

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
			<p>DENTAL, VISION, & HEARING CARE UTILIZATION QUESTIONNAIRE SPECIFICATIONS</p> <p><u>CRITERIA</u> INTTYPE=C001, C002, C004, C005, C006, C007, C010 SPALIVE=ALL SEASON=ALL SPPROXY=SP or PROXY Other: N/A</p> <p><u>PLACEMENT</u> Administer after HIQ.</p>		
DUINT	DUINTRO	no entry	<p>The next questions are about any medical care [you/(SP)] may have had between (REFERENCE DATE/UTILDATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD).</p> <p>(Now would be a good time to get out the planner that [you/(SP)] may have used to record health care visits or other medical expenses. We will also refer to any statements you may have received since the last interview.)</p> <p>First we'll talk about dental care.</p>		DU1 - DUPROBE
DUPROBE	DU1	yes/no	<p>[Since (REFERENCE DATE/UTILDATE)/Between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)], did [you/(SP)] go to a dentist or any other person for dental care? [Dental providers include dentists, dental surgeons, endodontists, periodontists, and dental hygienists.]</p>	(01) YES (02) NO (03) INDICATED YES BY DATAPREP (-8) Don't Know (-9) Refused	(01) DU2 - PROVIDER_DU (02) BOX DU5 (03) DO NOT DISPLAY. DATA EDITING ONLY. (-8) BOX DU6 (-9) BOX DU6
PROVIDER_DU	DU2	roster	<p>Who did [you/(SP)] see? SELECT OR ADD ONLY ONE PROVIDER.</p>	<p>[DISPLAY PROVIDER ROSTER AS RESPONSE OPTIONS: 1. [PROVIDER 1] 2. [PROVIDER 2] ... (01-N) LIST ALL PROVIDERS AS RESPONSE OPTIONS (N+1) ADD ANOTHER DISPLAY PROVIDER NAME, SPECIALITY, GROUP NAME FOR ALL PROVIDERS WHERE PROVNUM>02.</p>	(01-N) BOX DU1 (N+1) DU2B-PROVNAME IF EXISTING PROVIDER SELECTED, GO TO BOX DU1. ELSE IF "ADD ANOTHER" SELECTED, GO TO DU2-PROVNAME
PROVNAME	DU2B	verbatim text	<p>ENTER THE NAME OF THE PROVIDER AND THE BILLING GROUP OR PRACTICE NAME BELOW.</p> <p>YOU MUST ENTER A PROVIDER NAME IN THE 'NAME' FIELD. IF THE PROVIDER IS AN INDIVIDUAL BUT YOU DO NOT KNOW THE PROVIDER'S NAME, OR IF THE PROVIDER IS AN ORGANIZATION, ENTER THE GROUP OR PRACTICE NAME IN THE 'NAME' FIELD AND LEAVE THE 'GROUP' FIELD BLANK.</p> <p>YOU CAN CONSULT THE RESPONDENT'S STATEMENTS AND APPOINTMENT CARDS TO ENSURE THE PROVIDER NAME IS ENTERED CORRECTLY.</p> <p>[PROVIDER LOOKUP CALLED FROM THIS SCREEN]</p> <p>NAME:</p>		DU2B - GRPNAME
GRPNAME	DU2B	verbatim text	<p>GROUP:</p>		PROVSPEC
PROVSPEC	DU2C	code one	<p>What kind of dental provider is [PROVNAME]?</p>	(01) GENERAL DENTIST (35) DENTAL HYGIENIST (36) DENTAL TECHNICIAN (37) DENTAL/ORAL SURGEON (38) ORTHODONTIST (39) ENDODONTIST (40) PERIODONTIST (41) PROSTHODONTIST (91) OTHER MEDICAL PROVIDER SPECIALTY (-8) DON'T KNOW (-9) REFUSED	(01) BOX DU2 (02) BOX DU2 (03) BOX DU2 (04) BOX DU2 (05) BOX DU2 (06) BOX DU2 (07) BOX DU2 (08) BOX DU2 (91) DU2C - PROVSPECOTH (-8) BOX DU2 (-9) BOX DU2

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PROVSPEC	DU2C1	code one	What kind of dental provider is [PROVNAME]?	(01) DENTIST/DENTAL PROVIDER (DO NOT DISPLAY) (02) MEDICAL DOCTOR (03) AUDIOLOGIST (04) CHIROPRACTOR (05) CLINICAL SOCIAL WORKER (06) DIETITIAN-NUTRITIONIST (07) HEARING THERAPIST (08) HOME HEALTH/HEALTH AIDE (09) HOMEMAKER (10) HOSPICE WORKER (11) I.V. THERAPIST (12) NURSE (RN) (13) NURSE PRACTITIONER (14) NURSE'S AIDE (15) OCCUPATIONAL THERAPIST (OT) (16) OPTOMETRIST (OD) (17) OSTEOPATH (DO) (18) PARAMEDIC (19) PHYSICAL THERAPIST (PT) (20) PHYSICIAN'S ASSISTANT (21) PODIATRIST (FOOT DOCTOR) (22) PSYCHOLOGIST (23) RESPIRATORY THERAPIST (24) SOCIAL/CASE WORKER (25) SPEECH THERAPIST (26) THERAPIST (MENTAL HEALTH) (27) X-RAY TECHNICIAN (28) LICENSED PRACTICAL NURSE (LPN) (29) ACUPUNCTURIST (30) HOMEOPATH (31) MASSAGE THERAPIST (32) NATUROPATH (33) LICENSED PROFESSIONAL COUNSELOR [LPC] (34) LAB TECHNICIAN (91) OTHER MEDICAL PROVIDER SPECIALTY (-8) Don't Know (-9) Refused	(01) DO NOT DISPLAY (02) BOX DU2 (03) BOX DU2 (04) BOX DU2 (05) BOX DU2 (06) BOX DU2 (07) BOX DU2 (08) BOX DU2 (09) BOX DU2 (10) BOX DU2 (11) BOX DU2 (12) BOX DU2 (13) BOX DU2 (14) BOX DU2 (15) BOX DU2 (16) BOX DU2 (17) BOX DU2 (18) BOX DU2 (19) BOX DU2 (20) BOX DU2 (21) BOX DU2 (22) BOX DU2 (23) BOX DU2 (24) BOX DU2 (25) BOX DU2 (26) BOX DU2 (27) BOX DU2 (28) BOX DU2 (29) BOX DU2 (30) BOX DU2 (31) BOX DU2 (32) BOX DU2 (33) BOX DU2 (34) BOX DU2 (91) DU2D - PROVSPoS (-8) BOX DU2 (-9) BOX DU2
PROVSPOS	DU2D	verbatim text	OTHER MEDICAL PROVIDER (SPECIFY)	(01) [Continuous answer.]	BOX DU2
	BOX DU1	routing	IF (SP REPORTED RECEIVING HEALTH CARE SERVICES THROUGH V.A. IN THE CURRENT ROUND OR ANY PREVIOUS ROUND) AND (IF THIS PROVIDER IS ASSOCIATED WITH V.A. IS UNKNOWN), GO TO DU3 - VAPLACE. ELSE GO TO BOX DU2.		
VAPLACE	DU3	yes/no	Is (PROVIDER NAME) associated with a Department of Veterans Affairs, or V.A., facility?	(01) YES (02) NO (-8) Don't Know (-9) Refused	BOX DU2
	BOX DU2	routing	IF (SP COVERED BY A MANAGED CARE PLAN ANYTIME DURING THE CURRENT ROUND) AND (IF THIS PROVIDER IS ASSOCIATED WITH A MANAGED CARE PLAN IS UNKNOWN), GO TO DU4 - HMOASSOC. ELSE IF (SP COVERED BY A MANAGED CARE PLAN ANYTIME DURING THE CURRENT ROUND) AND (THIS PROVIDER IS NOT ASSOCIATED WITH A MANAGED CARE PLAN), GO TO DU5 - HMOREFER. ELSE GO TO DU6 - EVENT_DU.		
HMOASSOC	DU4	yes/no	Is (PROVIDER NAME) associated with [your/(SP's)] [READ MANAGED CARE PLAN NAME(S) BELOW] plan?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) DU6 - EVENT_DU (02) DU5 - HMOREFER (-8) DU5 - HMOREFER (-9) DU5 - HMOREFER

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HMOREFER	DU5	yes/no	[Were you/Was (SP)] referred to (PROVIDER NAME) by [READ MANAGED CARE PLAN NAME(S) BELOW]? [INCLUDE REFERRALS BY THE SAMPLE PERSON'S PRIMARY CARE PHYSICIAN (PCP).]	(01) YES (02) NO (-8) Don't Know (-9) Refused	DU6 - EVENT_DU
EVENT_DU	DU6	roster	When did [you/(SP)] see (PROVIDER NAME)? Please tell me all the dates [since (REFERENCE DATE/(UTILDATE))/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)]. ENTER ALL DATES. [IF THE RESPONDENT SAW THE SAME PROVIDER TWICE ON THE SAME DAY, ENTER THE DATE ONLY ONCE.] IF R HAD 5 OR MORE VISITS TO THIS PROVIDER DURING THIS REFERENCE PERIOD, SELECT "REPEAT VISITS" AND LEAVE THE DAY FIELD BLANK. ENTER EACH MONTH SEPARATELY.	(01) continuous answer (-8) Don't Know (-9) Refused MM: DD: YYYY: REPEAT VISIT: YES/NO # OF VISITS	DU6B-DUADD
DUADD	DU6B	chose one	HAVE ALL DATES BEEN ENTERED? [DISPLAY ALL EVENTS ASSOCIATED WITH THIS PROVIDER]	(01) ADD ANOTHER (02) ALL DONE	(01) DU6 -EVENT_DU (02) DU7-DVPROCDR
DVPROCDR	DU7	code all	SHOW CARD DVH1 For [your/(SP's)] [VISIT ON EVENT DATE], what did [you/(SP)] have done? CHECK ALL THAT APPLY.	(01) GENERAL EXAM, CHECKUP OR CONSULTATION (02) CLEANING, PROPHYLAXIS, OR POLISHING (03) X-RAYS, RADIOGRAPHS, OR BITEWINGS (04) FLUORIDE TREATMENT (05) SEALANT (PLASTIC COATINGS ON BACK TEETH) (06) FILLINGS (07) INLAYS (08) CROWNS OR CAPS (09) ROOT CANAL (10) PERIODONTAL SCALING, ROOT PLANING, OR GUM SURGERY (11) PERIODONTAL RECALL VISIT (PERIODIC OR REGULAR) (12) EXTRACTION, TOOTH PULLED (13) IMPLANTS (14) ABSCESS OR INFECTION TREATMENT (15) OTHER ORAL SURGERY (16) FIXED BRIDGES (17) DENTURES OR REMOVABLE PARTIAL DENTURES (18) RELINING OR REPAIR OF BRIDGES OR DENTURES (19) ORTHODONTIA, BRACES, OR RETAINERS (20) BOND, WHITEN, OR BLEACH (21) TREATMENT FOR TMD OR TMJ (91) OTHER (SPECIFY) (-8) DON'T KNOW (-9) REFUSED	(01) DU9-PRESMDCN (02) DU9-PRESMDCN (03) DU9-PRESMDCN (04) DU9-PRESMDCN (05) DU9-PRESMDCN (06) DU9-PRESMDCN (07) DU9-PRESMDCN (08) DU9-PRESMDCN (09) DU9-PRESMDCN (10) DU9-PRESMDCN (11) DU9-PRESMDCN (12) DU9-PRESMDCN (13) DU9-PRESMDCN (14) DU9-PRESMDCN (15) DU9-PRESMDCN (16) DU9-PRESMDCN (17) DU9-PRESMDCN (18) DU9-PRESMDCN (19) DU9-PRESMDCN (20) DU9-PRESMDCN (21) DU9-PRESMDCN (91) DU7A-EVOSTEXT (-8) DU9-PRESMDCN (-9) DU9-PRESMDCN
EVOSTEXT	DU7A	verbatim text	OTHER PROCEDURE OR REASON DURING VISIT (SPECIFY)	(01) [CONTINUOUS ANSWER]	DU9 - PRESMDCN
PRESMDCN	DU9	yes/no	Were any medicines prescribed for [you/(SP)] during (this visit/any of these visits)?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) DU10 - PRESFILL (02) BOX DU4 (-8) BOX DU4 (-9) BOX DU4
PRESFILL	DU10	yes/no	Were any of the prescriptions filled? [COUNT A MEDICINE AS "FILLED" REGARDLESS OF WHO OBTAINED IT FOR THE RESPONDENT, WHETHER OR NOT THE PRESCRIPTION COST ANYTHING, AND WHETHER OR NOT THE RESPONDENT ACTUALLY TOOK THE MEDICINE.]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) BOX DU3B (02) BOX DU4 (-8) BOX DU4 (-9) BOX DU4
	BOX DU3B	routing	IF THE PROBE FOR PRESCRIPTION MEDICINE BOTTLES HAS NOT BEEN ASKED IN THE CURRENT ROUND, GO TO DU10A - DUPMMEDS. ELSE GO TO BOX PM2.		

