

ANNEXURE D

ID Number

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Geographic
Location

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SIMPLIFIED QUESTIONNAIRE FOR INTERVIEWING ADULTS ON ORAL HEALTH

(Designed by WHO–Oral Health Programme)

1. How many natural teeth do you have?

No natural teeth 0

1-9 teeth 1

10-19 teeth 2

20 teeth or more 3

2. During the past 12 months did your teeth or mouth cause any pain or discomfort?

Yes 1

No 2

Don't know 9

No answer 0

3. Do you have any removable dentures?

(Read each item)

Yes	No
1	2

A partial denture?	<input type="checkbox"/>	<input type="checkbox"/>
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A full upper denture?	<input type="checkbox"/>	<input type="checkbox"/>
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A full lower denture?	<input type="checkbox"/>	<input type="checkbox"/>
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4. How would you describe the state of your teeth and gums? Is it “excellent”, “very good”, “good”, “average”, “poor”, or “very poor”?

- Excellent 1
 - Very good 2
 - Good 3
 - Average 4
 - Poor 5
 - Very poor 6
 - Don't know 9
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5. How often do you clean your teeth?

- Never 1
 - Once a month 2
 - 2-3 times a month 3
 - Once a week 4
 - 2-6 times a week 5
 - Once a day 6
 - Twice or more a day 7
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6. Do you use any of the following to clean your teeth?

(State each item)

	Yes	No
	1	2
Toothbrush	<input type="checkbox"/>	<input type="checkbox"/>
Wooden toothpicks	<input type="checkbox"/>	<input type="checkbox"/>
Plastic toothpicks?	<input type="checkbox"/>	<input type="checkbox"/>
Thread (dental floss)	<input type="checkbox"/>	<input type="checkbox"/>
Charcoal	<input type="checkbox"/>	<input type="checkbox"/>
Chewstick/miswak	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

7. Do you use toothpaste containing fluoride?

Yes	<input type="checkbox"/>	1
No	<input type="checkbox"/>	2
Don't use toothpaste	<input type="checkbox"/>	3
Don't know	<input type="checkbox"/>	9

8. How long is it since you last have seen a dentist?

Less than 6 months	<input type="checkbox"/>	1
6-12 months	<input type="checkbox"/>	2
More than 1 year, but less than 2 years	<input type="checkbox"/>	3
More than 2 years, but less than 5 years	<input type="checkbox"/>	4
More than 5 years	<input type="checkbox"/>	5
Never received dental care	<input type="checkbox"/>	6

9. How often do you eat or drink any of the following foods, even in small quantities?

(Read each item)

	Several times a day	Every day	Several times a week	Once a week	Several times a month	Seldom/ Never
	6	5	4	3	2	1
Fresh fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biscuits, cakes, cream cakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wafers, buns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lemonade, Cola, Mango shake,Soft drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jam or honey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chewing gum containing sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweets/Candy/Burfi/Gajak ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. How often do you use any of the following types of tobacco?

(Show card)

	Every day	Several times a week	Once a week	Several times a month	Seldom	Never
	6	5	4	3	2	1
I smoke cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I smoke cigars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I smoke pipe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have chewing tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have snuff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. What level of education do you have?

(Unfinished) primary school 1

Unfinished secondary school 2

Secondary school 3

Unfinished secondary special 4

Secondary special 5

Unfinished tertiary school (Graduation) 6

Tertiary school (Graduation) 7

That completes our interview

Thank you very much for your cooperation!
