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 ☐	1 ☐
b. Bleeding gums	0 ☐	1 ☐
c. Pain in your face	0 ☐	1 ☐
d. Pain in your jaw joint	0 ☐	1 ☐
e. Sores in your mouth	0 ☐	1 ☐
f. Difficulty chewing	0 ☐	1 ☐
g. Difficulty tasting	0 ☐	1 ☐
h. Difficulty swallowing	0 ☐	1 ☐
i. Bad breath	0 ☐	1 ☐
j. Bad taste in mouth	0 ☐	1 ☐
k. Dry mouth when you eat	0 ☐	1 ☐
l. Dry mouth when you sleep	0 ☐	1 ☐
m. Other (non toothache) pain in your mouth	0 ☐	1 ☐

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

No 0 ☐ → **GO TO QUESTION 6**
Yes 1 ☐

5. What type of dental care do you need now?

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

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 ☐	→ **GO TO QUESTION 8**
More than 6 months, but not more than 1 year ago	2 ☐	→ **GO TO QUESTION 8**
More than 1 year, but not more than 2 years ago	3 ☐	
More than 2 years ago, but not more than 3 years ago	4 ☐	
More than 3 years, but not more than 5 years ago	5 ☐	
More than 5 years ago	6 ☐	
Never have been	7 ☐	
Refused	8 ☐	
Don't know	9 ☐	

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 ☐	1 ☐
b. Nervous	0 ☐	1 ☐
c. Needles	0 ☐	1 ☐
d. Cost	0 ☐	1 ☐
e. Don't know dentist	0 ☐	1 ☐
f. Dentist too far	0 ☐	1 ☐
g. Can't find a dentist who speaks Spanish	0 ☐	1 ☐
h. Can't get there	0 ☐	1 ☐
i. No problems	0 ☐	1 ☐
j. No teeth	0 ☐	1 ☐
k. Not important	0 ☐	1 ☐
l. Didn't think of it	0 ☐	1 ☐
m. Other *If other, please specify:* _____	0 ☐	1 ☐
n. Don't know	0 ☐	1 ☐

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 ☐	
Yes	1 ☐	
No	2 ☐	→ **GO TO QUESTION 18**
Don't know, not sure	9 ☐	→ **GO TO QUESTION 18**

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 ☐	1 ☐
b. Pain in your face	0 ☐	1 ☐
c. Pain in your jaw joint	0 ☐	1 ☐
d. Sores in your mouth	0 ☐	1 ☐
e. Difficulty chewing	0 ☐	1 ☐
f. Difficulty tasting	0 ☐	1 ☐
g. Difficulty swallowing	0 ☐	1 ☐
h. Bad breath	0 ☐	1 ☐
i. Bad taste in mouth	0 ☐	1 ☐
j. Dry mouth when you eat	0 ☐	1 ☐
k. Dry mouth when you sleep	0 ☐	1 ☐
l. Other (non toothache) pain in your mouth	0 ☐	1 ☐

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 ☐	1 ☐
b. New or replace denture(s)	0 ☐	1 ☐
c. Denture repaired	0 ☐	1 ☐
d. Relief of pain	0 ☐	1 ☐
e. Other	0 ☐	1 ☐
*If other, please specify:*_____		
f. Don't know	0 ☐	1 ☐

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 ☐	→ **GO TO QUESTION 16**
More than 6 months, but not more than 1 year ago	2 ☐	→ **GO TO QUESTION 16**
More than 1 year, but not more than 2 years ago	3 ☐	
More than 2 years, but not more than 3 years ago	4 ☐	
More than 3 years, but not more than 5 years ago	5 ☐	
More than 5 years ago	6 ☐	
Never have been	7 ☐	
Refused	8 ☐	
Don't know	9 ☐	

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

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 ☐	
Yes	2 ☐	
No	3 ☐	→ **GO TO QUESTION 18**
Don't know, not sure	9 ☐	→ **GO TO QUESTION 18**

17. 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 ☐

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