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DUPMMEDS	DU10A	no entry	It would be helpful if I could look at any medicine bottle(s), container(s), or bag(s) that you have so that I can spell the medicine name correctly and enter the strength of the medicine. [Also, please take out [your/(SP's)] (MEDICARE PRESCRIPTION DRUG PLAN NAME) medicine statements, which should have that same information on them.] [IF RESPONDENT HAS BOTTLE, ASK:] I'll need that same information for all of the medicines [you/(SP)] obtained since (REFERENCE DATE/UTILDATE), if you'd like to get those bottles, too.	(01) INSTRUCTION WAS READ	BOX PM2
	BOX PM2	routing	IF THERE IS AT LEAST ONE MEDICINE FROM A PRIOR ROUND ON THE EVENT TABLE FOR THIS CASE, GO TO MEDICINE_PM1-MEDICINE_PM1. ELSE GO TO PM2B-PMBOTTLE.		
MEDICINE_PM1	MEDICINE_PM1	code one	What is the name of the medicine?	[DISPLAY MEDICINE ROSTER AS RESPONSE OPTIONS: 1. [MEDICINE 1] 2. [MEDICINE 2] ... N. [MEDICINE N] N+1. ADD ANOTHER [DISPLAY MEDICINE NAME AND STRENGTH FOR EACH.	BOX PM3
	BOX PM3	routing	IF THIS MEDICINE HAS AN EXACT MATCH TO THE FDB LIST (PMEDID^=.), THEN GO TO PM2A-SAMEFSAM. ELSE GO TO PMBOTTLE-PMBOTTLE.		
SAMEFSAM	SAMEFSAM	yes/no	CODE "YES" WITHOUT ASKING IF STATEMENT, RECEIPT, BOTTLE OR BAG IS PRESENT AND FORM, STRENGTH AND AMOUNT ARE <u>EXACTLY</u> THE SAME AS IN THE PREVIOUS INTERVIEW. At the time of the last interview, [you/(SP)] purchased (MEDICINE NAME) in the form of (MEDICINE FORM). The strength was [MEDICINE STRENGTH]. The amount -in the container when it was obtained was (PREVIOUS ROUND MEDICINE AMOUNT). Is this medicine in the same strength, form and amount? CODE "NO" UNLESS -FORM, STRENGTH, AND AMOUNT <u>EXACTLY</u> MATCH PREVIOUS ROUND.	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED	BOX PM4
	BOX PM4	routing	IF SAMEFSAM=1/YES, THEN DO NOT CREATE A NEW EVENT FOR THIS MEDICINE AND GO TO PM6A-GETNUM. ELSE, CREATE A NEW EVENT FOR THIS MEDICINE AND GO TO PM2B-PMBOTTLE.		
PMBOTTLE	PMBOTTLE	code one	CODE "YES" WITHOUT ASKING IF-BOTTLE, CONTAINER, BAG, STATEMENT, OR RECEIPT IS PRESENT. Do you have the medicine bottle, container or bag, or Prescription Drug Plan Statement available? IF R DOES NOT HAVE DOCUMENTATION, PROBE TO DETERMINE IF R CAN ANSWER QUESTIONS ABOUT THE FORM, STRENGTH, AND QUANTITY OF THE MEDICINE.	(01) YES (02) NO (03) NO BUT R CAN ANSWER QUESTIONS (-8) DON'T KNOW (-9) REFUSED	(01) MED-PMEDNAME (02) PMKNWNNM-PMKNWNNM (03) MED-PMEDNAME (-8) PMKNWNNM-PMKNWNNM (-9) PMKNWNNM-PMKNWNNM

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PMEDNAME	MED	lookup	<p>TO USE THE MEDICINE LOOKUP, START TYPING THE MEDICINE NAME IN THE PRESCRIBED MEDICINE LOOKUP BOX. CHECK STATEMENT OR MEDICINE BOTTLE FOR SPELLING.</p> <p>ONCE YOU HAVE ENTERED ALL DETAILS FOR A MEDICINE, IF YOU NEED TO GO BACK AND CORRECT, USE THE GREEN "RETURN TO PRESCRIBED MEDICINE LOOKUP" BUTTON.</p> <p>[PRESCRIBED MEDICINE LOOKUP TOOL]</p>	[MEDICINE NAME SELECTED FROM LOOKUP OR MANUALLY TYPED]	
PMBRNAME	MED	lookup	[PM BRAND NAME]		
PMGNNAME	MED	lookup	[PM GENERIC NAME]		
PMFORMFD	MED	lookup	Medicine Form [FDB LIST FORM NAME]		
PMFORMMC	MED	code one	Medicine Form [MCBS FORM]	(01) PILLS (TABLETS, CAPSULES) (02) LIQUID (TO BE TAKEN ORALLY) (03) DROPS (EYE/EAR/NOSE) (04) OINTMENT, CREAM, LOTION (TOPICAL OR INTERNAL) (05) SUPPOSITORIES (06) AEROSOL/SPRAY, INHALANT, SOLUTIONS, DISKUS (07) SHAMPOO, SOAP (08) INJECTION (09) IV INJECTION (10) PATCHES (11) GEL OR JELLY (TOPICAL OR INTERNAL) (12) POWDER, GRANULES (91) OTHER (-8) Don't Know	(01)-(12) MED-PMSTRNFD (91) MED-PMFORMOS (-8) MED-PMSTRNFD (-9) MED-PMSTRNFD
PMFORMOS	MED	verbatim	[MEDICINE FORM OTHER SPECIFY]	(01) CONTINUOUS ANSWER	
PMFORMFN	MED	verbatim	[FINAL CONCATENATED MEDICINE FORM]		
PMSTRNFD	MED	verbatim	Medicine Strength	(01) [MEDICINE FORM SELECTED FROM LOOKUP] (-7) NOT FOUND (-8) DON'T KNOW	
STRNUMBB	MED	numeric	Medicine strength number	(01) CONTINUOUS ANSWER	
STRNUNIT	MED	code one	Medicine strength unit	(01) MICROGRAMS (mcg, mc) (02) MILLIGRAMS (mg) (03) GRAINS (gr) (04) MILLIEQUIVALENTS (meq) (05) GRAMS (g, gm) (06) PERCENT (%) (07) INTERNATIONAL UNITS (IU) (08) UNITS (U) (91) OTHER (-8) Don't Know (-9) Refused	(01)-(08) MED-PMEDID (91) MED-PMSTRNOS (-8) MED-PMEDID (-9) MED-PMEDID
PMSTRNOS	MED	verbatim	[MEDICINE STRENGTH UNIT OTHER SPECIFY]		
PMSTRUNI	MED	lookup	[FINAL CONCATENATED MEDICINE STRENGTH]		

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PMEDID	MED	numeric	[THIS VARIABLE STORES THE UNIQUE IDENTIFIER FOR PRESCRIBED MEDICINES ADDED THROUGH THE LOOKUP. IT IS HIDDEN ON SCREEN.]		
FAMILYID	MED	numeric	[THIS VARIABLE STORES THE UNIQUE IDENTIFIER FOR PRESCRIBED MEDICINES BY NAME ONLY, EXCLUDING STRENGTH AND FORM, THROUGH THE LOOKUP. IT IS HIDDEN ON SCREEN.]		
PMKNWNM	PMKNWNM	code one	DOES THE RESPONDENT KNOW THE NAME OF THE MEDICINE?	(01) YES (02) NO (-9) REFUSED	(01) MED-PMEDNAME (02) PMCOND-PMCOND (-9) PMCOND-PMCOND
PMCOND	PMCOND	code one	What condition is this medicine prescribed for or what is its primary use? IF THIS MEDICINE IS TAKEN FOR MORE THAN ONE CONDITION, SELECT ONLY ONE.	(01) ALLERGY MEDICINE (02) ALZHEIMERS (03) ANTIBIOTICS (04) ANTIPSYCHOTIC (05) ASTHMA OR COPD (06) BLOOD PRESSURE (07) CHOLESTEROL (08) COUGH AND COLD MEDICINE (09) DEPRESSION (10) DIABETES (11) DIURETICS (WATER PILLS) (12) EAR DROPS (13) ESTROGEN (14) EYE DROPS OR PREPARATION (15) NASAL SPRAY/DROPS (16) OSTEOPOROSIS (BONE LOSS) (17) PAIN MEDICINE (18) STEROID (GLUCOCORTICOID) (19) STOMACH ACID OR ULCER (20) OTHER (-8) DON'T KNOW (-9) REFUSED	(01)-(19) GETNUM-GETNUM (20) PMCOND-PMCONDOS (-8) GETNUM-GETNUM (-9) GETNUM-GETNUM
PMCONDOS	PMCOND	verbatim	OTHER (SPECIFY)	(01) CONTINUOUS ANSWER (-8) DON'T KNOW (-9) REFUSED	
GETNUM	GETNUM	numeric	How many times [since (REFERENCE DATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)] did [(you/(SP))] obtain (MEDICINE NAME)]? [IF THE MEDICINE WAS ENTERED IN ERROR AND WAS NOT OBTAINED IN THE CURRENT ROUND, CHECK "ENTERED IN ERROR" AND LEAVE THE BOX BLANK WHERE YOU ENTER THE NUMBER OF REFILLS.]	(01) continuous answer (996) EVENT ENTERED IN ERROR (-8) Don't Know (-9) Refused	BOX PM5
	BOX PM5	routing	IF GETNUM=996/EVENT ENTERED IN ERROR OR PMKNWNM=02/NO OR SAMEFSAM=1/YES, GO TO PMMORE-PMMORE; ELSE IF MEDICINE FORM IS PILLS, TABLETS OR CAPSULES [PMFORMMC=1 OR PMFORMFD CONTAINS ("PILL", "TAB", "CAP") GO TO TABNUM-TABNUM; ELSE GO TO PM16-AMTUNIT.		
TABNUM	TABNUM	numeric	HOW MANY PILLS, TABLETS, OR CAPSULES WERE IN THE CONTAINER WHEN IT WAS OBTAINED?	(01) CONTINUOUS ANSWER (-8) DON'T KNOW	BOX PM6
AMTUNIT	PM16	quantity unit	HOW MUCH MEDICINE WAS IN THE CONTAINER WHEN IT WAS OBTAINED? [PLEASE ENTER THE AMOUNT IN THE CONTAINER, NOT THE STRENGTH OF THE MEDICINE.]	(01) OUNCES (oz) (02) GRAMS (g, gm) (03) MILLILITERS (ml, cc) (04) MILLIEQUIVALENTS (meq) (05) MILLIGRAMS (mg) (06) MICROGRAMS (mcg) (07) PUFFS, DOSES, BLISTERS (91) OTHER (-8) DON'T KNOW	(01) PM16 - AMTNUM (02) PM16 - AMTNUM (03) PM16 - AMTNUM (04) PM16 - AMTNUM (05) PM16 - AMTNUM (06) PM16 - AMTNUM (07) PM16 - AMTNUM (91) PM16 - AMTNUM (-8) BOX PM6
AMTUNOS	PM16	text	OTHER (SPECIFY)	(01) CONTINUOUS ANSWER	PM16 - AMTNUM
AMTNUM	PM16	numeric		(01) CONTINUOUS ANSWER	BOX PM6

