

**ORAL HEALTH AND QUALITY OF LIFE  
(UAB STUDY OF AGING)**

Interviewer initials

Subject initials

Date of interview   /   /

Subject Number

Time interview began \_\_\_\_\_

Total time in minutes

Thank you very much for agreeing to participate in this study. Let me read aloud a short paragraph to you that tells about how this interview is supposed to work. I have a set of questions that I have to ask exactly the way they are written. That way we know everyone in the study is answering the same questions and we can compare their answers. For most questions I will read a list of answers. Whenever possible you should choose one of the answers I read with the questions. It is important that your answers be as accurate as you can make them. So take time, if you need it, to think about your answers and please stop me if you have any questions about the kind of information we want. OK?

*Interviewer: Read each question and each responses category aloud.*

**First, please tell me if you have avoided doing any of these things in the past 6 months.**

**IN THE PAST 6 MONTHS.....**

**1. Did you avoid laughing or smiling because of unattractive teeth, gums, or dentures?**

- |                          |                             |   |   |
|--------------------------|-----------------------------|---|---|
| <input type="radio"/> No | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒                             | <b>How much of a problem has it been?</b> |
| ↓                        |                             | <input type="radio"/> Almost every day          | <input type="radio"/> Mild                |
|                          |                             | <input type="radio"/> At least once each week   | <input type="radio"/> Moderate            |
|                          |                             | <input type="radio"/> At least once each month  | <input type="radio"/> Severe              |
|                          |                             | <input type="radio"/> Less than once each month |   |

**2. Did you avoid talking to someone because of unattractive teeth, gums, dentures, or bad breath?**

- |                          |                             |   |   |
|--------------------------|-----------------------------|---|---|
| <input type="radio"/> No | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒                             | <b>How much of a problem has it been?</b> |
| ↓                        |                             | <input type="radio"/> Almost every day          | <input type="radio"/> Mild                |
|                          |                             | <input type="radio"/> At least once each week   | <input type="radio"/> Moderate            |
|                          |                             | <input type="radio"/> At least once each month  | <input type="radio"/> Severe              |
|                          |                             | <input type="radio"/> Less than once each month |   |

**3. Did you avoid chewing hard things such as hard bread or apples, because of your teeth, mouth, or dentures?**

- |                          |                             |   |   |
|--------------------------|-----------------------------|---|---|
| <input type="radio"/> No | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒                             | <b>How much of a problem has it been?</b> |
| ↓                        |                             | <input type="radio"/> Almost every day          | <input type="radio"/> Mild                |
|                          |                             | <input type="radio"/> At least once each week   | <input type="radio"/> Moderate            |
|                          |                             | <input type="radio"/> At least once each month  | <input type="radio"/> Severe              |
|                          |                             | <input type="radio"/> Less than once each month |   |

**4. Did you avoid eating foods you would like to eat because of your teeth, mouth, or dentures?**

- |                          |                             |   |   |
|--------------------------|-----------------------------|---|---|
| <input type="radio"/> No | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒                             | <b>How much of a problem has it been?</b> |
| ↓                        |                             | <input type="radio"/> Almost every day          | <input type="radio"/> Mild                |
|                          |                             | <input type="radio"/> At least once each week   | <input type="radio"/> Moderate            |
|                          |                             | <input type="radio"/> At least once each month  | <input type="radio"/> Severe              |
|                          |                             | <input type="radio"/> Less than once each month |   |

**5. Did you avoid eating with other people because of problems with chewing?**

- |                          |                             |   |   |
|--------------------------|-----------------------------|---|---|
| <input type="radio"/> No | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒                             | <b>How much of a problem has it been?</b> |
| ↓                        |                             | <input type="radio"/> Almost every day          | <input type="radio"/> Mild                |
|                          |                             | <input type="radio"/> At least once each week   | <input type="radio"/> Moderate            |
|                          |                             | <input type="radio"/> At least once each month  | <input type="radio"/> Severe              |
|                          |                             | <input type="radio"/> Less than once each month |   |

**6. Did you cut food into small pieces because of mouth or chewing problems?**

- |                          |                             |   |   |
|--------------------------|-----------------------------|---|---|
| <input type="radio"/> No | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒                             | <b>How much of a problem has it been?</b> |
| ↓                        |                             | <input type="radio"/> Almost every day          | <input type="radio"/> Mild                |
|                          |                             | <input type="radio"/> At least once each week   | <input type="radio"/> Moderate            |
|                          |                             | <input type="radio"/> At least once each month  | <input type="radio"/> Severe              |
|                          |                             | <input type="radio"/> Less than once each month |   |

