your most important accomplishments or the things that you are most proud of.

We are very interested to read what you write.


**Q24**

Were the questions in this booklet answered by the person whose first name is written on the front cover? [Check one box]

- YES, the person whose name is on the front cover completed the questionnaire by him/herself.
- YES, the person whose name is on the front cover answered the questions, but someone else assisted by writing in the answers for that person.
- NO, the person whose name is on the front cover did not answer/complete the questionnaire.

**Q25**

Approximately, how long did it take you to complete this questionnaire?

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number of minutes

**Q26**

If there is anything else you would like to tell us, please write in the space below. We appreciate your feedback.


**THANK YOU!**





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