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	BOX PM6	routing	IF PRESCRIPTION MEDICINE FORM IS PILLS, TABLETS OR CAPSULES, GO TO PM12 - TABSADAY. ELSE GO TO BOX PM7.		
TABSADAY	PM12	numeric	HOW MANY PILLS, TABLETS, OR CAPSULES ARE PRESCRIBED TO BE TAKEN IN A DAY? IF LESS THAN ONE UNIT IS TO BE TAKEN PER DAY, ENTER THE APPROPRIATE DECIMAL VALUE (EX: HALF A PILL SHOULD BE ENTERED AS "0.5") FOR MEDICINES TO BE TAKEN "AS NEEDED," ENTER THE MAXIMUM AMOUNT THAT IS TO BE TAKEN IN A DAY AND SELECT "TAKE AS NEEDED". FOR MEDICINES TO BE TAKEN ON AN IRREGULAR SCHEDULE OR THAT VARY BY DAY, SELECT "OTHER DOSING INSTRUCTIONS". IF THE AMOUNT TO BE TAKEN PER DAY IS NOT CLEAR OR NOT INDICATED, SELECT "DON'T KNOW".	(01) CONTINUOUS ANSWER	PM12 - TABSADAY95
TABSADAY95	PM12	code one		(02) TAKE AS NEEDED (03) OTHER DOSING INSTRUCTIONS (-7) Empty	PM13-TABTAKE
TABTAKE	PM13	numeric	How many pills, tablets, or capsules (do/did/does) [you/(SP)] usually take in a day? [READ IF NECESSARY: This question is asking about how often you actually take the medicine, not how often the medicine is prescribed to be taken.] IF LESS THAN ONE UNIT IS TAKEN PER DAY, ENTER THE APPROPRIATE DECIMAL VALUE (EX: HALF A PILL SHOULD BE ENTERED AS "0.5") FOR MEDICINES TAKEN "AS NEEDED," SELECT "TAKE AS NEEDED". FOR MEDICINES TAKEN ON AN IRREGULAR SCHEDULE OR THAT VARY BY DAY, SELECT "OTHER DOSING INSTRUCTIONS".	(01) CONTINUOUS ANSWER (-7) EMPTY (-8) DON'T KNOW	PM13 - TABTAKE96
TABTAKE96	PM13	code one		(01) DON'T TAKE EVERY DAY (02) TAKE AS NEEDED (03) OTHER DOSING INSTRUCTIONS (-7) EMPTY	BOX PM7
	BOX PM7	routing	IF (SP REPORTED RECEIVING HEALTH CARE SERVICES THROUGH V.A. IN THE CURRENT ROUND OR ANY PREVIOUS ROUND), GO TO PMSATVA - PMSATVA. ELSE GO TO BOX PM8.		
PMSATVA	PMSATVA	yes/no	Did [you/(SP)] obtain (this purchase/any of these purchases) of (MEDICINE NAME) through the Department of Veterans Affairs or V.A.?	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED	BOX PM8
	BOX PM8	routing	IF SP COVERED BY A MEDICARE MANAGED CARE PLAN OR A PRIVATE MANAGED CARE PLAN ANYTIME DURING THE CURRENT ROUND, GO TO PMSATHMO - PMSATHMO. ELSE GO TO PMMORE-PMMORE.		
PMSATHMO	PMSATHMO	yes/no	Did [you/(SP)] obtain (this purchase/any of these purchases) of (MEDICINE NAME) at [READ MANAGED CARE PLAN NAME(S) BELOW] or through a service or discount offered through [READ MANAGED CARE PLAN NAME(S) BELOW]? [PROBE: This could include obtaining the purchases at a plan pharmacy; at a pharmacy that honors [your/(SP's)] plan card; or through a mail order service that the managed care plan referred [you/(SP)] to.]	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED	PMMORE-PMMORE
PMMORE	PM17	yes/no	([NO MEDICINES HAVE BEEN REPORTED FOR (SP) FOR THE CURRENT REFERENCE PERIOD/THE NAMES OF ALL MEDICINES REPORTED FOR THE CURRENT REFERENCE PERIOD ARE DISPLAYED BELOW.]) [REVIEW THE INFORMATION BELOW WITH THE RESPONDENT. ASK, OR CODE AS APPROPRIATE IF R ALREADY INDICATED: Are there any (more) medicines since (REFERENCE DATE/UTILDATE) that we haven't talked about?]	(01) ADD ANOTHER (02) ALL DONE	(01) BOX PM2 (02) BOX DU4
	BOX DU4	routing	IF ANOTHER EVENT WAS ADDED WITH THIS PROVIDER, GO TO DU7-DVPROCDR. ELSE GO TO DU14-DUMORE.		
DUMORE	DU14	yes/no	[Since (REFERENCE DATE/UTILDATE)/Between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)], did [you/(SP)] have any other dental care visits to this or any other provider?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) DU2 - PROVIDER_DU (02) BOX DU5 (-8) BOX DU5 (-9) BOX DU5
	BOX DU5	routing	IF SPALIVE=1 (ALIVE) GO TO DU15-DVNEED. ELSE GO TO BOX DU6.		

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DVNEED	DU15	yes/no	Since (REFERENCE DATE), was there a time when {you/SP} needed dental care but could not get it at that time?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) DU16 - DVNDRS (02) BOX DU6 (-8) BOX DU6 (-9) BOX DU6
DVNDRS	DU16	code all	What were the reasons that {you/SP} could not get the dental care {you/she/he} needed?	(01) COULD NOT AFFORD THE COST (02) DID NOT WANT TO SPEND THE MONEY (03) INSURANCE DID NOT COVER RECOMMENDED PROCEDURES (04) DENTAL OFFICE IS TOO FAR AWAY (05) DENTAL OFFICE IS NOT OPEN AT CONVENIENT TIMES (06) ANOTHER DENTIST RECOMMENDED NOT DOING IT (07) AFRAID OR DO NOT LIKE DENTISTS (08) UNABLE TO TAKE TIME OFF FROM WORK (09) TOO BUSY (10) I DID NOT THINK ANYTHING SERIOUS WAS WRONG/EXPECTED DENTAL PROBLEMS TO GO AWAY (91) OTHER (SPECIFY) (-8) DON'T KNOW (-9) REFUSED	(01) BOX DU6 (02) BOX DU6 (03) BOX DU6 (04) BOX DU6 (05) BOX DU6 (06) BOX DU6 (07) BOX DU6 (08) BOX DU6 (09) BOX DU6 (10) BOX DU6 (91) DU16A - DVNDRSOS (-8) BOX DU6 (-9) BOX DU6
DVNDRSOS	DU16A	verbatim text	WHAT OTHER REASON (SPECIFY)	(01) continuous answer	BOX DU6
	BOX DU6	routing	GO TO VU1-VUPROBE.		
VUPROBE	VU1	yes/no	[Since (REFERENCE DATE/UTILDATE)/Between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)], did {you/(SP)} go to an eye doctor or any other person for eye care? [Eye care providers include ophthalmologists, optometrists, and opticians.]	(01) YES (02) NO (03) INDICATED YES BY DATAPREP (-8) Don't Know (-9) Refused	(01) VU2 - PROVIDER_VU (02) OM1-OMPREYEG (03) DO NOT DISPLAY. DATA EDITING ONLY. (-8) OM1-OMPREYEG (-9) OM1-OMPREYEG
PROVIDER_VU	VU2	roster	Who did {you/(SP)} see? SELECT OR ADD ONLY ONE PROVIDER.	[DISPLAY PROVIDER ROSTER AS RESPONSE OPTIONS: 1. [PROVIDER 1] 2. [PROVIDER 2] ... (01-N) LIST ALL PROVIDERS AS RESPONSE OPTIONS (N+1) ADD ANOTHER DISPLAY PROVIDER NAME, SPECIALITY, GROUP NAME FOR ALL PROVIDERS WHERE PROVNUM>02.	(01-N) BOX VU1 (N+1) VU2B-PROVNAME IF EXISTING PROVIDER SELECTED, GO TO BOX VU1. ELSE IF "ADD ANOTHER" SELECTED, GO TO VU2-PROVNAME
VPRVNAME	VU2B	verbatim text	ENTER THE NAME OF THE PROVIDER AND THE BILLING GROUP OR PRACTICE NAME BELOW. YOU MUST ENTER A PROVIDER NAME IN THE 'NAME' FIELD. IF THE PROVIDER IS AN INDIVIDUAL BUT YOU DO NOT KNOW THE PROVIDER'S NAME, OR IF THE PROVIDER IS AN ORGANIZATION, ENTER THE GROUP OR PRACTICE NAME IN THE 'NAME' FIELD AND LEAVE THE 'GROUP' FIELD BLANK. YOU CAN CONSULT THE RESPONDENT'S STATEMENTS AND APPOINTMENT CARDS TO ENSURE THE PROVIDER NAME IS ENTERED CORRECTLY. [PROVIDER LOOKUP CALLED FROM THIS SCREEN] NAME:		VU2B - GRPNAME
VGRPNAME	VU2B	verbatim text	GROUP:		PROVSPEC
PROVSPEC	VU2C	code one	What kind of eye care provider is [PROVNAME]?	(02) MEDICAL DOCTOR, INCLUDING OPHTHALMOLOGIST (16) OPTOMETRIST (OD) (43) OPTICIAN (91) OTHER MEDICAL PROVIDER SPECIALTY (-8) DON'T KNOW (-9) REFUSED	(02) BOX VU1 (16) BOX VU1 (43) BOX VU1 (91) VU2C - PROVSPECOTH (-8) BOX VU1 (-9) BOX VU1

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
PROVSPEC	VU2C1	code one	What kind of eye care provider is [PROVNAME]?	(01) DENTIST/DENTAL PROVIDER (02) MEDICAL DOCTOR (DO NOT DISPLAY) (03) AUDIOLOGIST (04) CHIROPRACTOR (05) CLINICAL SOCIAL WORKER (06) DIETITIAN-NUTRITIONIST (07) HEARING THERAPIST (08) HOME HEALTH/HEALTH AIDE (09) HOMEMAKER (10) HOSPICE WORKER (11) I.V. THERAPIST (12) NURSE (RN) (13) NURSE PRACTITIONER (14) NURSE'S AIDE (15) OCCUPATIONAL THERAPIST (OT) (16) OPTOMETRIST (OD) (DO NOT DISPLAY) (17) OSTEOPATH (DO) (18) PARAMEDIC (19) PHYSICAL THERAPIST (PT) (20) PHYSICIAN'S ASSISTANT (21) PODIATRIST (FOOT DOCTOR) (22) PSYCHOLOGIST (23) RESPIRATORY THERAPIST (24) SOCIAL/CASE WORKER (25) SPEECH THERAPIST (26) THERAPIST (MENTAL HEALTH) (27) X-RAY TECHNICIAN (28) LICENSED PRACTICAL NURSE (LPN) (29) ACUPUNCTURIST (30) HOMEOPATH (31) MASSAGE THERAPIST (32) NATUROPATH (33) LICENSED PROFESSIONAL COUNSELOR [LPC] (34) LAB TECHNICIAN (91) OTHER MEDICAL PROVIDER SPECIALTY (-8) Don't Know (-9) Refused	(01) BOX VU1 (02) DO NOT DISPLAY (03) BOX VU1 (04) BOX VU1 (05) BOX VU1 (06) BOX VU1 (07) BOX VU1 (08) BOX VU1 (09) BOX VU1 (10) BOX VU1 (11) BOX VU1 (12) BOX VU1 (13) BOX VU1 (14) BOX VU1 (15) BOX VU1 (16) DO NOT DISPLAY (17) BOX VU1 (18) BOX VU1 (19) BOX VU1 (20) BOX VU1 (21) BOX VU1 (22) BOX VU1 (23) BOX VU1 (24) BOX VU1 (25) BOX VU1 (26) BOX VU1 (27) BOX VU1 (28) BOX VU1 (29) BOX VU1 (30) BOX VU1 (31) BOX VU1 (32) BOX VU1 (33) BOX VU1 (34) BOX VU1 (91) VU2D - PROVSPoS (-8) BOX VU1 (-9) BOX VU1
PROVSPOS	VU2D	verbatim text	OTHER MEDICAL PROVIDER (SPECIFY)	(01) [Continuous answer.]	BOX VU1
	BOX VU1	routing	IF (SP REPORTED RECEIVING HEALTH CARE SERVICES THROUGH V.A. IN THE CURRENT ROUND OR ANY PREVIOUS ROUND) AND (IF THIS PROVIDER IS ASSOCIATED WITH V.A. IS UNKNOWN), GO TO VU3 - VAPLACE. ELSE GO TO BOX VU2.		
VAPLACE	VU3	yes/no	Is (PROVIDER NAME) associated with a Department of Veterans Affairs, or V.A., facility?	(01) YES (02) NO (-8) Don't Know (-9) Refused	BOX VU2
	BOX VU2	routing	IF (SP COVERED BY A MANAGED CARE PLAN ANYTIME DURING THE CURRENT ROUND) AND (IF THIS PROVIDER IS ASSOCIATED WITH A MANAGED CARE PLAN IS UNKNOWN), GO TO VU4 - HMOASSOC. ELSE IF (SP COVERED BY A MANAGED CARE PLAN ANYTIME DURING THE CURRENT ROUND) AND (THIS PROVIDER IS NOT ASSOCIATED WITH A MANAGED CARE PLAN), GO TO VU5 - HMOREFER. ELSE GO TO VU6 - EVENT_VU.		
HMOASSC	VU4	yes/no	Is (PROVIDER NAME) associated with [your/(SP's)] [READ MANAGED CARE PLAN NAME(S) BELOW] plan?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) VU6 - EVENT_VU (02) VU5 - HMOREFER (-8) VU5 - HMOREFER (-9) VU5 - HMOREFER
HMOREFR	VU5	yes/no	[Were you/Was (SP)] referred to (PROVIDER NAME) by [READ MANAGED CARE PLAN NAME(S) BELOW]? [INCLUDE REFERRALS BY THE SAMPLE PERSON'S PRIMARY CARE PHYSICIAN (PCP).]	(01) YES (02) NO (-8) Don't Know (-9) Refused	VU6 - EVENT_VU