**7. Did you cook food longer or differently to make it softer, because of mouth or chewing problems?**

- |                          |                             |   |   |
|--------------------------|-----------------------------|---|---|
| <input type="radio"/> No | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒                             | <b>How much of a problem has it been?</b> |
| ↓                        |                             | <input type="radio"/> Almost every day          | <input type="radio"/> Mild                |
|                          |                             | <input type="radio"/> At least once each week   | <input type="radio"/> Moderate            |
|                          |                             | <input type="radio"/> At least once each month  | <input type="radio"/> Severe              |
|                          |                             | <input type="radio"/> Less than once each month |   |

**8. Did you reduce the total amount of food that you eat because of mouth or chewing problems?**

- |                          |                             |   |   |
|--------------------------|-----------------------------|---|---|
| <input type="radio"/> No | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒                             | <b>How much of a problem has it been?</b> |
| ↓                        |                             | <input type="radio"/> Almost every day          | <input type="radio"/> Mild                |
|                          |                             | <input type="radio"/> At least once each week   | <input type="radio"/> Moderate            |
|                          |                             | <input type="radio"/> At least once each month  | <input type="radio"/> Severe              |
|                          |                             | <input type="radio"/> Less than once each month |   |

**9. Did you lose any weight because of mouth or chewing problems?**

- |                          |                             |   |   |
|--------------------------|-----------------------------|---|---|
| <input type="radio"/> No | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒                             | <b>How much of a problem has it been?</b> |
| ↓                        |                             | <input type="radio"/> Almost every day          | <input type="radio"/> Mild                |
|                          |                             | <input type="radio"/> At least once each week   | <input type="radio"/> Moderate            |
|                          |                             | <input type="radio"/> At least once each month  | <input type="radio"/> Severe              |
|                          |                             | <input type="radio"/> Less than once each month |   |

**10. Were you uncomfortable eating in front of other people because of problems with your teeth, mouth, or dentures?**

- |                          |                             |   |   |
|--------------------------|-----------------------------|---|---|
| <input type="radio"/> No | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒                             | <b>How much of a problem has it been?</b> |
| ↓                        |                             | <input type="radio"/> Almost every day          | <input type="radio"/> Mild                |
|                          |                             | <input type="radio"/> At least once each week   | <input type="radio"/> Moderate            |
|                          |                             | <input type="radio"/> At least once each month  | <input type="radio"/> Severe              |
|                          |                             | <input type="radio"/> Less than once each month |   |

**11. Did you limit contact with other people because of the condition of your teeth, mouth, or dentures?**

- |                          |                             |   |   |
|--------------------------|-----------------------------|---|---|
| <input type="radio"/> No | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒                             | <b>How much of a problem has it been?</b> |
| ↓                        |                             | <input type="radio"/> Almost every day          | <input type="radio"/> Mild                |
|                          |                             | <input type="radio"/> At least once each week   | <input type="radio"/> Moderate            |
|                          |                             | <input type="radio"/> At least once each month  | <input type="radio"/> Severe              |
|                          |                             | <input type="radio"/> Less than once each month |   |

**12. Did you avoid going outside your neighborhood because of the condition of your teeth, mouth, or dentures?**

- |                          |                             |   |   |
|--------------------------|-----------------------------|---|---|
| <input type="radio"/> No | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒                             | <b>How much of a problem has it been?</b> |
| ↓                        |                             | <input type="radio"/> Almost every day          | <input type="radio"/> Mild                |
|                          |                             | <input type="radio"/> At least once each week   | <input type="radio"/> Moderate            |
|                          |                             | <input type="radio"/> At least once each month  | <input type="radio"/> Severe              |
|                          |                             | <input type="radio"/> Less than once each month |   |

13. Did you avoid going outside your house because of the condition of your teeth, mouth, or dentures?

- No    Yes ⇒   **How often?** ⇒   **How much of a problem has it been?**
- ↓
- Almost every day    Mild
- At least once each week    Moderate
- At least once each month    Severe
- Less than once each month

14. Were you embarrassed by the appearance or bad condition of your teeth, gums, or dentures?

- No    Yes ⇒   **How often?** ⇒   **How much of a problem has it been?**
- ↓
- Almost every day    Mild
- At least once each week    Moderate
- At least once each month    Severe
- Less than once each month

