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HCHS/SOL Oral Health Questionnaire

ID NUMBER:

FORM CODE: OHE
VERSION: A 7/09/07

Contact Occasion

SEQ #

Acrostic: _____

ADMINISTRATIVE INFORMATION

0a. Completion Date: / /
Month Day Year

0b. Staff ID:

Instructions: For each question, mark the appropriate response. Unless instructed, mark **ONLY** one response.

A. Natural Teeth

1. Do you have any of your natural teeth?

No 0 → **GO TO QUESTION 10**
Yes 1

2. How often do you limit the kinds or amounts of food you eat because of problems with your teeth?
Would you say:

Always 1
Very often 2
Often 3
Sometimes 4
Seldom 5
Never 6
Refused 7
Don't know 9

3. In the past 12 months have you had or do you currently have:

	No	Yes
a. Pain in a tooth or teeth	0 <input type="checkbox"/>	1 <input type="checkbox"/>
b. Bleeding gums	0 <input type="checkbox"/>	1 <input type="checkbox"/>
c. Pain in your face	0 <input type="checkbox"/>	1 <input type="checkbox"/>
d. Pain in your jaw joint	0 <input type="checkbox"/>	1 <input type="checkbox"/>
e. Sores in your mouth	0 <input type="checkbox"/>	1 <input type="checkbox"/>
f. Difficulty chewing	0 <input type="checkbox"/>	1 <input type="checkbox"/>
g. Difficulty tasting	0 <input type="checkbox"/>	1 <input type="checkbox"/>
h. Difficulty swallowing	0 <input type="checkbox"/>	1 <input type="checkbox"/>
i. Bad breath	0 <input type="checkbox"/>	1 <input type="checkbox"/>
j. Bad taste in mouth	0 <input type="checkbox"/>	1 <input type="checkbox"/>
k. Dry mouth when you eat	0 <input type="checkbox"/>	1 <input type="checkbox"/>
l. Dry mouth when you sleep	0 <input type="checkbox"/>	1 <input type="checkbox"/>
m. Other (non toothache) pain in your mouth	0 <input type="checkbox"/>	1 <input type="checkbox"/>

4. Do you think or believe that you are currently in need of dental treatment?

No 0 → **GO TO QUESTION 6**
Yes 1

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5. What type of dental care do you need now? (Mark all that apply)

- a. Cleaning or checkup
- b. Teeth filled or replaced (for example, fillings, crowns, and/or bridges)
- c. Teeth pulled
- d. Gum treatment
- e. New or replace denture(s)
- f. Denture repaired
- g. Relief of pain
- h. Work to improve appearance (for example, braces, bonding, or whitening)
- i. Other
- If other, please specify:* _____
- j. Don't know

6. About how long has it been since you last visited a dentist? Include all types of dentists, such as, orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists. (Mark only one)

- 6 months or less → **GO TO QUESTION 8**
- More than 6 months, but not more than 1 year ago → **GO TO QUESTION 8**
- More than 1 year, but not more than 2 years ago
- More than 2 years ago, but not more than 3 years ago
- More than 3 years, but not more than 5 years ago
- More than 5 years ago
- Never have been
- Refused
- Don't know

7. What are the reasons you have not visited the dentist in over 12 months/never gone to the dentist? (Mark all that apply)

- a. Afraid
- b. Nervous
- c. Needles
- d. Cost
- e. Don't know dentist
- f. Dentist too far
- g. Can't find a dentist who speaks Spanish
- h. Can't get there
- i. No problems
- j. No teeth
- k. Not important
- l. Didn't think of it
- m. Other
- If other, please specify:* _____
- n. Don't know

8. Have you ever had a test {/exam} for oral or mouth cancer in which the doctor or dentist, pulls on your tongue, sometimes with gauze wrapped around it, and feels under the tongue and inside the cheeks?

- I think so
- Yes
- No → **GO TO QUESTION 18**
- Don't know, not sure → **GO TO QUESTION 18**

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Contact
Occasion

		SEQ #		
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9. When did you have your most recent oral or mouth cancer exam?