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
EVENT_VU	VU6	roster	When did [you/(SP)] see (PROVIDER NAME)? Please tell me all the dates [since (REFERENCE DATE/(UTILDATE))/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)]. ENTER ALL DATES. [IF THE RESPONDENT SAW THE SAME PROVIDER TWICE ON THE SAME DAY, ENTER THE DATE ONLY ONCE.] IF R HAD 5 OR MORE VISITS TO THIS PROVIDER DURING THIS REFERENCE PERIOD, SELECT "REPEAT VISITS" AND LEAVE THE DAY FIELD BLANK. ENTER EACH MONTH SEPARATELY.	(01) continuous answer (-8) Don't Know (-9) Refused MM: DD: YYYY: REPEAT VISIT: YES/NO # OF VISITS	VU6B-VUADD
VUADD	VU6B	chose one	HAVE ALL DATES BEEN ENTERED? [DISPLAY ALL EVENTS ASSOCIATED WITH THIS PROVIDER]	(01) ADD ANOTHER (02) ALL DONE	(01) VU6 -EVENT_VU (02) VU7-VUPROCDR
VUPROCDR	VU7	code all	SHOW CARD DVH2 For [your/(SP's)] [VISIT ON EVENT DATE], what did [you/(SP)] have done? CHECK ALL THAT APPLY.	(01) EYE OR VISION EXAM (02) CONTACT LENS FITTING (03) CONTACT LENS PURCHASE (04) EYE GLASS FRAME FITTING OR ADJUSTMENT (05) EYE GLASS PURCHASE (06) REFRACTIVE SURGERY (CORRECTIVE VISION SURGERY) (07) CATARACT SURGERY (08) GLAUCOMA SURGERY (09) CORNEAL SURGERY (10) VITREO-RETINAL SURGERY (11) OCULOPLASTIC SURGERY (12) EYE MUSCLE SURGERY (13) EYE REMOVAL (91) OTHER (-8) DON'T KNOW (-9) REFUSED	(01) VU9-PRESMDCN (02) VU9-PRESMDCN (03) VU9-PRESMDCN (04) VU9-PRESMDCN (05) VU9-PRESMDCN (06) VU9-PRESMDCN (07) VU9-PRESMDCN (08) VU9-PRESMDCN (09) VU9-PRESMDCN (10) VU9-PRESMDCN (11) VU9-PRESMDCN (12) VU9-PRESMDCN (13) VU9-PRESMDCN (91) VU7A-EVOSTEXT (-8) VU9-PRESMDCN (-9) VU9-PRESMDCN
EVOSTEXT	VU7A	verbatim text	OTHER PROCEDURE OR REASON DURING VISIT (SPECIFY)	(01) [CONTINUOUS ANSWER]	VU9 - PRESMDCN
PRESMDCN	VU9	yes/no	Were any medicines prescribed for [you/(SP)] during (this visit/any of these visits)?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) VU10 - PRESFILL (02) BOX VU4 (-8) BOX VU4 (-9) BOX VU4
PRESFILL	VU10	yes/no	Were any of the prescriptions filled? [COUNT A MEDICINE AS "FILLED" REGARDLESS OF WHO OBTAINED IT FOR THE RESPONDENT, WHETHER OR NOT THE PRESCRIPTION COST ANYTHING, AND WHETHER OR NOT THE RESPONDENT ACTUALLY TOOK THE MEDICINE.]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) BOX VU3B (02) BOX VU4 (-8) BOX VU4 (-9) BOX VU4
	BOX VU3B	routing	IF THE PROBE FOR PRESCRIPTION MEDICINE BOTTLES HAS NOT BEEN ASKED IN THE CURRENT ROUND, GO TO VU10A - VUPMMEDS. ELSE GO TO BOX PM2.		
VUPMMEDS	VU10A	no entry	It would be helpful if I could look at any medicine bottle(s), container(s), or bag(s) that you have so that I can spell the medicine name correctly and enter the strength of the medicine. [Also, please take out [your/(SP's)] (MEDICARE PRESCRIPTION DRUG PLAN NAME) medicine statements, which should have that same information on them.] [IF RESPONDENT HAS BOTTLE, ASK:] I'll need that same information for all of the medicines [you/(SP)] obtained since (REFERENCE DATE/UTILDATE), if you'd like to get those bottles, too.	(01) INSTRUCTION WAS READ	BOX PM2
	BOX PM2	routing	IF THERE IS AT LEAST ONE MEDICINE FROM A PRIOR ROUND ON THE EVENT TABLE FOR THIS CASE, GO TO MEDICINE_PM1-MEDICINE_PM1. ELSE GO TO PM2B-PMBOTTLE.		

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
MEDICINE_PM1	MEDICINE_PM1	code one	What is the name of the medicine?	[DISPLAY MEDICINE ROSTER AS RESPONSE OPTIONS: 1. [MEDICINE 1] 2. [MEDICINE 2] ... N. [MEDICINE N] N+1. ADD ANOTHER [DISPLAY MEDICINE NAME AND STRENGTH FOR EACH.	BOX PM3
	BOX PM3	routing	IF THIS MEDICINE HAS AN EXACT MATCH TO THE FDB LIST (PMEDID^=.), THEN GO TO PM2A-SAMEFSAM. ELSE GO TO PMBOTTLE-PMBOTTLE.		
SAMEFSAM	SAMEFSAM	yes/no	CODE "YES" WITHOUT ASKING IF STATEMENT, RECEIPT, BOTTLE OR BAG IS PRESENT AND FORM, STRENGTH AND AMOUNT ARE <u>EXACTLY</u> THE SAME AS IN THE PREVIOUS INTERVIEW. At the time of the last interview, [you/(SP)] purchased (MEDICINE NAME) in the form of (MEDICINE FORM). The strength was [MEDICINE STRENGTH]. The amount -in the container when it was obtained was (PREVIOUS ROUND MEDICINE AMOUNT). Is this medicine in the same strength, form and amount? CODE "NO" UNLESS -FORM, STRENGTH, AND AMOUNT <u>EXACTLY</u> MATCH PREVIOUS ROUND.	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED	BOX PM4
	BOX PM4	routing	IF SAMEFSAM=1/YES, THEN DO NOT CREATE A NEW EVENT FOR THIS MEDICINE AND GO TO PM6A-GETNUM. ELSE, CREATE A NEW EVENT FOR THIS MEDICINE AND GO TO PM2B-PMBOTTLE.		
PMBOTTLE	PMBOTTLE	code one	CODE "YES" WITHOUT ASKING IF-BOTTLE, CONTAINER, BAG, STATEMENT, OR RECEIPT IS PRESENT. Do you have the medicine bottle, container or bag, or Prescription Drug Plan Statement available? IF R DOES NOT HAVE DOCUMENTATION, PROBE TO DETERMINE IF R CAN ANSWER QUESTIONS ABOUT THE FORM, STRENGTH, AND QUANTITY OF THE MEDICINE.	(01) YES (02) NO (03) NO BUT R CAN ANSWER QUESTIONS (-8) DON'T KNOW (-9) REFUSED	(01) MED-PMEDNAME (02) PMKNWNM-PMKNWNM (03) MED-PMEDNAME (-8) PMKNWNM-PMKNWNM (-9) PMKNWNM-PMKNWNM
PMEDNAME	MED	lookup	TO USE THE MEDICINE LOOKUP, START TYPING THE MEDICINE NAME IN THE PRESCRIBED MEDICINE LOOKUP BOX. CHECK STATEMENT OR MEDICINE BOTTLE FOR SPELLING. ONCE YOU HAVE ENTERED ALL DETAILS FOR A MEDICINE, IF YOU NEED TO GO BACK AND CORRECT, USE THE GREEN "RETURN TO PRESCRIBED MEDICINE LOOKUP" BUTTON. [PRESCRIBED MEDICINE LOOKUP TOOL]	[MEDICINE NAME SELECTED FROM LOOKUP OR MANUALLY TYPED]	
PMBRNAME	MED	lookup	[PM BRAND NAME]		
PMGNNNAME	MED	lookup	[PM GENERIC NAME]		
PMFORMFD	MED	lookup	Medicine Form [FDB LIST FORM NAME]		
PMFMCODE	MED	lookup	Medicine Form [FDB LIST FORM CODE]		

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
PMFORMMC	MED	code one	Medicine Form [MCBS FORM]	(01) PILLS (TABLETS, CAPSULES) (02) LIQUID (TO BE TAKEN ORALLY) (03) DROPS (EYE/EAR/NOSE) (04) OINTMENT, CREAM, LOTION (TOPICAL OR INTERNAL) (05) SUPPOSITORIES (06) AEROSOL/SPRAY, INHALANT, SOLUTIONS, DISKUS (07) SHAMPOO, SOAP (08) INJECTION (09) IV INJECTION (10) PATCHES (11) GEL OR JELLY (TOPICAL OR INTERNAL) (12) POWDER, GRANULES (91) OTHER (-8) Don't Know	(01)-(12) MED-PMSTRNFD (91) MED-PMFORMOS
PMFORMOS	MED	verbatim	[MEDICINE FORM OTHER SPECIFY]	(01) CONTINUOUS ANSWER	
PMFORMFN	MED	verbatim	[FINAL CONCATENATED MEDICINE FORM]		
PMSTRNFD	MED	verbatim	Medicine Strength	(01) [MEDICINE FORM SELECTED FROM LOOKUP] (-7) NOT FOUND (-8) DON'T KNOW	
STRNNUBB	MED	numeric	Medicine strength number	(01) CONTINUOUS ANSWER	
STRNUNIT	MED	code one	Medicine strength unit	(01) MICROGRAMS (mcg, mc) (02) MILLIGRAMS (mg) (03) GRAINS (gr) (04) MILLIEQUIVALENTS (meq) (05) GRAMS (g, gm) (06) PERCENT (%) (07) INTERNATIONAL UNITS (IU) (08) UNITS (U) (91) OTHER (-8) Don't Know (-9) Refused	(01)-(08) MED-PMEDID (91) MED-PMSTRNOS (-8) MED-PMEDID (-9) MED-PMEDID
PMSTRNOS	MED	verbatim	[MEDICINE STRENGTH UNIT OTHER SPECIFY]		
PMSTRUNI	MED	lookup	[FINAL CONCATENATED MEDICINE STRENGTH]		
PMEDID	MED	numeric	[THIS VARIABLE STORES THE UNIQUE IDENTIFIER FOR PRESCRIBED MEDICINES ADDED THROUGH THE LOOKUP. IT IS HIDDEN ON SCREEN.]		
FAMILYID	MED	numeric	[THIS VARIABLE STORES THE UNIQUE IDENTIFIER FOR PRESCRIBED MEDICINES BY NAME ONLY, EXCLUDING STRENGTH AND FORM, THROUGH THE LOOKUP. IT IS HIDDEN ON SCREEN.]		
PMKNWNM	PMKNWNM	code one	DOES THE RESPONDENT KNOW THE NAME OF THE MEDICINE?	(01) YES (02) NO (-9) REFUSED	(01) MED-PMEDNAME (02) PMCOND-PMCOND (-9) PMCOND-PMCOND