15. Did pain or discomfort from your teeth keep you from doing the things you normally do in a day?

- No    Yes ⇒   **How often?** ⇒   **How much of a problem has it been?**
- ↓
- Almost every day    Mild
- At least once each week    Moderate
- At least once each month    Severe
- Less than once each month

16. Did you have trouble sleeping because you had pain or discomfort from your teeth, gums, mouth, or dentures?

- No    Yes ⇒   **How often?** ⇒   **How much of a problem has it been?**
- ↓
- Almost every day    Mild
- At least once each week    Moderate
- At least once each month    Severe
- Less than once each month

17. Did you have difficulty speaking or pronouncing any words because of problems with your teeth, gums, mouth, or dentures?

- No    Yes ⇒   **How often?** ⇒   **How much of a problem has it been?**
- ↓
- Almost every day    Mild
- At least once each week    Moderate
- At least once each month    Severe
- Less than once each month

18. Did you ever feel depressed because of problems with your teeth, gums, mouth, or dentures?

- |                          |                             |   |   |
|--------------------------|-----------------------------|---|---|
| <input type="radio"/> No | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒                             | <b>How much of a problem has it been?</b> |
| ↓                        |                             | <input type="radio"/> Almost every day          | <input type="radio"/> Mild                |
|                          |                             | <input type="radio"/> At least once each week   | <input type="radio"/> Moderate            |
|                          |                             | <input type="radio"/> At least once each month  | <input type="radio"/> Severe              |
|                          |                             | <input type="radio"/> Less than once each month |   |

19. Did you ever feel stressed because of problems with your teeth, gums, mouth, or dentures?

- |                          |                             |   |   |
|--------------------------|-----------------------------|---|---|
| <input type="radio"/> No | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒                             | <b>How much of a problem has it been?</b> |
| ↓                        |                             | <input type="radio"/> Almost every day          | <input type="radio"/> Mild                |
|                          |                             | <input type="radio"/> At least once each week   | <input type="radio"/> Moderate            |
|                          |                             | <input type="radio"/> At least once each month  | <input type="radio"/> Severe              |
|                          |                             | <input type="radio"/> Less than once each month |   |

Thank you -- Now we have some questions about the dryness of your mouth. Please tell me if mouth dryness affected you in the past 6 months.

**IN THE PAST 6 MONTHS.....**

20. Did mouth dryness limit the kinds of food that you eat?

- |                          |                             |   |   |
|--------------------------|-----------------------------|---|---|
| <input type="radio"/> No | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒                             | <b>How much of a problem has it been?</b> |
| ↓                        |                             | <input type="radio"/> Almost every day          | <input type="radio"/> Mild                |
|                          |                             | <input type="radio"/> At least once each week   | <input type="radio"/> Moderate            |
|                          |                             | <input type="radio"/> At least once each month  | <input type="radio"/> Severe              |
|                          |                             | <input type="radio"/> Less than once each month |   |

21. Did mouth dryness cause you any discomfort or pain?

- |                          |                             |   |   |
|--------------------------|-----------------------------|---|---|
| <input type="radio"/> No | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒                             | <b>How much of a problem has it been?</b> |
| ↓                        |                             | <input type="radio"/> Almost every day          | <input type="radio"/> Mild                |
|                          |                             | <input type="radio"/> At least once each week   | <input type="radio"/> Moderate            |
|                          |                             | <input type="radio"/> At least once each month  | <input type="radio"/> Severe              |
|                          |                             | <input type="radio"/> Less than once each month |   |

22. Did mouth dryness cause you any worry or concern?

- |                          |                             |   |   |
|--------------------------|-----------------------------|---|---|
| <input type="radio"/> No | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒                             | <b>How much of a problem has it been?</b> |
| ↓                        |                             | <input type="radio"/> Almost every day          | <input type="radio"/> Mild                |
|                          |                             | <input type="radio"/> At least once each week   | <input type="radio"/> Moderate            |
|                          |                             | <input type="radio"/> At least once each month  | <input type="radio"/> Severe              |
|                          |                             | <input type="radio"/> Less than once each month |   |

