# Disability

ERROR! You must complete the enrollment form and the visit form before you can start this form.

Date of Disability form collection: _____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

**Before [stem_your]:**

| | Yes | No | Prefer not to answer |
|---|---|---|---|
| Were you deaf, or did you have serious difficulty hearing? | ○ | ○ | ○ |
| Were you blind, or did you have serious difficulty seeing, even when wearing glasses? | ○ | ○ | ○ |
| Because of a physical, mental, or emotional condition, did you have serious difficulty concentrating, remembering, or making decisions? | ○ | ○ | ○ |
| Did you have serious difficulty walking or climbing stairs? | ○ | ○ | ○ |
| Did you have difficulty dressing or bathing? | ○ | ○ | ○ |
| Because of a physical, mental, or emotional condition, did you have difficulty doing errands alone such as visiting a doctor's office or shopping? | ○ | ○ | ○ |