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OMB#: 0925-0584
Exp.2/28/2011

HCHS/SOL Oral Health Questionnaire

ID NUMBER:

FORM CODE: OHE
VERSION: A 9/07/07

Contact Occasion

SEQ #

Acrostic: _____

ADMINISTRATIVE INFORMATION

0a. Completion Date: / /
Month Day Year

0b. Staff ID:

Instructions: Enter the answer given by the participant for each response. The special value, "Q", is allowed for cases where the response 'Don't know/refused' is not listed as an option.

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?

- | | No | Yes |
|---|----------------------------|----------------------------|
| a. Cleaning or checkup | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| b. Teeth filled or replaced (for example, fillings, crowns, and/or bridges) | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| c. Teeth pulled | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| d. Gum treatment | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| e. New or replace denture(s) | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| f. Denture repaired | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| g. Relief of pain | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| h. Work to improve appearance (for example, braces, bonding, or whitening) | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| i. Other | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| <i>If other, please specify: _____</i> | | |
| j. Don't know | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |

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 | 1 <input type="checkbox"/> | → GO TO QUESTION 8 |
| More than 6 months, but not more than 1 year ago | 2 <input type="checkbox"/> | → GO TO QUESTION 8 |
| More than 1 year, but not more than 2 years ago | 3 <input type="checkbox"/> | |
| More than 2 years ago, 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"/> | |

7. What are the reasons you have not visited the dentist in over 12 months/never gone to the dentist?

- | | No | Yes |
|--|----------------------------|----------------------------|
| a. Afraid | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| b. Nervous | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| c. Needles | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| d. Cost | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| e. Don't know dentist | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| f. Dentist too far | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| g. Can't find a dentist who speaks Spanish | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| h. Can't get there | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| i. No problems | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| j. No teeth | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| k. Not important | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| l. Didn't think of it | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| m. Other | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| <i>If other, please specify: _____</i> | | |
| n. Don't know | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |

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 | 0 <input type="checkbox"/> | |
| Yes | 1 <input type="checkbox"/> | |
| No | 2 <input type="checkbox"/> | → GO TO QUESTION 18 |
| Don't know, not sure | 9 <input type="checkbox"/> | → GO TO QUESTION 18 |

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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?

- | | No | Yes |
|--|----------------------------|----------------------------|
| a. Gum treatment | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| b. New or replace denture(s) | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| c. Denture repaired | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| d. Relief of pain | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| e. Other | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| <i>If other, please specify: _____</i> | | |
| f. Don't know | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |

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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?

- | | No | Yes |
|--|----------------------------|----------------------------|
| a. Afraid | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| b. Nervous | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| c. Needles | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| d. Cost | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| e. Don't know dentist | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| f. Dentist too far | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| g. Can't find a dentist who speaks Spanish | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| h. Can't get there | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| i. No problems | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| j. No teeth | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| k. Not important | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| l. Didn't think of it | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| m. Other | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| <i>If other, please specify:</i> _____ | | |
| n. Don't know | 0 <input type="checkbox"/> | 1 <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"/> |