**23. Did mouth dryness keep you from socializing or going out?**

- |                               |                             |   |   |
|-------------------------------|-----------------------------|---|---|
| <input type="radio"/> No<br>↓ | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒<br><input type="radio"/> Almost every day<br><input type="radio"/> At least once each week<br><input type="radio"/> At least once each month<br><input type="radio"/> Less than once each month | <b>How much of a problem has it been?</b><br><input type="radio"/> Mild<br><input type="radio"/> Moderate<br><input type="radio"/> Severe |
|-------------------------------|-----------------------------|---|---|

**24. Did mouth dryness make you uncomfortable when eating in front of other people?**

- |                               |                             |   |   |
|-------------------------------|-----------------------------|---|---|
| <input type="radio"/> No<br>↓ | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒<br><input type="radio"/> Almost every day<br><input type="radio"/> At least once each week<br><input type="radio"/> At least once each month<br><input type="radio"/> Less than once each month | <b>How much of a problem has it been?</b><br><input type="radio"/> Mild<br><input type="radio"/> Moderate<br><input type="radio"/> Severe |
|-------------------------------|-----------------------------|---|---|

**25. Did mouth dryness have a bad effect on how food tastes for you?**

- |                               |                             |   |   |
|-------------------------------|-----------------------------|---|---|
| <input type="radio"/> No<br>↓ | <input type="radio"/> Yes ⇒ | <b>How often?</b> ⇒<br><input type="radio"/> Almost every day<br><input type="radio"/> At least once each week<br><input type="radio"/> At least once each month<br><input type="radio"/> Less than once each month | <b>How much of a problem has it been?</b><br><input type="radio"/> Mild<br><input type="radio"/> Moderate<br><input type="radio"/> Severe |
|-------------------------------|-----------------------------|---|---|

**Thank you for answering those questions about how things affected you in the past 6 months. Next we have some questions about things that have to do with conditions that you might HAVE NOW.**

**26. Are you able to chew or bite raw carrots or celery sticks, or something very similar to that?**

- Yes
- No
- Have not tried

*Interviewer: Discourage this response by repeating "something very similar to that"*

**27. Are you able to chew or bite steak, chops, or firm meat, or something very similar to that?**

- Yes
- No
- Have not tried

*Interviewer: Discourage this response by repeating "something very similar to that"*

28. Are you able to chew or bite a whole fresh apple without cutting it, or something very similar to that?

- Yes  $\Rightarrow$  Skip to question 31
- No
- Have not tried

*Interviewer: Discourage this response by repeating "something very similar to that"*

29. Are you able to chew or bite fresh lettuce or spinach salad, or something very similar to that?

- Yes  $\Rightarrow$  Skip to question 31
- No
- Have not tried

*Interviewer: Discourage this response by repeating "something very similar to that"*

30. Are you able to chew or bite boiled peas, carrots, or green or yellow beans or something similar to that?

- Yes
- No
- Have not tried

*Interviewer: Discourage this response by repeating "something very similar to that"*

31. How would you rate your ability to chew food? Would you say that your ability to chew food is... ?

- Excellent
- Very good
- Good
- Fair
- Poor

32. How satisfied are you with your ability to chew? Would you say...?

- Completely satisfied
- Somewhat satisfied
- Neither satisfied nor dissatisfied
- Somewhat dissatisfied
- Completely dissatisfied

33. How would you rate the appearance of your teeth and/or dentures when you go out in public? Would you say that the appearance of your teeth and/or dentures is...?

- Excellent
- Very good
- Good
- Fair
- Poor

- 34. How satisfied are you with the appearance of your teeth and/or dentures when you go out in public? Would you say ...?**
- Completely satisfied
  - Somewhat satisfied
  - Neither satisfied nor dissatisfied
  - Somewhat dissatisfied
  - Completed dissatisfied
- 35. How would you rate the health of your mouth? Would you say the health of your mouth is...?**
- Excellent
  - Very good
  - Good
  - Fair
  - Poor
- 36. How satisfied are you with the health of your mouth? Would you say...?**
- Completely satisfied
  - Somewhat satisfied
  - Neither satisfied nor dissatisfied
  - Somewhat dissatisfied
  - Completed dissatisfied
- 37. How would you rate your ability to smell food? Would you say that your ability to smell food is...?**
- Excellent
  - Very good
  - Good
  - Fair
  - Poor
- 38. How would you rate your ability to taste food? Would you say that your ability to taste food is...?**
- Excellent
  - Very good
  - Good
  - Fair
  - Poor

Next I would like to ask you about certain dental problems you may or may not have NOW.

