

Section R – OROFACIAL PAIN

RT 73

3-4

CHECK ITEM 1	Status of sample person.	0 <input type="checkbox"/> No person 18+ in family (Cover page of HIS-1A) 1 <input type="checkbox"/> Available (Intro) 2 <input type="checkbox"/> Callback required (Hhhd page of HIS-1) 3 <input type="checkbox"/> Noninterview (Section T)	5
INTRO These next questions concern conditions of the teeth, mouth, or face. Tell me if you experienced any of these conditions MORE THAN ONCE in the past 6 months.			
CHECK ITEM 2	Refer to 4b and 4f, "Dental" page 26, for sample person.	1 <input type="checkbox"/> Sample person has no teeth (2) 8 <input type="checkbox"/> Other (1)	6
1a.	During the past 6 months, did you have a toothache more than once, when biting or chewing?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2)	7
b.	Did you first have this pain more than 6 months ago?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	8
2a.	(During the past 6 months) Did you have painful sores or irritations around the lips or on the tongue, cheeks, or gums more than once?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (3)	9
b.	Did you first have the sores or irritations more than 6 months ago?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	10
3a.	(During the past 6 months) Did you have a prolonged, unexplained burning sensation in your tongue or any other part of your mouth more than once?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (4)	11
b.	When you have this sensation, does it come and go or is it continuous and uninterrupted?	1 <input type="checkbox"/> Come and go 2 <input type="checkbox"/> Continuous/uninterrupted 8 <input type="checkbox"/> Other 9 <input type="checkbox"/> DK	12
c.	During how many DIFFERENT MONTHS in the past 6 months did you have this sensation?	<input type="text"/> Months	13
d.	How many total days in the past 6 months did you have this sensation?	1 <input type="checkbox"/> 1-3 days 4 <input type="checkbox"/> 16-30 days 7 <input type="checkbox"/> "Everyday" 2 <input type="checkbox"/> 4-10 days 5 <input type="checkbox"/> 31-45 days 9 <input type="checkbox"/> DK 3 <input type="checkbox"/> 11-15 days 6 <input type="checkbox"/> 46+ days	14
e.	Did you first have this sensation more than 6 months ago?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	15
4a.	(During the past 6 months) Did you have pain in the jaw joint or in front of the ear more than once?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)	16
b.	When you have this pain, does it come and go or is it continuous and uninterrupted?	1 <input type="checkbox"/> Come and go 2 <input type="checkbox"/> Continuous/uninterrupted 8 <input type="checkbox"/> Other 9 <input type="checkbox"/> DK	17
c.	During how many DIFFERENT MONTHS in the past 6 months did you have this pain?	<input type="text"/> Months	18
d.	How many total days in the past 6 months did you have this pain?	1 <input type="checkbox"/> 1-3 days 4 <input type="checkbox"/> 16-30 days 7 <input type="checkbox"/> "Everyday" 2 <input type="checkbox"/> 4-10 days 5 <input type="checkbox"/> 31-45 days 9 <input type="checkbox"/> DK 3 <input type="checkbox"/> 11-15 days 6 <input type="checkbox"/> 46+ days	19
e.	Did you first have this pain more than 6 months ago?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	20
f.	On a scale of 1-10, where 1 is mild and 10 is severe, how would you rate this pain at its worst? Circle only one.	1 2 3 4 5 6 7 8 9 10	21-22
5a.	(During the past 6 months) Did you have a dull, aching pain across your face or cheek more than once? Do not count sinus pain.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Check Item 3)	23
b.	When you have this pain, does it come and go or is it continuous and uninterrupted?	1 <input type="checkbox"/> Come and go 2 <input type="checkbox"/> Continuous/uninterrupted 8 <input type="checkbox"/> Other 9 <input type="checkbox"/> DK	24
c.	During how many DIFFERENT MONTHS in the past 6 months did you have this pain?	<input type="text"/> Months	25
d.	How many total days in the past 6 months did you have this pain?	1 <input type="checkbox"/> 1-3 days 4 <input type="checkbox"/> 16-30 days 7 <input type="checkbox"/> "Everyday" 2 <input type="checkbox"/> 4-10 days 5 <input type="checkbox"/> 31-45 days 9 <input type="checkbox"/> DK 3 <input type="checkbox"/> 11-15 days 6 <input type="checkbox"/> 46+ days	26
e.	Did you first have this pain more than 6 months ago?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	27
f.	On a scale of 1-10, where 1 is mild and 10 is severe, how would you rate this pain at its worst? Circle only one.	1 2 3 4 5 6 7 8 9 10	28-29

Section R — OROFACIAL PAIN — Continued

**CHECK
ITEM 3**

Refer to 3c, 4c, and 5c.

- 1 Two or more months in any one of 3c, 4c, or 5c (6)
 8 Other (Section S)

30

6a. In the past 6 months, did you see or talk to a **DENTIST** for the pain we just discussed?

- 1 Yes
 2 No (6c)

31

b. How many times during the last 6 months did you see or talk to a dentist about the pain?

_____ Times
 999 DK

32-34

c. (In the past 6 months) Did you see or talk to a **MEDICAL DOCTOR** about the pain?

- 1 Yes
 2 No (6e)

35

d. How many times?

_____ Times
 999 DK

36-38

6. (In the past 6 months) Did you see or talk to any other type of health professional about the pain?

- 1 Yes
 2 No (6h)

39

f. What kind of health professional?

Health professional

40-41

g. How many times during the past 6 months did you see or talk to the person in 6f?

_____ Times
 999 DK

42-44

h. (In the past 6 months) Did you worry about the health of your teeth and gums because of the pain?

- 1 Yes
 2 No

45

i. (In the past 6 months) Did you worry about the health of your body because of the pain?

- 1 Yes
 2 No

46

HAND CARD R1 . Read list if telephone interview.

7. Here is a list of things people do when they have teeth, mouth, or face pain. Please tell me the things you did for the pain during the past 6 months.

Circle all that apply.

1 — Use a hot or cold compress

1

1

47

2 — Take a prescription drug

2

2

48

3 — Take an over-the-counter drug

3

3

49

4 — Drink some liquor or wine because of the pain

4

4

50

5 — Take time off work

5

5

51

6 — Stay home more than usual

6

6

52

7 — Avoid family and friends

7

7

53

8 — Anything else? (Specify)

8 (Specify) _____

8

54

0 — None of the above

0

0

55

9 — Don't know

9

9

56

Notes

CARD Q2

- 00. Nowhere
- 01. Doctor's office – doctor
- 02. Doctor's office – nurse
- 03. Dietitian or nutritionist
- 04. Doctor or nurse in a hospital
- 05. Relative or friend
- 06. Another diabetic
- 07. Health department
- 08. Diabetes organization
- 09. National Diabetes Information Clearing House
- 10. Diabetes support group
- 11. Library
- 12. Newspapers
- 13. Diabetes education class
- 88. Other

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CARD R1

- 1. Use a hot or cold compress
- 2. Take a prescription drug
- 3. Take an over-the-counter drug
- 4. Drink some liquor or wine because of the pain
- 5. Take time off work
- 6. Stay home more than usual
- 7. Avoid family and friends
- 8. Something else

Card Q2

Card R1

(Not along with Card R1)

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