ORAL HEALTH - OHQ

OHQ.010  Now I have some questions about (your/SP's) mouth and teeth.

How would you describe the condition of (your/SP's) mouth and teeth? Would you say . . .

INCLUDE FALSE TEETH AND DENTURES

very good, ............................... 1
good, ................................. 2
fair, or ................................ 3
poor? ................................. 4
REFUSED ................................ 7
DON'T KNOW ........................... 9

CHECK ITEM OHQ.015:
IF SP'S AGE >= 18, CONTINUE.
OTHERWISE, GO TO OHQ.030.

OHQ.020  How often (do you/does SP) limit the kinds or amounts of food (you/s/he) eat(s) because of problems with (your/his/her) teeth or dentures? Would you say . . .

always, ............................... 1
very often, ............................ 2
often, ................................. 3
sometimes, ........................... 4
seldom, or ............................ 5
never? ............................... 6
REFUSED ............................. 7
DON'T KNOW .......................... 9

OHQ.030  About how long has it been since (you/SP) last visited a dentist? Include all types of dentists, such as, orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists.

6 MONTHS OR LESS .......................... 1
MORE THAN 6 MONTHS, BUT NOT MORE THAN 1 YEAR AGO .......................... 2
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 (END OF SECTION)
REFUSED ................................. 77
DON'T KNOW ............................. 99
OHQ.033 What was the main reason (you/SP) last visited the dentist?

WENT IN ON OWN FOR CHECK-UP, EXAMINATION OR CLEANING ........... 1
WAS CALLED IN BY THE DENTIST FOR CHECK-UP, EXAMINATION OR CLEANING ........................................... 2
SOMETHING WAS WRONG, BOTHERING OR HURTING (ME/SP) ..... 3
WENT FOR TREATMENT OF A CONDITION THAT DENTIST DISCOVERED AT EARLIER CHECK-UP OR EXAMINATION .................. 4
OTHER ........................................................................ 5
REFUSED .................................................................... 7
DON'T KNOW ............................................................ 9

BOX 2

CHECK ITEM OHQ.035:
IF OHQ.030 = 5 OR 6, GO TO OHQ.060.
OTHERWISE, CONTINUE WITH BOX 3.

BOX 3

CHECK ITEM OHQ.037:
IF OHQ.033 = 1 OR 2, GO TO OHQ.050.
OTHERWISE, CONTINUE WITH OHQ.040.

OHQ.040 During the past 3 years, (have/has) (you/SP) been to the dentist for routine check-ups or cleanings?

YES ......................................................... 1
NO ..................................................... 2 (OHQ.060)
REFUSED ................................................... 7 (OHQ.060)
DON'T KNOW ................................. 9 (OHQ.060)

OHQ.050 During the past 3 years, how often (have you/has SP) gone to the dentist for routine check-ups or cleanings?

HAND CARD OHQ1

2 OR MORE TIMES A YEAR .............. 1
ONCE A YEAR ............................... 2
LESS THAN ONCE A YEAR ........... 3
WHENEVER NEEDED, NO REGULAR SCHEDULE ......................... 4
REFUSED ........................................... 7
DON'T KNOW ................................. 9

OHQ.060 Is there a particular dentist or dental clinic that (you/SP) usually (go/goes) to if (you/he/she) need(s) dental care or dental advice?

YES ......................................................... 1
NO ..................................................... 2 (END OF SECTION)
OHQ.070  For how long has this been your/SP’s regular source of dental care?

|___|___|___|
ENTER NUMBER (OF DAYS, WEEKS, MONTHS OR YEARS)

REFUSED ........................... 777
DON’T KNOW .......................... 999

ENTER UNIT

DAYS ............................ 1
WEEKS ............................ 2
MONTHS ............................ 3
YEARS ............................ 4
REFUSED ............................ 7
DON’T KNOW .......................... 9

BOX 4

CHECK ITEM OHQ.075:
IF SP AGE >= 40, CONTINUE.
OTHERWISE, GO TO END OF SECTION.

OHQ.080  (Do you/Does SP) sip liquids to aid in swallowing any foods?

YES .............................. 1
NO .............................. 2
REFUSED ............................ 7
DON’T KNOW .......................... 9

OHQ.090  Does the amount of saliva in your/SP’s mouth seem to be too little, too much, or (do you/does s/he) not notice it?

TOO LITTLE ............................ 1
TOO MUCH ............................. 2
DOESN’T NOTICE IT ..................... 3
REFUSED ............................. 7
DON’T KNOW .......................... 9

OHQ.100  (Do you/Does SP) have difficulties swallowing any foods?

YES .............................. 1
NO .............................. 2
REFUSED ............................ 7
DON’T KNOW .......................... 9

OHQ.110  Does your/SP’s mouth feel dry when you/s/he eat(s) a meal?

YES .............................. 1
NO .............................. 2
REFUSED ............................ 7
DON'T KNOW ...................... 9