**39. Do you have infected or sore gums?**

- |                             |                                    |                                |
|-----------------------------|------------------------------------|--------------------------------|
| <input type="radio"/> Yes ⇒ | <b>How long have you had this?</b> | ⇒ <b>How bad has it been?</b>  |
| <input type="radio"/> No    | <input type="radio"/> Days         | <input type="radio"/> Mild     |
| ↓                           | <input type="radio"/> Weeks        | <input type="radio"/> Moderate |
|                             | <input type="radio"/> Months       | <input type="radio"/> Severe   |
|                             | <input type="radio"/> Years        |                                |

**40. Do you have pain or discomfort in your teeth or mouth when you chew food?**

- |                             |                                    |                                |
|-----------------------------|------------------------------------|--------------------------------|
| <input type="radio"/> Yes ⇒ | <b>How long have you had this?</b> | ⇒ <b>How bad has it been?</b>  |
| <input type="radio"/> No    | <input type="radio"/> Days         | <input type="radio"/> Mild     |
| ↓                           | <input type="radio"/> Weeks        | <input type="radio"/> Moderate |
|                             | <input type="radio"/> Months       | <input type="radio"/> Severe   |
|                             | <input type="radio"/> Years        |                                |

**41. Do you have sores or irritations in your mouth that are painful or uncomfortable?**

- |                             |                                    |                                |
|-----------------------------|------------------------------------|--------------------------------|
| <input type="radio"/> Yes ⇒ | <b>How long have you had this?</b> | ⇒ <b>How bad has it been?</b>  |
| <input type="radio"/> No    | <input type="radio"/> Days         | <input type="radio"/> Mild     |
| ↓                           | <input type="radio"/> Weeks        | <input type="radio"/> Moderate |
|                             | <input type="radio"/> Months       | <input type="radio"/> Severe   |
|                             | <input type="radio"/> Years        |                                |

**42. Do you have any teeth that look bad or do you wear a denture that looks bad?**

- |                             |                                       |                                |
|-----------------------------|---------------------------------------|--------------------------------|
| <input type="radio"/> Yes ⇒ | <b>How long have they looked bad?</b> | ⇒ <b>How bad has it been?</b>  |
| <input type="radio"/> No    | <input type="radio"/> Days            | <input type="radio"/> Mild     |
| ↓                           | <input type="radio"/> Weeks           | <input type="radio"/> Moderate |
|                             | <input type="radio"/> Months          | <input type="radio"/> Severe   |
|                             | <input type="radio"/> Years           |                                |

**43. Do you have bad breath that you are aware of?**

- |                             |                                    |                                |
|-----------------------------|------------------------------------|--------------------------------|
| <input type="radio"/> Yes ⇒ | <b>How long have you had this?</b> | ⇒ <b>How bad has it been?</b>  |
| <input type="radio"/> No    | <input type="radio"/> Days         | <input type="radio"/> Mild     |
| ↓                           | <input type="radio"/> Weeks        | <input type="radio"/> Moderate |
|                             | <input type="radio"/> Months       | <input type="radio"/> Severe   |
|                             | <input type="radio"/> Years        |                                |

44. Do you think you need to see a dentist now or in the next couple of weeks?

Yes ⇒ Is that for...

A routine check-up

A dental problem ⇒ What problem? Specify:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

No ⇒ Is that because...

You have a problem that can wait ⇒ What problem? Specify:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Your mouth is in good shape now/no problems now

You believe you never need to see a dentist

45. Have you ever had any dentures or plates regardless of whether or not you wear them?

Yes

No ⇒ If no, skip to question 52

46. Have you ever had a full denture for your upper jaw?

Yes ⇒ How often do you wear it now?

No



Never

All the time

All the time during the day

Only when eating

All during the day except when eating

All the time except when eating

47. Have you ever had a full denture for your lower jaw?

Yes ⇒ How often do you wear it now?

