Appendix B3: General dental care questionnaire

THE UNIVERSITY OF ADELAIDE
AUSTRALIA

Patient ID

RELATIVE NEEDS INDEX STUDY

General Dental Care

A study of the need for dental care.

Conducted by:

Social and Preventive Dentistry
The University of Adelaide
AUSTRALIA 5005

Relative Needs Index Study

RESPONSES RECORDED MUST BE THOSE OF THE PATIENT.

1 Please indicate your ■ date of birth: ☐☐ ☐☐ ☐☐☐☐ (day month year)

■ sex: Male ☐1 Female ☐2

2 Were you born in Australia? Yes ☐1 No ☐2

If No, (a) in what country were you born? _____ (country)

(b) in which year did you first arrive in Australia to live? _____ (year)

3 Are you of Aboriginal and/or Torres Strait Islander origin?

No ☐1
Yes, Aboriginal ☐2
Yes, Torres Strait Islander ☐3

4 What is the postcode of the suburb/area you live in? ☐☐☐☐

5 Which language do you ***mainly*** speak at home? *(Please tick one box)*

English	☐1	Mandarin	☐6
Italian	☐2	Arabic	☐7
Greek	☐3	Russian	☐8
Cantonese	☐4	German	☐9
Vietnamese	☐5	Other *(please specify)*	☐10

_____

6 Australia's population is made up of many ethnic communities or groups.
With which community or group do you ***mainly*** identify?

(State only one, eg. Italian. If no ethnic identity, write "none"). _____

2

7 Which of the following best describes where you live? *(Please tick one box)*

- House/flat/unit ☐ 1
- Caravan ☐ 2
- Boarding house/hostel/refuge/rehabilitation ☐ 3
- Group home ☐ 4
- Institution ☐ 5
- Aged care facility *(incl. Nursing home, aged care hostel)* ☐ 6
- Retirement village ☐ 7
- Other *(please specify)* ☐ 8

8 Which of the following best describes the household in which you live? *(Please tick one box)*

- With spouse/partner only ☐ 1
- With spouse/partner and child/ren ☐ 2
- With parents ☐ 3
- By self ☐ 4
- With my child/ren only ☐ 5
- Share with other adults ☐ 6
- Other *(please specify)* ☐ 7

9 How old were you when you left school? *(Please tick one box)*

- Did not go to school ☐ 1
- 14 years or younger ☐ 2
- 15 years ☐ 3
- 16 years ☐ 4
- 17 years ☐ 5
- 18 years ☐ 6
- 19 years or older ☐ 7

10 What is the highest level of education you have attained? *(Please tick one box)*

- Primary School ☐ 1
- Some secondary school ☐ 2
- Completed secondary school ☐ 3
- Some University, higher education ☐ 4
- Completed a University, higher education course ☐ 5
- Some TAFE, CAE or vocational course ☐ 6
- Completed TAFE, CAE or vocational course ☐ 7
- Other ☐ 8
- Don't know ☐ 9

3

11 What is your usual/previous occupation?

12 (a) Do you have

- Pensioner concession card (full entitlement)? ☐1
- Pensioner concession card (part entitlement)? ☐2
- Health care card? ☐3
- Veterans Affairs Card? ☐4
- Commonwealth Seniors Health Card? ☐5

(b) How long have you had your concession card(s)?

- Pensioner concession card (full entitlement)
- Pensioner concession card (part entitlement)
- Health care card
- Veterans Affairs card
- Commonwealth Seniors Health card

13 (a) Do you have private dental insurance? Yes ☐1 → **Go to (b)**; No ☐2 → **Go to Q14**

(b) How long have you had private dental insurance?

Less than 6 months	☐1	2 years to less than 3 years	☐4
6 months to less than 12 months	☐2	3 years to less than 5 years	☐5
1 year to less than 2 years	☐3	5 years or more	☐6

14 Are you usually able to

(a)	chew a piece of fresh carrot?	Yes ☐1	No ☐2
(b)	chew boiled vegetables?	Yes ☐1	No ☐2
(c)	chew fresh lettuce salad?	Yes ☐1	No ☐2
(d)	chew firm foods such as steaks or dried apricots?	Yes ☐1	No ☐2
(e)	bite off and chew a piece of whole fresh apple?	Yes ☐1	No ☐2
(f)	chew hamburger?	Yes ☐1	No ☐2

4

15 (a) How often do you add sugar to your food *(eg. cereal, sauces etc)*?