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
PMCOND	PMCOND	code one	What condition is this medicine prescribed for or what is its primary use? IF THIS MEDICINE IS TAKEN FOR MORE THAN ONE CONDITION, SELECT ONLY ONE.	(01) ALLERGY MEDICINE (02) ALZHEIMERS (03) ANTIBIOTICS (04) ANTIPSYCHOTIC (05) ASTHMA OR COPD (06) BLOOD PRESSURE (07) CHOLESTEROL (08) COUGH AND COLD MEDICINE (09) DEPRESSION (10) DIABETES (11) DIURETICS (WATER PILLS) (12) EAR DROPS (13) ESTROGEN (14) EYE DROPS OR PREPARATION (15) NASAL SPRAY/DROPS (16) OSTEOPOROSIS (BONE LOSS) (17) PAIN MEDICINE (18) STEROID (GLUCOCORTICOID) (19) STOMACH ACID OR ULCER (20) OTHER (-8) DON'T KNOW (-9) REFUSED	(01)-(19) GETNUM-GETNUM (20) PMCOND-PMCONDOS (-8) GETNUM-GETNUM (-9) GETNUM-GETNUM
PMCONDOS	PMCOND	verbatim	OTHER (SPECIFY)	(01) CONTINUOUS ANSWER (-8) DON'T KNOW (-9) REFUSED	
GETNUM	GETNUM	numeric	How many times [since (REFERENCE DATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)] did [(you/(SP)) obtain (MEDICINE NAME)]? [IF THE MEDICINE WAS ENTERED IN ERROR AND WAS NOT OBTAINED IN THE CURRENT ROUND, CHECK "ENTERED IN ERROR" AND LEAVE THE BOX BLANK WHERE YOU ENTER THE NUMBER OF REFILLS.]	(01) continuous answer (996) EVENT ENTERED IN ERROR (-8) Don't Know (-9) Refused	BOX PM5
	BOX PM5	routing	IF GETNUM=996/EVENT ENTERED IN ERROR OR PMKNWNM=02/NO OR SAMEFSAM=1/YES, GO TO PMMORE-PMMORE; ELSE IF MEDICINE FORM IS PILLS, TABLETS OR CAPSULES [PMFORMMC=1 OR PMFORMFD CONTAINS ("PILL", "TAB", "CAP") GO TO TABNUM-TABNUM; ELSE GO TO PM16-AMTNUM.		
TABNUM	TABNUM	numeric	HOW MANY PILLS, TABLETS, OR CAPSULES WERE IN THE CONTAINER WHEN IT WAS OBTAINED?	(01) CONTINUOUS ANSWER (-8) DON'T KNOW	BOX PM6
AMTUNIT	PM16	quantity unit	HOW MUCH MEDICINE WAS IN THE CONTAINER WHEN IT WAS OBTAINED? [PLEASE ENTER THE AMOUNT IN THE CONTAINER, NOT THE STRENGTH OF THE MEDICINE.]	(01) OUNCES (oz) (02) GRAMS (g, gm) (03) MILLILITERS (ml, cc) (04) MILLIEQUIVALENTS (meq) (05) MILLIGRAMS (mg) (06) MICROGRAMS (mcg) (07) PUFFS, DOSES, BLISTERS (91) OTHER (-8) DON'T KNOW	(01) PM16 - AMTNUM (02) PM16 - AMTNUM (03) PM16 - AMTNUM (04) PM16 - AMTNUM (05) PM16 - AMTNUM (06) PM16 - AMTNUM (07) PM16 - AMTNUM (91) PM16 - AMTUNOS (-8) BOX PM6
AMTUNOS	PM16	text	OTHER (SPECIFY)	(01) CONTINUOUS ANSWER	PM16 - AMTNUM
AMTNUM	PM16	numeric		(01) CONTINUOUS ANSWER	BOX PM6
	BOX PM6	routing	IF PRESCRIPTION MEDICINE FORM IS PILLS, TABLETS OR CAPSULES, GO TO PM12 - TABSADAY. ELSE GO TO BOX PM7.		
TABSADAY	PM12	numeric	HOW MANY PILLS, TABLETS, OR CAPSULES ARE PRESCRIBED TO BE TAKEN IN A DAY? IF LESS THAN ONE UNIT IS TO BE TAKEN PER DAY, ENTER THE APPROPRIATE DECIMAL VALUE (EX: HALF A PILL SHOULD BE ENTERED AS "0.5") FOR MEDICINES TO BE TAKEN "AS NEEDED," ENTER THE MAXIMUM AMOUNT THAT IS TO BE TAKEN IN A DAY AND SELECT "TAKE AS NEEDED". FOR MEDICINES TO BE TAKEN ON AN IRREGULAR SCHEDULE OR THAT VARY BY DAY, SELECT "OTHER DOSING INSTRUCTIONS". IF THE AMOUNT TO BE TAKEN PER DAY IS NOT CLEAR OR NOT INDICATED, SELECT "DON'T KNOW".	(01) CONTINUOUS ANSWER	PM12 - TABSADAY95

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
TABSADAY95	PM12	code one		(02) TAKE AS NEEDED (03) OTHER DOSING INSTRUCTIONS (-7) Empty	PM13-TABTAKE
TABTAKE	PM13	numeric	How many pills, tablets, or capsules (do/did/does) [you/(SP)] usually take in a day? [READ IF NECESSARY: This question is asking about how often you actually take the medicine, not how often the medicine is prescribed to be taken.] IF LESS THAN ONE UNIT IS TAKEN PER DAY, ENTER THE APPROPRIATE DECIMAL VALUE (EX: HALF A PILL SHOULD BE ENTERED AS "0.5") FOR MEDICINES TAKEN "AS NEEDED," SELECT "TAKE AS NEEDED". FOR MEDICINES TAKEN ON AN IRREGULAR SCHEDULE OR THAT VARY BY DAY, SELECT "OTHER DOSING INSTRUCTIONS".	(01) CONTINUOUS ANSWER (-7) EMPTY (-8) DON'T KNOW	PM13 - TABTAKE96
TABTAKE96	PM13	code one		(01) DON'T TAKE EVERY DAY (02) TAKE AS NEEDED (03) OTHER DOSING INSTRUCTIONS (-7) EMPTY	BOX PM7
	BOX PM7	routing	IF (SP REPORTED RECEIVING HEALTH CARE SERVICES THROUGH V.A. IN THE CURRENT ROUND OR ANY PREVIOUS ROUND), GO TO PMSATVA - PMSATVA. ELSE GO TO BOX PM8.		
PMSATVA	PMSATVA	yes/no	Did [you/(SP)] obtain (this purchase/any of these purchases) of (MEDICINE NAME) through the Department of Veterans Affairs or V.A.?	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED	BOX PM8
	BOX PM8	routing	IF SP COVERED BY A MEDICARE MANAGED CARE PLAN OR A PRIVATE MANAGED CARE PLAN ANYTIME DURING THE CURRENT ROUND, GO TO PMSATHMO - PMSATHMO. ELSE GO TO PMMORE-PMMORE.		
PMSATHMO	PMSATHMO	yes/no	Did [you/(SP)] obtain (this purchase/any of these purchases) of (MEDICINE NAME) at [READ MANAGED CARE PLAN NAME(S) BELOW] or through a service or discount offered through [READ MANAGED CARE PLAN NAME(S) BELOW]? [PROBE: This could include obtaining the purchases at a plan pharmacy; at a pharmacy that honors [your/(SP's)] plan card; or through a mail order service that the managed care plan referred [you/(SP)] to.]	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED	PMMORE-PMMORE
PMMORE	PM17	yes/no	([NO MEDICINES HAVE BEEN REPORTED FOR (SP) FOR THE CURRENT REFERENCE PERIOD/THE NAMES OF ALL MEDICINES REPORTED FOR THE CURRENT REFERENCE PERIOD ARE DISPLAYED BELOW.]) [REVIEW THE INFORMATION BELOW WITH THE RESPONDENT. ASK, OR CODE AS APPROPRIATE IF R ALREADY INDICATED: Are there any (more) medicines since (REFERENCE DATE/UTILDATE) that we haven't talked about?]	(01) ADD ANOTHER (02) ALL DONE	(01) BOX PM2 (02) BOX VU4
	BOX VU4	routing	IF ANOTHER EVENT WAS ADDED WITH THIS PROVIDER, GO TO VU7-VUPROCDR. ELSE GO TO VU14-VUMORE.		
VUMORE	VU14	yes/no	[Since (REFERENCE DATE/UTILDATE)/Between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)], did [you/(SP)] have any other eye care visits to this or any other provider?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) VU2 - PROVIDER_VU (02) OM1-OMPNEYEG (-8) OM1-OMPNEYEG (-9) OM1-OMPNEYEG
OMPNEYEG	OM1	yes/no	Next I'm going to ask you about other medical expenses related to vision care that [you/(SP)] may have had [between (REFERENCE DATE/SURVEY REFERENCE DATE/UTILDATE) and (today/(DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)]. [Since (REFERENCE DATE/SURVEY REFERENCE DATE/UTILDATE)/Between (REFERENCE DATE/SURVEY REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)], did [you/(SP)] buy, replace, or pay for repairs of eyeglasses or contact lenses? [Please include the purchases you made during the visit(s) to eye care providers on (EVENT DATES) that you just told me about.] [INCLUDE NON-PRESCRIPTION READING GLASSES.]	(01) YES (02) NO (03) INDICATED YES BY DATAPREP (-8) Don't Know (-9) Refused	(01) OM1B-VUTYPE (02) BOX VU5 (03) DO NOT DISPLAY. (-8) BOX VU5 (-9) BOX VU5

