

**N. DENTAL CARE PAGE**

**PERSON 1**

*Hand calendar.* These next questions are about dental care received during the 2 weeks outlined in red on that calendar.

- 1 a.** DURING THOSE 2 WEEKS, did anyone in the family go to a dentist? Include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists.  Yes  No (3)
- b.** Who was this? Mark "Dental visit" box in person's column.
- c.** During those 2 weeks, did anyone else in the family go to a dentist?  Yes (Reask 1b and c)  No
- d.** Ask for each person with "Dental visit" in 1b: During those 2 weeks, how many times did -- go to a dentist?

**1b.**  Dental visit 5

**d.**  Number 6-7

**N1** Refer to "Dental visit" in 1b.

**N1**  "Dental visit" marked in 1b (N2) 8  
 Other (NP)

**N2** Refer to age.

**N2**  Under 17 (2) 9  
 17 and over, available (2)  
 17 and over, callback required (NP)

Complete a separate column for each 2-week dental visit.

**2a.** (Earlier I was told -- went to the dentist during the 2 week period beginning Monday, (date) and ending Sunday, (date).) (Now I am going to read a list of dental services.)

When -- went to the dentist ((the last time/the time before that)), did -- have:

- A. An x-ray taken?
- B. A tooth filled?
- C. A tooth pulled?
- D. Any other oral surgery?
- E. A fluoride treatment?
- F. Teeth cleaned?
- G. Teeth straightened, that is, orthodontia?
- H. Treatment for gums?
- I. Work done on a complete denture?
- J. Work done on a partial denture?
- K. Work done on a bridge?
- L. Work done on a crown or cap?
- M. Work done on a root canal?
- N. An examination?
- O. Something else done? (Specify for appropriate visit, THEN reask O)

**b.** During that visit, did -- see a regular dentist or a dental specialist?

Ask only if "Dental specialist" in 2b:

**c.** What kind of dental specialist did -- see?

**d.** How long did it take for -- to get to this dentist this time?

	1	2	3		
A.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-ray	10
B.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Filled	11-12
C.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pulled	13
D.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oral surgery	14
E.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fluoride	15
F.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cleaned	16
G.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Straightened	17-18
H.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gums	19-20
I.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Complete denture	21-22
J.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Partial denture	23-24
K.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bridge	25-26
L.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crown or cap	27
M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Root canal	28-29
N.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Examination	30
O.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(Specify, THEN reask O)	31

Visit 1 \_\_\_\_\_  
 Visit 2 \_\_\_\_\_  
 Visit 3 \_\_\_\_\_

**b.**

1	2	3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

 Regular dentist 32-33  
 Dental specialist 34-35  
36-45

**c.** Visit 1 \_\_\_\_\_  
 Visit 2 \_\_\_\_\_  
 Visit 3 \_\_\_\_\_

**d.** Visit 1 \_\_\_\_\_ Minutes 46-75  
 Visit 2 \_\_\_\_\_ Minutes  
 Visit 3 \_\_\_\_\_ Minutes

**N3** Review 1d for additional visits for this person. If additional visits, reask 2a-d for each visit.

**N3**  Self Resp. 76  
 Proxy (Footnote reason if 17 and over)

N. DENTAL CARE PAGE, Continued		PERSON 1	
<p>Mark box if "One year old or under 1."</p> <p><b>3a. During the past 12 months (that is, since (12-month date) a year ago) about how many visits did -- make to a dentist? (Include the (number in 1d) visit(s) you already told me about.)</b></p> <p>Mark "2-week dental visit" box in person's column if visit(s) reported in 1d.</p> <p><b>b. ABOUT how long has it been since -- LAST went to a dentist?</b></p>		<p><b>3a.</b> 998 <input type="checkbox"/> One year old or under 1 (NP) <span style="float: right;">77-79</span></p> <p>_____ Visits</p> <p>000 <input type="checkbox"/> None</p> <p><b>b.</b> 1 <input type="checkbox"/> Past 2 weeks not reported (Reask 1) <span style="float: right;">80</span></p> <p>2 <input type="checkbox"/> 2-week dental visit</p> <p>3 <input type="checkbox"/> Over 2 weeks, less than 6 months</p> <p>4 <input type="checkbox"/> 6 months, less than 1 year</p> <p>5 <input type="checkbox"/> 1 year, less than 2 years</p> <p>6 <input type="checkbox"/> 2 years, less than 5 years</p> <p>7 <input type="checkbox"/> 5 years or more</p> <p>0 <input type="checkbox"/> Never</p>	
<p><b>4a. Does anyone in the family use toothpaste with fluoride?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (5) <input type="checkbox"/> DK (5)</p> <p><b>b. Who is this?</b> Mark "Toothpaste" box in person's column.</p> <p><b>c. Anyone else?</b> <input type="checkbox"/> Yes (Reask 4b and c) <input type="checkbox"/> No</p>		<p><b>4b.</b> 1 <input type="checkbox"/> Toothpaste <span style="float: right;">81</span></p>	
<p><b>5a. Does anyone in the family use fluoride drops, tablets, or any other fluoride supplements which are swallowed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (6) <input type="checkbox"/> DK (6)</p> <p><b>b. Who is this?</b> Mark "Fluoride supplements" box in person's column.</p> <p><b>c. Anyone else?</b> <input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No</p>		<p><b>5b.</b> 1 <input type="checkbox"/> Fluoride supplements <span style="float: right;">82</span></p>	
<p><b>6a. Does anyone in the family use a fluoride mouth rinse which is NOT swallowed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (7) <input type="checkbox"/> DK (7)</p> <p><b>b. Who is this?</b> Mark "Fluoride mouth rinse" box in person's column.</p> <p><b>c. Anyone else?</b> <input type="checkbox"/> Yes (Reask 6b and c) <input type="checkbox"/> No</p>		<p><b>6b.</b> 1 <input type="checkbox"/> Fluoride mouth rinse <span style="float: right;">83</span></p>	
<p><b>7a. Is there anyone in the family who has lost ALL of his or her teeth?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (NEXT PAGE)</p> <p><b>b. Who is this?</b> Mark "Lost all teeth" box in person's column.</p> <p><b>c. Anyone else?</b> <input type="checkbox"/> Yes (Reask 7b and c) <input type="checkbox"/> No</p>		<p><b>7b.</b> 1 <input type="checkbox"/> Lost all teeth <span style="float: right;">84</span></p>	
<p>Ask 8a-f as appropriate for each person with "Lost all teeth" in 7b.</p> <p><b>8a. Does -- have false teeth?</b></p> <p><b>b. Does -- have an upper plate, a lower plate, or both?</b></p> <p><b>c. Does -- usually wear -- plate(s) while eating?</b></p> <p><b>d. Does -- usually wear -- plate(s) when not eating?</b></p> <p><b>e. Does -- need new false teeth?</b></p> <p><b>f. Do the ones -- has need refitting?</b></p>		<p><b>8a.</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP) <span style="float: right;">85</span></p> <p><b>b.</b> 1 <input type="checkbox"/> Upper 3 <input type="checkbox"/> Both <span style="float: right;">86</span></p> <p>2 <input type="checkbox"/> Lower</p> <p><b>c.</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No <span style="float: right;">87</span></p> <p><b>d.</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No <span style="float: right;">88</span></p> <p><b>e.</b> 1 <input type="checkbox"/> Yes (NP) 2 <input type="checkbox"/> No <span style="float: right;">89</span></p> <p><b>f.</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No <span style="float: right;">90</span></p>	