No



Never

All the time

All the time during the day

Only when eating

All during the day except when eating

All the time except when eating

48. Have you ever had a ***partial*** denture for your ***upper*** jaw?

- Yes ⇒ How often do you wear it now?  
 No                       Never  
 ↓                               All the time  
                                   All the time during the day  
                                   Only when eating  
                                   All during the day except when eating  
                                   All the time except when eating

49. Have you ever had a ***partial*** denture for your ***lower*** jaw?

- Yes ⇒ How often do you wear it now?  
 No                       Never  
 ↓                               All the time  
                                   All the time during the day  
                                   Only when eating  
                                   All during the day except when eating  
                                   All the time except when eating

50. Do you currently use a denture that makes your mouth sore?

- Yes ⇒ How long have you had denture soreness? ⇒ How bad has it been?  
 No                       Days                                       Mild  
 ↓                               Weeks                                       Moderate  
                                   Months                                       Severe  
                                   Years

51. Do you currently use a denture that is broken?

- Yes ⇒ How long has this denture been broken? ⇒ How bad has it been?  
 No                       Days                                       Mild  
 ↓                               Weeks                                       Moderate  
                                   Months                                       Severe  
                                   Years

***Interviewer: If the participant has no teeth (has both an upper and a lower full denture) then skip to question 55.***

52. Do you have a toothache in any of your teeth?

- Yes ⇒ How long have you had this toothache? ⇒ How bad has it been?  
 No                       Days                                       Mild  
 ↓                               Weeks                                       Moderate  
                                   Months                                       Severe  
                                   Years

**53. Are any of your teeth sensitive to hot or cold fluids?**

- Yes ⇒ **How long have you had this sensitive tooth?** ⇒ **How bad has it been?**  
 No       Days       Mild  
                    Weeks       Moderate  
                    Months       Severe  
                    Years

**54. Are any of your teeth sensitive to sweets?**

- Yes ⇒ **How long have you had this sensitive tooth?** ⇒ **How bad has it been?**  
 No       Days       Mild  
                    Weeks       Moderate  
                    Months       Severe  
                    Years

**INTERVIEWER PLEASE NOTE: INFORMATION ON THIS FORM WAS PROVIDED BY**

- Subject  
 Mostly by subject with minimal proxy assistance  
 Subject and proxy  
 Proxy

**LIFE SPACE (page 13)**

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## DENTAL STUDY - LIFE SPACE ASSESSMENT