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
VUTYPE	OM1B	code all	What did [you/(SP)] buy or repair? FOR EACH DATE, CHECK ALL THAT APPLY. THE DATE WILL BE ENTERED ON THE NEXT SCREEN.	(01) BUY EYEGLASS LENSES (02) BUY EYEGLASS FRAMES (03) BUY CONTACT LENSES (04) REPAIR EYEGLASSES (-8) DON'T KNOW (-9) REFUSED	OM2-EVENT_OMEYEG
EVENT_OMEYEG	OM2	roster	SELECT OR ADD ALL DATES AT THIS ROSTER. When did [you/(SP)] buy or repair glasses or contact lenses? Please tell me all the dates [since (REFERENCE DATE/SURVEY REFERENCE DATE/UTILDATE)/between (REFERENCE DATE/SURVEY REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)]. [INCLUDE NON-PRESCRIPTION READING GLASSES.]	(01) continuous answer (-8) Don't Know (-9) Refused MM: DD: YYYY:	BOX OM1AA
OMADD	OM2AA	code one	In addition to the medical expenses related to vision care you just told me about, did [you/(SP)] buy, replace, or pay for repairs for any other eyeglasses or contact lenses [since (REFERENCE DATE/SURVEY REFERENCE DATE/UTILDATE)/between (REFERENCE DATE/SURVEY REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)]? [DISPLAY ALL EVENTS ENTERED]	(01) ADD ANOTHER (02) ALL DONE	(01) OM1B - VUTYPE (02) BOX OM1AA
	BOX OM1AA	routing	IF SP COVERED BY AN MEDICARE MANAGED CARE PLAN OR PRIVATE MANAGED CARE PLAN ANYTIME DURING THE CURRENT ROUND, GO TO OM2A-OMSATHMO. ELSE GO TO BOX OM1AA2.		
OMSATHMO	OM2A	yes/no	On (EVENT DATE), did [you/(SP)] buy or repair the glasses or contact lenses at [READ MANAGED CARE PLAN NAME(S) BELOW] or through a service or discount offered through [READ MANAGED CARE PLAN NAME(S) BELOW]? [PROBE: This could include buying or repairing the glasses or lenses at a plan center; at an optician, optometrist or other place that honors [your/(SP's)] plan card; or through a place or service that the plan referred [you/(SP)] to.] [INCLUDE NON-PRESCRIPTION READING GLASSES.]	(01) YES (02) NO (-8) Don't Know (-9) Refused	BOX OM1AA2
	BOX OM1AA2	routing	IF ADMINISTERING ST, GO TO BOX ST36. ELSE IF ADMINISTERING NS, GO TO BOX NS36. ELSE GO TO BOX VU5.		
	BOX VU5	routing	IF SPALIVE=1 (ALIVE) GO TO VU15-VUNEED. ELSE GO TO BOX VU6.		
VUNEED	VU15	yes/no	Since (REFERENCE DATE), was there a time when {you/SP} needed vision care but could not get it at that time?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) VU16 - VUVNDRS (02) BOX VU6 (-8) BOX VU6 (-9) BOX VU6
VUVNDRS	VU16	code all	What were the reasons that {you/SP} could not get the vision care {you/she/he} needed?	(01) COULD NOT AFFORD THE COST (02) DID NOT WANT TO SPEND THE MONEY (03) INSURANCE DID NOT COVER RECOMMENDED PROCEDURES (04) DOCTOR'S OFFICE IS TOO FAR AWAY (05) DOCTOR'S OFFICE IS NOT OPEN AT CONVENIENT TIMES (06) ANOTHER DOCTOR RECOMMENDED NOT DOING IT (07) AFRAID OR DO NOT LIKE DOCTORS (08) UNABLE TO TAKE TIME OFF FROM WORK (09) TOO BUSY (10) I DID NOT THINK ANYTHING SERIOUS WAS WRONG/EXPECTED PROBLEMS TO GO AWAY (91) OTHER (SPECIFY) (-8) DON'T KNOW (-9) REFUSED	(01) BOX VU6 (02) BOX VU6 (03) BOX VU6 (04) BOX VU6 (05) BOX VU6 (06) BOX VU6 (07) BOX VU6 (08) BOX VU6 (09) BOX VU6 (10) BOX VU6 (91) VU16A - VUVNDRSOS (-8) BOX VU6 (-9) BOX VU6

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
VUVNDRSOS	VU16A	verbatim text	WHAT OTHER REASON (SPECIFY)	(01) continuous answer	BOX VU6
	BOX VU6	routing	GO TO HU1-HUPROBE		
HUPROBE	HU1	yes/no	[Since (REFERENCE DATE/UTILDATE)/Between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)], did [you/(SP)] go to a doctor or any other person for hearing care? [Hearing care providers include otorhinolaryngologists (ear nose and throat doctors), otologists, neurotologists, audiologists, audiometrists, and hearing instrument specialists.]	(01) YES (02) NO (03) INDICATED YES BY DATAPREP (-8) Don't Know (-9) Refused	(01) HU2 - PROVIDER_HU (02) HU15--OMHEARAD (03) DO NOT DISPLAY. DATA EDITING ONLY. (-8) OM3-OMPRHEAR (-9) OM3-OMPRHEAR
PROVIDER_HU	HU2	roster	Who did [you/(SP)] see? SELECT OR ADD ONLY ONE PROVIDER.	[DISPLAY PROVIDER ROSTER AS RESPONSE OPTIONS: 1. [PROVIDER 1] 2. [PROVIDER 2] ... (01-N) LIST ALL PROVIDERS AS RESPONSE OPTIONS (N+1) ADD ANOTHER DISPLAY PROVIDER NAME, SPECIALITY, GROUP NAME FOR ALL PROVIDERS WHERE PROVNUM>02.	(01-N) BOX HU1 (N+1) HU2B-PROVNAME IF EXISTING PROVIDER SELECTED, GO TO BOX HU1. ELSE IF "ADD ANOTHER" SELECTED, GO TO HU2-PROVNAME
HPRVNAME	HU2B	verbatim text	ENTER THE NAME OF THE PROVIDER AND THE BILLING GROUP OR PRACTICE NAME BELOW. YOU MUST ENTER A PROVIDER NAME IN THE 'NAME' FIELD. IF THE PROVIDER IS AN INDIVIDUAL BUT YOU DO NOT KNOW THE PROVIDER'S NAME, OR IF THE PROVIDER IS AN ORGANIZATION, ENTER THE GROUP OR PRACTICE NAME IN THE 'NAME' FIELD AND LEAVE THE 'GROUP' FIELD BLANK. YOU CAN CONSULT THE RESPONDENT'S STATEMENTS AND APPOINTMENT CARDS TO ENSURE THE PROVIDER NAME IS ENTERED CORRECTLY. [PROVIDER LOOKUP CALLED FROM THIS SCREEN] NAME:		HU2B - GRPNAME
HGRPNAM	HU2B	verbatim text	GROUP:		PROVSPEC
PROVSPEC	HU2C	code one	What kind of hearing care provider is [PROVNAME]?	(02) MEDICAL DOCTOR, INCLUDING OTOLARYNGOLOGIST (ENT), OTOLOGIST, NEUROTOLOGIST (03) AUDIOLOGIST (44) AUDIOMETRIST (45) HEARING INSTRUMENT SPECIALIST (91) OTHER (-8) Don't Know (-9) Refused	(02) BOX HU1 (03) BOX HU1 (44) BOX HU1 (45) BOX HU1 (91) HU2C - PROVSPECOTH (-8) BOX HU1 (-9) BOX HU1

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
PROVSPEC	HU2C1	code one	What kind of hearing care provider is [PROVNAME]?	(01) DENTIST/DENTAL PROVIDER (02) MEDICAL DOCTOR (DO NOT DISPLAY) (03) AUDIOLOGIST (DO NOT DISPLAY) (04) CHIROPRACTOR (05) CLINICAL SOCIAL WORKER (06) DIETITIAN-NUTRITIONIST (07) HEARING THERAPIST (08) HOME HEALTH/HEALTH AIDE (09) HOMEMAKER (10) HOSPICE WORKER (11) I.V. THERAPIST (12) NURSE (RN) (13) NURSE PRACTITIONER (14) NURSE'S AIDE (15) OCCUPATIONAL THERAPIST (OT) (16) OPTOMETRIST (OD) (17) OSTEOPATH (DO) (18) PARAMEDIC (19) PHYSICAL THERAPIST (PT) (20) PHYSICIAN'S ASSISTANT (21) PODIATRIST (FOOT DOCTOR) (22) PSYCHOLOGIST (23) RESPIRATORY THERAPIST (24) SOCIAL/CASE WORKER (25) SPEECH THERAPIST (26) THERAPIST (MENTAL HEALTH) (27) X-RAY TECHNICIAN (28) LICENSED PRACTICAL NURSE (LPN) (29) ACUPUNCTURIST (30) HOMEOPATH (31) MASSAGE THERAPIST (32) NATUROPATH (33) LICENSED PROFESSIONAL COUNSELOR [LPC] (34) LAB TECHNICIAN (91) OTHER MEDICAL PROVIDER SPECIALTY (-8) Don't Know (-9) Refused	(01) BOX HU1 (02) DO NOT DISPLAY (03) DO NOT DISPLAY (04) BOX HU1 (05) BOX HU1 (06) BOX HU1 (07) BOX HU1 (08) BOX HU1 (09) BOX HU1 (10) BOX HU1 (11) BOX HU1 (12) BOX HU1 (13) BOX HU1 (14) BOX HU1 (15) BOX HU1 (16) BOX HU1 (17) BOX HU1 (18) BOX HU1 (19) BOX HU1 (20) BOX HU1 (21) BOX HU1 (22) BOX HU1 (23) BOX HU1 (24) BOX HU1 (25) BOX HU1 (26) BOX HU1 (27) BOX HU1 (28) BOX HU1 (29) BOX HU1 (30) BOX HU1 (31) BOX HU1 (32) BOX HU1 (33) BOX HU1 (34) BOX HU1 (91) HU2D - PROVSPoS (-8) BOX HU1 (-9) BOX HU1
PROVSPOS	HU2D	verbatim text	OTHER MEDICAL PROVIDER (SPECIFY)	(01) [Continuous answer.]	BOX HU1
	BOX HU1	routing	IF (SP REPORTED RECEIVING HEALTH CARE SERVICES THROUGH V.A. IN THE CURRENT ROUND OR ANY PREVIOUS ROUND) AND (IF THIS PROVIDER IS ASSOCIATED WITH V.A. IS UNKNOWN), GO TO HU3 - VAPLACE. ELSE GO TO BOX HU2.		
VAPLACE	HU3	yes/no	Is (PROVIDER NAME) associated with a Department of Veterans Affairs, or V.A., facility?	(01) YES (02) NO (-8) Don't Know (-9) Refused	BOX HU2
	BOX HU2	routing	IF (SP COVERED BY A MANAGED CARE PLAN ANYTIME DURING THE CURRENT ROUND) AND (IF THIS PROVIDER IS ASSOCIATED WITH A MANAGED CARE PLAN IS UNKNOWN), GO TO HU4 - HMOASSOC. ELSE IF (SP COVERED BY A MANAGED CARE PLAN ANYTIME DURING THE CURRENT ROUND) AND (THIS PROVIDER IS NOT ASSOCIATED WITH A MANAGED CARE PLAN), GO TO HU5 - HMOREFER. ELSE GO TO HU6 - EVENT_HU.		
HMOASSC	HU4	yes/no	Is (PROVIDER NAME) associated with [your/(SP's)] [READ MANAGED CARE PLAN NAME(S) BELOW] plan?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HU6 - EVENT_HU (02) HU5 - HMOREFER (-8) HU5 - HMOREFER (-9) HU5 - HMOREFER
HMOREFR	HU5	yes/no	[Were you/Was (SP)] referred to (PROVIDER NAME) by [READ MANAGED CARE PLAN NAME(S) BELOW]? [INCLUDE REFERRALS BY THE SAMPLE PERSON'S PRIMARY CARE PHYSICIAN (PCP).]	(01) YES (02) NO (-8) Don't Know (-9) Refused	HU6 - EVENT_HU