Never ☐1
Rarely ☐2
Sometimes ☐3 → How many teaspoons of sugar do you add to your food? ☐
Often/always ☐4

(b) How often do you add sugar to your drink *(eg. tea, coffee)*?

Never ☐1
Rarely ☐2
Sometimes ☐3 → How many teaspoons of sugar do you add to your drink? ☐
Often/always ☐4

(c) How many times did you have a dessert or sweet snack yesterday ? ☐

(d) How many times did you have a sweet drink yesterday *(eg. juice, non-diet soft drink, tea, coffee)*? ☐

16 Thinking about problems with your teeth or mouth,

(a)	do you ever have difficulty pronouncing any words?	Yes	☐1	No	☐2
(b)	do you ever have difficulty speaking clearly?	Yes	☐1	No	☐2
(c)	do you ever have difficulty making yourself understood?	Yes	☐1	No	☐2

17 In the last four weeks, have you had the following problems?

(a)	toothache	Yes	☐1	No	☐2		
(b)	pain in teeth with hot foods or fluids	Yes	☐1	No	☐2		
(c)	pain in teeth with cold foods or fluids	Yes	☐1	No	☐2		
(d)	pain in teeth with sweet foods	Yes	☐1	No	☐2		
(e)	pain in jaw while chewing	Yes	☐1	No	☐2		
(f)	pain in jaw when opening mouth wide	Yes	☐1	No	☐2		
(g)	pain which is worse in the middle of the day	Yes	☐1	No	☐2		
(h)	pain at night	Yes	☐1	No	☐2		
(i)	pain in front of ear	Yes	☐1	No	☐2		
(j)	burning sensation in tongue or other parts of mouth	Yes	☐1	No	☐2		
(k)	shooting pain in face or cheeks	Yes	☐1	No	☐2		
(l)	pain or discomfort from denture	Yes	☐1	No	☐2	NA	☐3

18 In the last four weeks, have you had the following problems?

(a)	mouth ulcers	Yes	☐1	No	☐2
(b)	cold sores	Yes	☐1	No	☐2
(c)	sore gums	Yes	☐1	No	☐2
(d)	bleeding gums	Yes	☐1	No	☐2
(e)	swelling on gums	Yes	☐1	No	☐2
(f)	bad breath	Yes	☐1	No	☐2
(g)	dryness of mouth	Yes	☐1	No	☐2
(h)	unpleasant taste	Yes	☐1	No	☐2
(i)	changes in ability to taste	Yes	☐1	No	☐2
(j)	clicking/grating noise in jaw joint	Yes	☐1	No	☐2
(k)	swelling of your face or neck	Yes	☐1	No	☐2
(l)	a lost filling	Yes	☐1	No	☐2
(m)	a lost crown	Yes	☐1	No	☐2
(n)	a broken filling	Yes	☐1	No	☐2
(o)	a broken crown	Yes	☐1	No	☐2
(p)	a loose tooth	Yes	☐1	No	☐2
(q)	a chipped tooth	Yes	☐1	No	☐2
(r)	a cracked tooth	Yes	☐1	No	☐2
(s)	a broken tooth from an accident	Yes	☐1	No	☐2
(t)	visible pink areas on the tooth as a result of a broken tooth	Yes	☐1	No	☐2
(u)	high temperature	Yes	☐1	No	☐2

19 What category best describes your teeth? *(Please tick one box)*

Natural teeth only	☐1	→ **Go to Q21**
Natural teeth and upper denture only	☐2	→ **Go to Q20**
Natural teeth and lower denture only	☐3	→ **Go to Q20**
Both upper and lower dentures with some natural teeth	☐4	→ **Go to Q20**

20 (a) How long ago did you receive your first denture(s)?