Interview (Follow-up) Month B <input type="radio"/> 1 <input type="radio"/> 6 <input type="radio"/> 12 <input type="radio"/> 18 <input type="radio"/> 24 <input type="radio"/> 30 <input type="radio"/> 36 <input type="radio"/> 42 <input type="radio"/> 48 <input type="radio"/> 54 <input type="radio"/> 60	Subject Number <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	Date: <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>		
THE NEXT QUESTIONS REFER TO YOUR ACTIVITIES JUST WITHIN THE PAST MONTH. DURING THE PAST FOUR WEEKS HAVE YOU ...				
BEEN TO OTHER ROOMS OF YOUR HOME besides the room where you sleep?  <i>LIFE-SPACE 1*</i>	Yes <input type="radio"/> No <input type="radio"/>	A. IN THE LAST FOUR WEEKS, HOW OFTEN HAVE YOU BEEN TO (Name of appropriate Life-space)?  Frequency Less than once a week <input type="radio"/> 1-3 times a week <input type="radio"/> 4-6 times a week <input type="radio"/> Daily <input type="radio"/>	B. DID YOU USE AIDS OR SPECIAL EQUIPMENT TO GET TO (Name of Life-space)?  Yes <input type="radio"/> No <input type="radio"/> Don't Know or Refused <input type="radio"/>	C. DID YOU NEED HELP FROM ANOTHER PERSON TO GET TO (Name of Life-space)?  Yes <input type="radio"/> No <input type="radio"/> Don't Know or Refused <input type="radio"/>
BEEN TO AN AREA OUTSIDE YOUR HOME such as your porch, deck or patio, hallway (of an apartment building) or garage, in your own yard or driveway?  <i>LIFE-SPACE 2</i>	Yes <input type="radio"/> No <input type="radio"/>	A. IN THE LAST FOUR WEEKS, HOW OFTEN HAVE YOU BEEN TO (Name of appropriate Life-space)?  Frequency Less than once a week <input type="radio"/> 1-3 times a week <input type="radio"/> 4-6 times a week <input type="radio"/> Daily <input type="radio"/>	B. DID YOU USE AIDS OR SPECIAL EQUIPMENT TO GET TO (Name of Life-space)?  Yes <input type="radio"/> No <input type="radio"/> Don't Know or Refused <input type="radio"/>	C. DID YOU NEED HELP FROM ANOTHER PERSON TO GET TO (Name of Life-space)?  Yes <input type="radio"/> No <input type="radio"/> Don't Know or Refused <input type="radio"/>
BEEN TO PLACES IN YOUR NEIGHBORHOOD, other than your own yard or apartment building?  <i>LIFE-SPACE 3</i>	Yes <input type="radio"/> No <input type="radio"/>	A. IN THE LAST FOUR WEEKS, HOW OFTEN HAVE YOU BEEN TO (Name of appropriate Life-space)?  Frequency Less than once a week <input type="radio"/> 1-3 times a week <input type="radio"/> 4-6 times a week <input type="radio"/> Daily <input type="radio"/>	B. DID YOU USE AIDS OR SPECIAL EQUIPMENT TO GET TO (Name of Life-space)?  Yes <input type="radio"/> No <input type="radio"/> Don't Know or Refused <input type="radio"/>	C. DID YOU NEED HELP FROM ANOTHER PERSON TO GET TO (Name of Life-space)?  Yes <input type="radio"/> No <input type="radio"/> Don't Know or Refused <input type="radio"/>
BEEN TO PLACES OUTSIDE YOUR NEIGHBORHOOD, but within your town?  <i>LIFE-SPACE 4</i>	Yes <input type="radio"/> No <input type="radio"/>	A. IN THE LAST FOUR WEEKS, HOW OFTEN HAVE YOU BEEN TO (Name of appropriate Life-space)?  Frequency Less than once a week <input type="radio"/> 1-3 times a week <input type="radio"/> 4-6 times a week <input type="radio"/> Daily <input type="radio"/>	B. DID YOU USE AIDS OR SPECIAL EQUIPMENT TO GET TO (Name of Life-space)?  Yes <input type="radio"/> No <input type="radio"/> Don't Know or Refused <input type="radio"/>	C. DID YOU NEED HELP FROM ANOTHER PERSON TO GET TO (Name of Life-space)?  Yes <input type="radio"/> No <input type="radio"/> Don't Know or Refused <input type="radio"/>
BEEN TO PLACES OUTSIDE YOUR TOWN?  <i>LIFE-SPACE 5</i>	Yes <input type="radio"/> No <input type="radio"/>	A. IN THE LAST FOUR WEEKS, HOW OFTEN HAVE YOU BEEN TO (Name of appropriate Life-space)?  Frequency Less than once a week <input type="radio"/> 1-3 times a week <input type="radio"/> 4-6 times a week <input type="radio"/> Daily <input type="radio"/>	B. DID YOU USE AIDS OR SPECIAL EQUIPMENT TO GET TO (Name of Life-space)?  Yes <input type="radio"/> No <input type="radio"/> Don't Know or Refused <input type="radio"/>	C. DID YOU NEED HELP FROM ANOTHER PERSON TO GET TO (Name of Life-space)?  Yes <input type="radio"/> No <input type="radio"/> Don't Know or Refused <input type="radio"/>

This is the last of the questions before the dental exam. Thank you for answering them.  
Before we go to the dental exam, do you have any questions?

# CLINICAL EXAMINATION

**Recorder Number**  1=Love; 2=Mathews; 3=Other1; 4=Other2; 5=Other3

**Dentist Number**  1=Boykin; 2-Bradford; 3=Fisher; 4=Gilbert; 5=Mathews; 6=Other1

**Exam Location**  Participant's home  
 Other ⇒ Specify below

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Before we do the dental examination, I need to ask one medical question:

Are you allergic to latex or rubber gloves, which we will use during the dentalexmination?

- Yes
- No
- Don't know

## 1. STABILITY OF DENTURES

IF REMOVABLE DENTURES ARE PRESENT AND THE PARTICIPANT WEARS THE DENTURE WHILE EATING, THE STABILITY OF EACH REMOVABLE DENTURE IS NOTED NEXT.

IF THE PARTICIPANT DOES NOT WEAR ANY GIVEN DENTURE WHILE EATING, IT SHOULD BE REMOVED FOR THE EXAMINATION.

Placing the index finger on the denture's premolar area (if applicable), apply mild apical force to assess stability. Do this for each premolar area (if applicable), and record the worse score.