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
EVENT_HU	HU6	roster	When did [you/(SP)] see (PROVIDER NAME)? Please tell me all the dates [since (REFERENCE DATE/(UTILDATE))/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)]. ENTER ALL DATES. [IF THE RESPONDENT SAW THE SAME PROVIDER TWICE ON THE SAME DAY, ENTER THE DATE ONLY ONCE.] IF R HAD 5 OR MORE VISITS TO THIS PROVIDER DURING THIS REFERENCE PERIOD, SELECT "REPEAT VISITS" AND LEAVE THE DAY FIELD BLANK. ENTER EACH MONTH SEPARATELY.	(01) continuous answer (-8) Don't Know (-9) Refused MM: DD: YYYY: REPEAT VISIT: YES/NO # OF VISITS	HU6B-HUADD
HUADD	HU6B	chose one	HAVE ALL DATES BEEN ENTERED? [DISPLAY ALL EVENTS ASSOCIATED WITH THIS PROVIDER]	(01) ADD ANOTHER (02) ALL DONE	(01) HU6 -EVENT_HU (02) HU7 - DVPROCDR
HUPROCDR	HU7	code all	SHOW CARD DVH3 For [your/(SP's)] [VISIT ON EVENT DATE], what did [you/(SP)] have done? CHECK ALL THAT APPLY.	(01) HEARING AID FITTING/EVALUATION (02) HEARING AID PURCHASE/REPAIR (03) HEARING EXAM (04) EAR WAX REMOVAL (05) EAR VENTILATION TUBES (06) TYMPANOPLASTY (RECONSTRUCTION OF EAR DRUM) (07) COCHLEAR IMPLANT SURGERY (08) HEARING REHABILITATIVE SERVICES (91) OTHER (-8) DON'T KNOW (-9) REFUSED	(01) HU9-PRESMDCN (02) HU9-PRESMDCN (03) HU9-PRESMDCN (04) HU9-PRESMDCN (05) HU9-PRESMDCN (06) HU9-PRESMDCN (07) HU9-PRESMDCN (91) HU7A-EVOSTEXT (-8) HU9-PRESMDCN (-9) HU9-PRESMDCN
EVOSTEXT	HU7A	verbatim text	OTHER PROCEDURE OR REASON DURING VISIT (SPECIFY)	(01) [CONTINUOUS ANSWER]	HU9 - PRESMDCN
PRESMDCN	HU9	yes/no	Were any medicines prescribed for [you/(SP)] during (this visit/any of these visits)?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HU10 - PRESFILL (02) BOX HU4 (-8) BOX HU4 (-9) BOX HU4
PRESFILL	HU10	yes/no	Were any of the prescriptions filled? [COUNT A MEDICINE AS "FILLED" REGARDLESS OF WHO OBTAINED IT FOR THE RESPONDENT, WHETHER OR NOT THE PRESCRIPTION COST ANYTHING, AND WHETHER OR NOT THE RESPONDENT ACTUALLY TOOK THE MEDICINE.]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) BOX HU3B (02) BOX HU4 (-8) BOX HU4 (-9) BOX HU4
	BOX HU3B	routing	IF THE PROBE FOR PRESCRIPTION MEDICINE BOTTLES HAS NOT BEEN ASKED IN THE CURRENT ROUND, GO TO HU10A - HUPMMEDS. ELSE GO TO BOX PM2.		
HUPMMEDS	HU10A	no entry	It would be helpful if I could look at any medicine bottle(s), container(s), or bag(s) that you have so that I can spell the medicine name correctly and enter the strength of the medicine. [Also, please take out [your/(SP's)] (MEDICARE PRESCRIPTION DRUG PLAN NAME) medicine statements, which should have that same information on them.] [IF RESPONDENT HAS BOTTLE, ASK:] I'll need that same information for all of the medicines [you/(SP)] obtained since (REFERENCE DATE/UTILDATE), if you'd like to get those bottles, too.	(01) INSTRUCTION WAS READ	BOX PM2
	BOX PM2	routing	IF THERE IS AT LEAST ONE MEDICINE FROM A PRIOR ROUND ON THE EVENT TABLE FOR THIS CASE, GO TO MEDICINE_PM1-MEDICINE_PM1. ELSE GO TO PM2B-PMBOTTLE.		

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
MEDICINE_PM1	MEDICINE_PM1	code one	What is the name of the medicine?	[DISPLAY MEDICINE ROSTER AS RESPONSE OPTIONS: 1. [MEDICINE 1] 2. [MEDICINE 2] ... N. [MEDICINE N] N+1. ADD ANOTHER [DISPLAY MEDICINE NAME AND STRENGTH FOR EACH.	BOX PM3
	BOX PM3	routing	IF THIS MEDICINE HAS AN EXACT MATCH TO THE FDB LIST (PMEDID^=.), THEN GO TO PM2A-SAMEFSAM. ELSE GO TO PMBOTTLE-PMBOTTLE.		
SAMEFSAM	SAMEFSAM	yes/no	CODE "YES" WITHOUT ASKING IF STATEMENT, RECEIPT, BOTTLE OR BAG IS PRESENT AND FORM, STRENGTH AND AMOUNT ARE <u>EXACTLY</u> THE SAME AS IN THE PREVIOUS INTERVIEW. At the time of the last interview, [you/(SP)] purchased (MEDICINE NAME) in the form of (MEDICINE FORM). The strength was [MEDICINE STRENGTH]. The amount -in the container when it was obtained was (PREVIOUS ROUND MEDICINE AMOUNT). Is this medicine in the same strength, form and amount? CODE "NO" UNLESS -FORM, STRENGTH, AND AMOUNT <u>EXACTLY</u> MATCH PREVIOUS ROUND.	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED	BOX PM4
	BOX PM4	routing	IF SAMEFSAM=1/YES, THEN DO NOT CREATE A NEW EVENT FOR THIS MEDICINE AND GO TO PM6A-GETNUM. ELSE, CREATE A NEW EVENT FOR THIS MEDICINE AND GO TO PM2B-PMBOTTLE.		
PMBOTTLE	PMBOTTLE	code one	CODE "YES" WITHOUT ASKING IF-BOTTLE, CONTAINER, BAG, STATEMENT, OR RECEIPT IS PRESENT. Do you have the medicine bottle, container or bag, or Prescription Drug Plan Statement available? IF R DOES NOT HAVE DOCUMENTATION, PROBE TO DETERMINE IF R CAN ANSWER QUESTIONS ABOUT THE FORM, STRENGTH, AND QUANTITY OF THE MEDICINE.	(01) YES (02) NO (03) NO BUT R CAN ANSWER QUESTIONS (-8) DON'T KNOW (-9) REFUSED	(01) MED-PMEDNAME (02) PMKNWNM-PMKNWNM (03) MED-PMEDNAME (-8) PMKNWNM-PMKNWNM (-9) PMKNWNM-PMKNWNM
PMEDNAME	MED	lookup	TO USE THE MEDICINE LOOKUP, START TYPING THE MEDICINE NAME IN THE PRESCRIBED MEDICINE LOOKUP BOX. CHECK STATEMENT OR MEDICINE BOTTLE FOR SPELLING. ONCE YOU HAVE ENTERED ALL DETAILS FOR A MEDICINE, IF YOU NEED TO GO BACK AND CORRECT, USE THE GREEN "RETURN TO PRESCRIBED MEDICINE LOOKUP" BUTTON. [PRESCRIBED MEDICINE LOOKUP TOOL]	[MEDICINE NAME SELECTED FROM LOOKUP OR MANUALLY TYPED]	
PMBRNAME	MED	lookup	[PM BRAND NAME]		
PMGNNAME	MED	lookup	[PM GENERIC NAME]		
PMFORMFD	MED	lookup	Medicine Form [FDB LIST FORM NAME]		
PMFMCODE	MED	lookup	Medicine Form [FDB LIST FORM CODE]		

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
PMFORMMC	MED	code one	Medicine Form [MCBS FORM]	(01) PILLS (TABLETS, CAPSULES) (02) LIQUID (TO BE TAKEN ORALLY) (03) DROPS (EYE/EAR/NOSE) (04) OINTMENT, CREAM, LOTION (TOPICAL OR INTERNAL) (05) SUPPOSITORIES (06) AEROSOL/SPRAY, INHALANT, SOLUTIONS, DISKUS (07) SHAMPOO, SOAP (08) INJECTION (09) IV INJECTION (10) PATCHES (11) GEL OR JELLY (TOPICAL OR INTERNAL) (12) POWDER, GRANULES (91) OTHER (-8) Don't Know	(01)-(12) MED-PMSTRNFD (91) MED-PMFORMOS
PMFORMOS	MED	verbatim	[MEDICINE FORM OTHER SPECIFY]	(01) CONTINUOUS ANSWER	
PMFORMFN	MED	verbatim	[FINAL CONCATENATED MEDICINE FORM]		
PMSTRNFD	MED	verbatim	Medicine Strength	(01) [MEDICINE FORM SELECTED FROM LOOKUP] (-7) NOT FOUND (-8) DON'T KNOW	
STRNNUBB	MED	numeric	Medicine strength number	(01) CONTINUOUS ANSWER	
STRNUNIT	MED	code one	Medicine strength unit	(01) MICROGRAMS (mcg, mc) (02) MILLIGRAMS (mg) (03) GRAINS (gr) (04) MILLIEQUIVALENTS (meq) (05) GRAMS (g, gm) (06) PERCENT (%) (07) INTERNATIONAL UNITS (IU) (08) UNITS (U) (91) OTHER (-8) Don't Know (-9) Refused	(01)-(08) MED-PMEDID (91) MED-PMSTRNOS (-8) MED-PMEDID (-9) MED-PMEDID
PMSTRNOS	MED	verbatim	[MEDICINE STRENGTH UNIT OTHER SPECIFY]		
PMSTRUNI	MED	lookup	[FINAL CONCATENATED MEDICINE STRENGTH]		
PMEDID	MED	numeric	[THIS VARIABLE STORES THE UNIQUE IDENTIFIER FOR PRESCRIBED MEDICINES ADDED THROUGH THE LOOKUP. IT IS HIDDEN ON SCREEN.]		
FAMILYID	MED	numeric	[THIS VARIABLE STORES THE UNIQUE IDENTIFIER FOR PRESCRIBED MEDICINES BY NAME ONLY, EXCLUDING STRENGTH AND FORM, THROUGH THE LOOKUP. IT IS HIDDEN ON SCREEN.]		
PMKNWNM	PMKNWNM	code one	DOES THE RESPONDENT KNOW THE NAME OF THE MEDICINE?	(01) YES (02) NO (-9) REFUSED	(01) MED-PMEDNAME (02) PMCOND-PMCOND (-9) PMCOND-PMCOND