- Within past year 1
 Between 1 and 3 years ago 2
 Over 3 years ago 3

GO TO SECTION C, QUESTION 18

B. Edentulous Questions

10. How often do you limit the kinds or amounts of food you eat because of problems with your dentures?

Would you say:

- Always 1
 Very often 2
 Often 3
 Sometimes 4
 Seldom 5
 Never 6
 Refused 7
 Don't know 9

11. In the past 12 months have you had or do you currently have:

- | | No | Yes |
|---|----------------------------|----------------------------|
| a. Bleeding gums | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| b. Pain in your face | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| c. Pain in your jaw joint | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| d. Sores in your mouth | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| e. Difficulty chewing | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| f. Difficulty tasting | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| g. Difficulty swallowing | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| h. Bad breath | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| i. Bad taste in mouth | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| j. Dry mouth when you eat | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| k. Dry mouth when you sleep | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| l. Other (non toothache) pain in your mouth | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |

12. Do you think or believe that you are currently in need of dental treatment?

- No 0 → **GO TO QUESTION 14**
 Yes 1

13. What type of dental care do you need now? (Mark all that apply)

- a. Gum treatment
 b. New or replace denture(s)
 c. Denture repaired
 d. Relief of pain
 e. Other
 f. Don't know

If other, please specify: _____

14. About how long has it been since you last visited a dentist? Include all types of dentists. (Mark only one)

- | | | | | |
|--|---|--------------------------|---|--------------------------|
| 6 months or less | 1 | <input type="checkbox"/> | → | GO TO QUESTION 16 |
| More than 6 months, but not more than 1 year ago | 2 | <input type="checkbox"/> | → | GO TO QUESTION 16 |
| More than 1 year, but not more than 2 years ago | 3 | <input type="checkbox"/> | | |
| More than 2 years, but not more than 3 years ago | 4 | <input type="checkbox"/> | | |
| More than 3 years, but not more than 5 years ago | 5 | <input type="checkbox"/> | | |
| More than 5 years ago | 6 | <input type="checkbox"/> | | |
| Never have been | 7 | <input type="checkbox"/> | | |
| Refused | 8 | <input type="checkbox"/> | | |
| Don't know | 9 | <input type="checkbox"/> | | |

15. What are the reasons you have not visited the dentist in over 12 months/never gone to the dentist? (Mark all that apply)

- | | |
|--|--------------------------|
| a. Afraid | <input type="checkbox"/> |
| b. Nervous | <input type="checkbox"/> |
| c. Needles | <input type="checkbox"/> |
| d. Cost | <input type="checkbox"/> |
| e. Don't know dentist | <input type="checkbox"/> |
| f. Dentist too far | <input type="checkbox"/> |
| g. Can't find a dentist who speaks Spanish | <input type="checkbox"/> |
| h. Can't get there | <input type="checkbox"/> |
| i. No problems | <input type="checkbox"/> |
| j. No teeth | <input type="checkbox"/> |
| k. Not important | <input type="checkbox"/> |
| l. Didn't think of it | <input type="checkbox"/> |
| m. Other | <input type="checkbox"/> |
| <i>If other, please specify:</i> _____ | |
| n. Don't know | <input type="checkbox"/> |

16. Have you ever had a test {/exam} for oral or mouth cancer in which the doctor or dentist, pulls on your tongue, sometimes with gauze wrapped around it, and feels under the tongue and inside the cheeks?

- | | | | | |
|----------------------|---|--------------------------|---|--------------------------|
| I think so | 1 | <input type="checkbox"/> | | |
| Yes | 2 | <input type="checkbox"/> | | |
| No | 3 | <input type="checkbox"/> | → | GO TO QUESTION 18 |
| Don't know, not sure | 9 | <input type="checkbox"/> | → | GO TO QUESTION 18 |

17. When did you have your most recent oral or mouth cancer exam?

- | | | |
|---------------------------|---|--------------------------|
| Within past year | 1 | <input type="checkbox"/> |
| Between 1 and 3 years ago | 2 | <input type="checkbox"/> |
| Over 3 years ago | 3 | <input type="checkbox"/> |

C. Problem with Teeth, Mouth, or Dentures

18. During the past month have you had difficulty doing your usual jobs or attending school because of problems with your teeth, mouth or dentures?

- | | | |
|------------|---|--------------------------|
| Always | 1 | <input type="checkbox"/> |
| Very often | 2 | <input type="checkbox"/> |
| Often | 3 | <input type="checkbox"/> |
| Sometimes | 4 | <input type="checkbox"/> |
| Seldom | 5 | <input type="checkbox"/> |
| Never | 6 | <input type="checkbox"/> |
| Refused | 7 | <input type="checkbox"/> |
| Don't know | 9 | <input type="checkbox"/> |