Upper denture ☐

Lower denture ☐

Q20 continued on next page

(b) How long have you had the denture(s) you wear now? Upper denture

Lower denture

21 What dental treatment do you think you currently need? *(Please tick one or more boxes)*

None	1	Gum Treatment	8
Check-up	2	Teeth straightened/braces	9
Dental filling	3	New or replacement dentures	10
Amalgam replacement	4	Teeth cleaned	11
Root canal filling	5	Whitening/bleaching	12
Crown	6	Denture repair	13
Tooth extracted	7	Other treatment (*please specify*)	14

22 (a) Have you ever had a tooth extracted? Yes 1 → **Go to (b), (c) & (d)**

No 2 → **Go to Q23**

(b) If Yes, why? *(eg. wisdom tooth, decay, orthodontic etc)*

(c) How long has it been since your last extraction?

(d) How many teeth have you had extracted in the past 2 years?

(Number)

23 What is your usual reason for visiting the dentist?

For a regular check-up	1
For an occasional check-up	2
When in discomfort/pain	3
When something needs to be fixed	4

24 How long has it been since your last dental visit? *(Please tick one box)*

Less than 12 months	1	3 years to less than 5 years	4
12 months to less than 2 years	2	5 years or more	5
2 years to less than 3 years	3	Never	6 → **Go to Q29**

25 Where was your last dental visit? *(Please tick one box)*

Private practice	☐ 1
Public hospital/clinic	☐ 2
School Dental Service	☐ 3
Dental technician	☐ 4
Health Fund	☐ 5
Prison, corrective/detention institution	☐ 6
Other	☐ 7
Don't know	☐ 8

26 How often do you usually go to the dentist? *(Please tick one box)*

More than 2 times a year	☐ 1	Once every 2 years	☐ 4
Two times a year	☐ 2	Once every 5 years	☐ 5
Once a year	☐ 3	Less often than that	☐ 6

27 In which country was your last dental visit? *(Please tick one box)*

Australia	☐ 1
Other *(please specify)*	☐ 2

28 What dental treatment did you receive at your last dental visit/s? *(Please tick one or more boxes)*

None	☐ 1	Gum Treatment	☐ 8
Check-up	☐ 2	Teeth straightened/braces	☐ 9
Dental filling	☐ 3	New or replacement dentures	☐ 10
Amalgam replacement	☐ 4	Teeth cleaned	☐ 11
Root canal filling	☐ 5	Whitening/bleaching	☐ 12
Crown	☐ 6	Denture repair	☐ 13
Tooth extracted	☐ 7	Other treatment (*please specify*)	☐ 14

29 Do you think that dental treatments can help make your teeth and mouth more healthy? *(Please tick one box)*

Yes/absolutely	☐ 1
Probably/sometimes	☐ 2
No	☐ 3
Don't know	☐ 4

For Q30 to Q35, please *circle* one number in each line to indicate the patient's level of agreement or disagreement with each statement.

30 Thinking about your dental health over the last year, how often ...	All the time	Very often	Fairly often	Some-times	Never
have you been prevented from eating foods you would like to eat?	1	2	3	4	5
have you found your enjoyment of food is less than it used to be?	1	2	3	4	5
did it take you longer to finish a meal than other people?	1	2	3	4	5
have you found your taste for salt to have increased?	1	2	3	4	5
did you avoid eating with other people because of problems with chewing?	1	2	3	4	5
were you embarrassed by the appearance or health of your teeth or mouth?	1	2	3	4	5
did you avoid laughing or smiling?	1	2	3	4	5
did you avoid conversation with others?	1	2	3	4	5

31 During the past year, how often have pain, discomfort, or other problems with your teeth, mouth or dentures caused you to ...	All the time	Very often	Fairly often	Some-times	Never	
have difficulty sleeping?	1	2	3	4	5	
stay home more than usual?	1	2	3	4	5	
stay in bed more than usual?	1	2	3	4	5	
take time off work?	1	2	3	4	5	NA
be unable to do household chores?	1	2	3	4	5	
avoid your usual leisure activities?	1	2	3	4	5	

32 During the past year, how often have you worried about ...	All the time	Very often	Fairly often	Some-times	Never
the appearance of your teeth or mouth?	1	2	3	4	5
the health of your teeth or mouth?	1	2	3	4	5

33 During the past year,

	All the time	Very often	Fairly often	Some-times	Never
how often did you use medication to relieve pain or discomfort in your teeth or mouth?	1	2	3	4	5