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
PMCOND	PMCOND	code one	What condition is this medicine prescribed for or what is its primary use? IF THIS MEDICINE IS TAKEN FOR MORE THAN ONE CONDITION, SELECT ONLY ONE.	(01) ALLERGY MEDICINE (02) ALZHEIMERS (03) ANTIBIOTICS (04) ANTIPSYCHOTIC (05) ASTHMA OR COPD (06) BLOOD PRESSURE (07) CHOLESTEROL (08) COUGH AND COLD MEDICINE (09) DEPRESSION (10) DIABETES (11) DIURETICS (WATER PILLS) (12) EAR DROPS (13) ESTROGEN (14) EYE DROPS OR PREPARATION (15) NASAL SPRAY/DROPS (16) OSTEOPOROSIS (BONE LOSS) (17) PAIN MEDICINE (18) STEROID (GLUCOCORTICOID) (19) STOMACH ACID OR ULCER (20) OTHER (-8) DON'T KNOW (-9) REFUSED	(01)-(19) GETNUM-GETNUM (20) PMCOND-PMCONDOS (-8) GETNUM-GETNUM (-9) GETNUM-GETNUM
PMCONDOS	PMCOND	verbatim	OTHER (SPECIFY)	(01) CONTINUOUS ANSWER (-8) DON'T KNOW (-9) REFUSED	
GETNUM	GETNUM	numeric	How many times [since (REFERENCE DATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)] did [(you/(SP))] obtain (MEDICINE NAME)]? [IF THE MEDICINE WAS ENTERED IN ERROR AND WAS NOT OBTAINED IN THE CURRENT ROUND, CHECK "ENTERED IN ERROR" AND LEAVE THE BOX BLANK WHERE YOU ENTER THE NUMBER OF REFILLS.]	(01) continuous answer (996) EVENT ENTERED IN ERROR (-8) Don't Know (-9) Refused	BOX PM5
	BOX PM5	routing	IF GETNUM=996/EVENT ENTERED IN ERROR OR PMKNWNM=02/NO OR SAMEFSAM=1/YES, GO TO PMMORE-PMMORE; ELSE IF MEDICINE FORM IS PILLS, TABLETS OR CAPSULES [PMFORMMC=1 OR PMFORMFD CONTAINS ("PILL", "TAB", "CAP")] GO TO TABNUM-TABNUM; ELSE GO TO PM16-AMTNUM.		
TABNUM	TABNUM	numeric	HOW MANY PILLS, TABLETS, OR CAPSULES WERE IN THE CONTAINER WHEN IT WAS OBTAINED?	(01) CONTINUOUS ANSWER (-8) DON'T KNOW	BOX PM6
AMTUNIT	PM16	quantity unit	HOW MUCH MEDICINE WAS IN THE CONTAINER WHEN IT WAS OBTAINED? [PLEASE ENTER THE AMOUNT IN THE CONTAINER, NOT THE STRENGTH OF THE MEDICINE.]	(01) OUNCES (oz) (02) GRAMS (g, gm) (03) MILLILITERS (ml, cc) (04) MILLIEQUIVALENTS (meq) (05) MILLIGRAMS (mg) (06) MICROGRAMS (mcg) (07) PUFFS, DOSES, BLISTERS (91) OTHER (-8) DON'T KNOW	(01) PM16 - AMTNUM (02) PM16 - AMTNUM (03) PM16 - AMTNUM (04) PM16 - AMTNUM (05) PM16 - AMTNUM (06) PM16 - AMTNUM (07) PM16 - AMTNUM (91) PM16 - AMTNUM (-8) BOX PM6
AMTUNOS	PM16	text	OTHER (SPECIFY)	(01) CONTINUOUS ANSWER	PM16 - AMTNUM
AMTNUM	PM16	numeric		(01) CONTINUOUS ANSWER	BOX PM6
	BOX PM6	routing	IF PRESCRIPTION MEDICINE FORM IS PILLS, TABLETS OR CAPSULES, GO TO PM12 - TABSADAY. ELSE GO TO BOX PM7.		
TABSADAY	PM12	numeric	HOW MANY PILLS, TABLETS, OR CAPSULES ARE PRESCRIBED TO BE TAKEN IN A DAY? IF LESS THAN ONE UNIT IS TO BE TAKEN PER DAY, ENTER THE APPROPRIATE DECIMAL VALUE (EX: HALF A PILL SHOULD BE ENTERED AS "0.5") FOR MEDICINES TO BE TAKEN "AS NEEDED," ENTER THE MAXIMUM AMOUNT THAT IS TO BE TAKEN IN A DAY AND SELECT "TAKE AS NEEDED". FOR MEDICINES TO BE TAKEN ON AN IRREGULAR SCHEDULE OR THAT VARY BY DAY, SELECT "OTHER DOSING INSTRUCTIONS". IF THE AMOUNT TO BE TAKEN PER DAY IS NOT CLEAR OR NOT INDICATED, SELECT "DON'T KNOW".	(01) CONTINUOUS ANSWER	PM12 - TABSADAY95
TABSADAY95	PM12	code one		(02) TAKE AS NEEDED (03) OTHER DOSING INSTRUCTIONS (-7) Empty	PM13-TABTAKE

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
TABTAKE	PM13	numeric	How many pills, tablets, or capsules (do/did/does) [you/(SP)] usually take in a day? [READ IF NECESSARY: This question is asking about how often you actually take the medicine, not how often the medicine is prescribed to be taken.] IF LESS THAN ONE UNIT IS TAKEN PER DAY, ENTER THE APPROPRIATE DECIMAL VALUE (EX: HALF A PILL SHOULD BE ENTERED AS "0.5") FOR MEDICINES TAKEN "AS NEEDED," SELECT "TAKE AS NEEDED". FOR MEDICINES TAKEN ON AN IRREGULAR SCHEDULE OR THAT VARY BY DAY, SELECT "OTHER DOSING INSTRUCTIONS".	(01) CONTINUOUS ANSWER (-7) EMPTY (-8) DON'T KNOW	PM13 - TABTAKE96
TABTAKE96	PM13	code one		(01) DON'T TAKE EVERY DAY (02) TAKE AS NEEDED (03) OTHER DOSING INSTRUCTIONS (-7) EMPTY	BOX PM7
	BOX PM7	routing	IF (SP REPORTED RECEIVING HEALTH CARE SERVICES THROUGH V.A. IN THE CURRENT ROUND OR ANY PREVIOUS ROUND), GO TO PMSATVA - PMSATVA. ELSE GO TO BOX PM8.		
PMSATVA	PMSATVA	yes/no	Did [you/(SP)] obtain (this purchase/any of these purchases) of (MEDICINE NAME) through the Department of Veterans Affairs or V.A.?	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED	BOX PM8
	BOX PM8	routing	IF SP COVERED BY A MEDICARE MANAGED CARE PLAN OR A PRIVATE MANAGED CARE PLAN ANYTIME DURING THE CURRENT ROUND, GO TO PMSATHMO - PMSATHMO. ELSE GO TO PMMORE-PMMORE.		
PMSATHMO	PMSATHMO	yes/no	Did [you/(SP)] obtain (this purchase/any of these purchases) of (MEDICINE NAME) at [READ MANAGED CARE PLAN NAME(S) BELOW] or through a service or discount offered through [READ MANAGED CARE PLAN NAME(S) BELOW]? [PROBE: This could include obtaining the purchases at a plan pharmacy; at a pharmacy that honors [your/(SP's)] plan card; or through a mail order service that the managed care plan referred [you/(SP)] to.] ([NO MEDICINES HAVE BEEN REPORTED FOR (SP) FOR THE CURRENT REFERENCE PERIOD/THE NAMES OF ALL MEDICINES REPORTED FOR THE CURRENT REFERENCE PERIOD ARE DISPLAYED BELOW.]	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED	PMMORE-PMMORE
PMMORE	PM17	yes/no	[REVIEW THE INFORMATION BELOW WITH THE RESPONDENT. ASK, OR CODE AS APPROPRIATE IF R ALREADY INDICATED: Are there any (more) medicines since (REFERENCE DATE/UTILDATE) that we haven't talked about?]	(01) ADD ANOTHER (02) ALL DONE	(01) BOX PM2 (02) BOX HU4
	BOX HU4	routing	IF ANOTHER EVENT WAS ADDED WITH THIS PROVIDER, GO TO HU7-HUPROCDR. ELSE GO TO HU14-HUMORE.		
HUMORE	HU14	yes/no	[Since (REFERENCE DATE/UTILDATE)/Between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)], did [you/(SP)] have any other hearing care visits to this or any other provider?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HU2 - PROVIDER_HU (02) HU15-OMHEARAD (-8) HU15-OMHEARAD (-9) HU15-OMHEARAD
OMHEARAD	HU15	yes/no	Next I'm going to ask you about other medical expenses related to hearing care that [you/(SP)] may have had [between (REFERENCE DATE/SURVEY REFERENCE DATE/UTILDATE) and (today/(DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD))]. [Since (REFERENCE DATE/SURVEY REFERENCE DATE/UTILDATE)/Between (REFERENCE DATE/SURVEY REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)], did [you/(SP)] buy, replace, or pay for repairs of a hearing aid? [Please include the purchases you made during the visit(s) to hearing care provider on (EVENT DATES) that you just told me about.] [DO NOT INCLUDE HEARING AID BATTERIES AT THIS QUESTION. ENTER HEARING AID BATTERIES IN THE OMQ AS A HEARING/SPEECH DEVICE.]	(01) YES (02) NO (03) INDICATED YES BY DATAPREP (-8) Don't Know (-9) Refused	(01) HU16-INTECANL (02) BOX HU9 (03) DO NOT DISPLAY. (-8) BOX HU9 (-9) BOX HU9

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
INTHCANL	HU16	list	<p>SHOW CARD DVH4</p> <p>What type of hearing aid(s) did [you/(SP)] buy or repair?</p> <p>[IF NEEDED: Were they for [your/(SP's)] left ear, right ear, or both?]</p> <p>PLEASE USE THE DVH JOB AID 1 TO HELP PROBE THE RESPONDENT FOR THE PROPER HEARING AID TYPE.</p> <p>FOR EACH DATE, CHECK ALL THAT APPLY. THE DATE WILL BE ENTERED ON THE NEXT SCREEN.</p> <p>In the canal hearing aid</p>	(01) LEFT EAR (02) RIGHT EAR	HU16-INTHEEAR
INTHEEAR	HU16	list	In the ear hearing aid	(01) LEFT EAR (02) RIGHT EAR	HU16-BHNDEAR
BHNDEAR	HU16	list	Behind the ear hearing aid	(01) LEFT EAR (02) RIGHT EAR	HU17-EVENT_OMHRAD
EVENT_OMHRAD	HU17	roster	<p>SELECT OR ADD ALL DATES AT THIS ROSTER.</p> <p>When did [you/(SP)] buy or repair the (HEARING AID ITEM)?</p> <p>Please tell me the dates of each purchase or repair [since (REFERENCE DATE/SURVEY REFERENCE DATE/UTILDATE)/between (REFERENCE DATE/SURVEY REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)].</p>	(01) continuous answer (-8) Don't Know (-9) Refused MM: DD: YYYY:	HU18-OMADD
OMADD	HU18	code one	<p>In addition to the medical expenses related to hearing care you just told me about, did [you/(SP)] buy, replace, or pay for repairs for any other hearing aids? [since (REFERENCE DATE/SURVEY REFERENCE DATE/UTILDATE)/between (REFERENCE DATE/SURVEY REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)]?</p> <p>[DISPLAY ALL EVENTS ENTERED]</p>	(01) ADD ANOTHER (02) ALL DONE	(01) HU16- INTHCANL (02) BOX HU6
	BOX HU6	routing	IF SP COVERED BY AN MEDICARE MANAGED CARE PLAN OR PRIVATE MANAGED CARE PLAN ANYTIME DURING THE CURRENT ROUND, GO TO HU19-OMSATHMO. ELSE GO TO BOX HU8.		
OMSATHMO	HU19	yes/no	<p>On (EVENT DATE), did [you/(SP)] buy or repair the hearing aid at [READ MANAGED CARE PLAN NAME(S) BELOW] or through a service or discount offered through [READ MANAGED CARE PLAN NAME(S) BELOW]?</p> <p>[PROBE: This could include buying or repairing the hearing aid at a plan center; from an audiologist, or other provider that honors [your/(SP's)] plan card; or through a place or service that the plan referred [you/(SP)] to.]</p>	(01) YES (02) NO (-8) Don't Know (-9) Refused	BOX HU8
	BOX HU8	routing	IF ADMINISTERING ST, GO TO BOX ST36. ELSE IF ADMINISTERING NS, GO TO BOX NS36. ELSE GO TO BOX HU9.		
	BOX HU9	routing	IF SPALIVE=1 (ALIVE) HU20-HVNEED. ELSE GO TO BOX HU10.		
HVNEED	HU20	yes/no	Since (REFERENCE DATE), was there a time when {you/SP} needed hearing care but could not get it at that time?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HU21- HVNDRS (02) BOX HU10 (-8) BOX HU10 (-9) BOX HU10
HVNDRS	HU21	code all	What were the reasons that {you/SP} could not get the hearing care {you/she/he} needed?	(01) COULD NOT AFFORD THE COST (02) DID NOT WANT TO SPEND THE MONEY (03) INSURANCE DID NOT COVER RECOMMENDED PROCEDURES (04) DOCTOR'S OFFICE IS TOO FAR AWAY (05) DOCTOR'S OFFICE IS NOT OPEN AT CONVENIENT TIMES (06) ANOTHER DOCTOR RECOMMENDED NOT DOING IT (07) AFRAID OR DO NOT LIKE DOCTORS (08) UNABLE TO TAKE TIME OFF FROM WORK (09) TOO BUSY (10) I DID NOT THINK ANYTHING SERIOUS WAS WRONG/EXPECTED PROBLEMS TO GO AWAY (91) OTHER (SPECIFY) (-8) DON'T KNOW (-9) REFUSED	(01) BOX HU10 (02) BOX HU10 (03) BOX HU10 (04) BOX HU10 (05) BOX HU10 (06) BOX HU10 (07) BOX HU10 (08) BOX HU10 (09) BOX HU10 (10) BOX HU10 (91) HU16A - HVNDRSOS (-8) BOX HU10 (-9) BOX HU10
HVNDRSOS	HU21A	verbatim text	WHAT OTHER REASON (SPECIFY)	(01) continuous answer	BOX HU10

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
	BOX HU10	routing	GO TO EMERGENCY ROOM UTILIZATION (ERQ).		