### Upper Denture

- Not present
- No stability, extreme rocking
- Moderate rocking
- Satisfactory, slight rocking
- No rocking

### Lower Denture

- Not present
- No stability, extreme rocking
- Moderate rocking
- Satisfactory, slight rocking
- No rocking

## 2. RETENTION OF DENTURES

IF REMOVABLE DENTURES ARE PRESENT AND THE PARTICIPANT WEARS THE DENTURE WHILE EATING, THE STABILITY OF EACH REMOVABLE DENTURE IS NOTED NEXT.

IF THE PARTICIPANT DOES NOT WEAR ANY GIVEN DENTURE WHILE EATING, IT SHOULD BE REMOVED FOR THE EXAMINATION.

Placing the index finger and thumb on either side of the denture, apply mild vertical force to assess retention.

### Upper Denture

- Not present
- No retention, displaces itself
- Minimum, slight resistance to vertical pull
- Moderate resistance to vertical pull
- Maximum resistance to vertical forces

### Lower Denture

- Not present
- No retention, displaces itself
- Minimum, slight resistance to vertical pull
- Moderate resistance to vertical pull
- Maximum resistance to vertical forces

### 3. TYPE AND LOCATION OF TEETH

IF REMOVABLE DENTURES ARE PRESENT AND THE PARTICIPANT WEARS THE DENTURE WHILE EATING, THE PRESENCE AND REPLACEMENT OF TEETH ARE NOTED WITH THE DENTURE STILL IN PLACE.

For each tooth or tooth space, record:

PP = Present (regardless of whether the crown of the tooth is broken down)

BB = Bridge, pontic, cantilever (fixed bridge or implant) replaces the tooth

DD = Denture replaces the tooth (either a full or partial removable denture)

MO = Missing, and the tooth space is open

MC = Missing, but more than half the tooth space is closed due to drifting or orthodontic correction

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
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32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
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**4. TOOTH MOBILITY**

**IF REMOVABLE DENTURES ARE PRESENT AND THE PARTICIPANT WEARS THE DENTURE WHILE EATING, THEN ASSESS MOBILITY WITH DENTURES STILL IN MOUTH.**

**For each tooth that is mobile, darken the circle where...**

O = the tooth has bucco-lingual mobility of 1 or more mm in either the buccal or lingual direction, then record the tooth as being mobile.

O None		Tooth Number													
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
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## PHYSICAL MEASUREMENTS

### Arm circumference.

To determine the midpoint of the participant's upper arm; bend the arm at the elbow to form a right degree angle. Place the tape at zero on the tip of the shoulder. Pull the tape straight down along the back of the arm past the tip of the elbow. Do not bend the tape around the elbow. Locate the tip of the elbow bone and read the number. Divide by two. The result is the midpoint. Mark the midpoint. Wrap the tape around the arm at the midpoint mark. Make sure that the tape is flat on the skin. Adjust tension on tape, record measurement.

Mid-arm circumference  
(Measure to the nearest centimeter)

Reading 1:    Centimeters

### Waist circumference.

Measure waist at narrowest point.

Waist circumference    Centimeters

### Hip circumference.

Measure hips at widest point.

Hip circumference    Centimeters

### Triceps skin fold measurement

Along the midline on the back of the triceps of the right arm, determine the midpoint located between the top of the acromial process (top of the shoulder) to the bottom of the olecranon process of the ulna (elbow). Pinch the skin so that the fold is running vertically. Grab the skin with the thumb and forefinger about 0.5 inch from the measurement site following the natural fold of the skin. Lift the skin up from the muscle, apply the calipers. Record measurement. Repeat for three measurements.

Reading 1   .  Millimeters

Reading 2   .  Millimeters

Reading 3   .  Millimeters

### Measured height without shoes:

Have subject stand against wall, measure height

.  Height in Inches

**CAUTION -- IF PARTICIPANT HAS A PACEMAKER, USE THE REGULAR SCALE TO GET WEIGHT, RECORD BELOW AND STOP. LEAVE BODY FAT MEASURE BOXES BLANK. MARK PACEMAKER IN USE.**

Pacemaker in use

**If no pacemaker is in use, procede as follows:**

1. Wipe Tanita scale surface with sanitized wipe
2. Input age
3. Input female/standard or male/standard
4. Input height
5. Note three readings for accuracy
6. Ask participant to remove shoes/socks and wipe bottom of participant's feet with second sanitized wipe.
7. Ask participant to stand on scale.
8. Request participant to remain as still as possible.
9. Record weight reading
10. Record body fat measure reading

**Measured weight without shoes:**

.  Pounds

**Body fat measure**

.  Percent