34

	Very Good	Good	Fair	Poor	Very Poor
How would you rate your general health?	1	2	3	4	5
How would you rate your oral health?	1	2	3	4	5

35 During the past year ...

	Very often	Fairly often	Occas-ionally	Hardly ever	Never
have you had trouble pronouncing any words because of problems with your teeth, mouth or dentures?	1	2	3	4	5
have you felt that your sense of taste has worsened because of problems with your teeth, mouth or dentures?	1	2	3	4	5
have you had a painful aching in your mouth?	1	2	3	4	5
have you found it uncomfortable to eat any foods because of problems with your teeth, mouth or dentures?	1	2	3	4	5
have you been self conscious because of your teeth, mouth or dentures?	1	2	3	4	5
have you felt tense because of problems with your teeth, mouth or dentures?	1	2	3	4	5
has your diet been unsatisfactory because of problems with your teeth, mouth or dentures?	1	2	3	4	5
have you had to interrupt meals because of problems with your teeth, mouth or dentures?	1	2	3	4	5
have you found it difficult to relax because of problems with your teeth, mouth or dentures?	1	2	3	4	5
have you been a bit embarrassed because of problems with your teeth, mouth or dentures?	1	2	3	4	5
have you been a bit irritable with other people because of problems with your teeth, mouth or dentures?	1	2	3	4	5
have you had difficulty doing your usual jobs because of problems with your teeth, mouth or dentures?	1	2	3	4	5
have you felt that life in general was less satisfying because of problems with your teeth, mouth or dentures?	1	2	3	4	5
have you been totally unable to function because of problems with your teeth, mouth or dentures?	1	2	3	4	5

36 Have you sought medical care in the last 6 months?

Yes ☐1
No ☐2

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37 (a) Do you take any regular medication?

Yes ☐1 → **Go to (b)**
No ☐2 → **Go to Q38**

(b) Was this medication recommended by a health care provider?

Yes ☐1
No ☐2

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38 Do you

(a) have diabetes?

Yes ☐1
No ☐2

(b) Do you smoke tobacco?

Yes ☐1
No ☐2
Occasionally ☐3

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39 Imagine you had an appointment to go to the dentist tomorrow, how would you feel about it? *(Please tick one box)*

I would look forward to it as a reasonably enjoyable experience ☐1
I wouldn't care one way or the other ☐2
I would be a little uneasy about it ☐3
I would be afraid that it would be unpleasant and painful ☐4
I would be very frightened of what the dentist might do ☐5

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40 Imagine you are waiting in the dentist's waiting room for your turn in the chair, how would you feel? *(Please tick one box)*

Relaxed ☐1
A little uneasy ☐2
Tense ☐3
Anxious ☐4
So anxious that I sometimes break out in a sweat or almost feel physically sick ☐5

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41 Imagine you are in the chair waiting while the dentist gets the drill ready to begin working on your teeth, how would you feel? *(Please tick one box)*

Relaxed ☐1
A little uneasy ☐2
Tense ☐3
Anxious ☐4
So anxious that I sometimes break out in a sweat or almost feel physically sick ☐5

42 Imagine you are in the dentist's chair to have your teeth cleaned. While you are waiting and the dentist is getting out the instruments to be used to scrape your teeth around the gums, how would you feel? *(Please tick one box)*

- Relaxed ☐1
- A little uneasy ☐2
- Tense ☐3
- Anxious ☐4
- So anxious that I sometimes break out in a sweat or almost feel physically sick ☐5

43 How characteristic of you are the following statements? *(Please circle one of the numbers in each line)*

	Uncharacteristic of me			Characteristic of me		
	very	rather	somewhat	somewhat	rather	very
I am quick to express an opinion when it comes to my dental health care needs.	1	2	3	4	5	6
I usually think my needs are not as important as other people's needs.	1	2	3	4	5	6
If treatment is not to my satisfaction, I let the dentist know I am not happy.	1	2	3	4	5	6
If the service received is not to my satisfaction, I complain to dental staff.	1	2	3	4	5	6

44 Was this interview done by proxy? Yes ☐1 No ☐2

INTERVIEWER'S COMMENTS

Thank you for your co-operation and time in answering this questionnaire.

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