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

BOX 1

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
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
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 (BOX 4)
REFUSED ............................................... 7 (BOX 4)
DON'T KNOW ........................................... 9 (BOX 4)

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 >= 18, 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?
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