Master ID #: _____

***INTERVIEWER - PLEASE READ TO ALL PARTICIPANTS*:**

This survey is part of a study called "Good Oral Health" that is working with older adults and adults with disabilities to learn about and improve oral health. By oral health I mean the health of teeth, gums and mouth. The results of this study will provide us with important information about what people do about oral health, and any concerns about oral health care, and getting oral health services. Everything you tell me will be kept strictly confidential. There are no right or wrong answers. Your views and experiences are important to us. If you don't understand a question, I will be happy to repeat it for you. If you have any questions, please feel free to ask me now or at any time during the interview.

Interviewer Name _____ Date: ___/ ___ / ___

START Time of Interview: _____ - _____ am/pm STOP Time: _____ - _____ am/pm

G.O.H.: Good Oral Health Survey Instrument

Building Code: _____

NOTE: USE APPROPRIATE LANGUAGE VERSIONS.

Interview Language: (circle number)	English	1
	Spanish	2
Participant Gender: (circle number)	Male	1
	Female	2

Date of Birth: Month: _____ Day: _____ Year: _____

Participant Age: _____

INTERVIEWERS: PLEASE HAVE PARTICIPANTS RESPOND TO AS MANY ITEMS AS POSSIBLE. ENCOURAGE THEM TO RESPOND AND NOT SKIP ITEMS.

Master Codes:
-6 = Not applicable (NA)
-7 = Don't know/unsure (DK/U)
-8 = Refused to answer (R)
-9 = Missing data (M)

***INTERVIEWER:* Were you at the Good Oral Health [GOH] presentation that was held in the community room on: _____ [date for building presentation]?**

___ Yes, for the entire session ___ Yes, for most of the session
___ Yes, for less than half of the session ___ No

DOMAIN 1. DEMOGRAPHIC CHARACTERISTICS

1.1. Where were you born? (check one)
____ In the U.S. (Including Puerto Rico, Virgin Islands, and other U.S. territories)
____ Outside the U.S.

INTERVIEWER: if participant was born in U.S., skip to 1.3
1.2. If born outside the U.S., how long have you lived in the United States? (years) _____

1.3. How long have you lived in this building? (years and months) _____(years) _____ (months)
1.4. What racial or ethnic group or groups do you consider yourself to be part of? _____
_____

1.5. Please tell me which one of these most closely matches how you think of yourself. Please answer only one of these.

____ Black/African American

____ Puerto Rican

____ Other Latino (specify): _____

____ West Indian/Caribbean (specify): _____

____ European-American/Caucasian (specify):_____

____ Asian/Pacific Islander

____ Native American/American Indian

____ Other (including mixed, specify):_____

1.6. What languages do you speak and write?

	Well (4)	Some (3)	Not well (2)	Not at all (1)
a. You can speak and understand SPOKEN English				
b. You can write in English.				
c. You can read in English.				
d. You speak and understand SPOKEN Spanish.				
e. You can write in Spanish				
f. You can read in Spanish.				

1.7. Do you speak any other languages? ____Yes ____No

1.7a. If yes, which language(s)? _____

1.8. "How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?"

___ Always ___ A lot of the time ___ Sometimes ___ Not Very Often ___Never

1.9. What is the highest grade of school you have completed? (*Check response*)

___ No formal schooling	1
___ 1st through 3rd grade	2
___ 4th – 8th grade	3
___ Less than high school graduation	4
___ High school graduate, GED, or equivalent	5
___ Some college	6
___ College graduate	7
___ Post graduate	8
___ Don't know/Unsure	-7
___ Refused	-8

1.10. Have you had any trade or technical training?

___ No (0) ___ Yes (1) ___ DK/U (-7) ___ Refused (-8)

1.11. Are you now: [*INTERVIEWER: Read list, check only one response*]

___ Single (never married)	1
___ Married/Common law/living as married	2
___ Separated	3
___ Divorced	4
___ Widowed	5
___ Other _____	6
___ Don't know/unsure	-7
___ Refused	-8

1.12. Does anyone, other than yourself, live with you in your apartment all the time?

___ No ___ Yes

INTERVIEWER: If no skip to question 1.13.

1.12a. If yes, who lives with you <u>all</u> of the time? (Check all that apply)

_____ Spouse or partner
_____ Adult children
_____ Other adult relatives
_____ Children, grandchildren or other relatives under the age of 18
_____ Other (specify): _____

INCOME

1.13. Now I am going to ask you about your sources of income. Do you receive any income from any of the following sources?

	No (0)	Yes (1)	DK/Unsure (-7)	Refused (-8)
a. Full time employment				
b. Part time employment				
c. Social Security				
d. Pension				
e. Disability				
f. Food stamps				
g. General assistance				
h. Contributions from family				
i. Selling services, food etc. (hustling)				
j. Other (specify)_____				

1.14. What is your TOTAL monthly income from ALL sources before any expenses? (*INTERVIEWER: Help resident with the math if necessary*)

$_____

1.15. How much do you worry about money? (circle)

____Not at all (4) ____A little (3) ____ Some (2) ____ A lot (1)

1.16. How well does your current income meet your basic needs (food, medication, rent, etc.)?

____Not well at all (1)____Pretty well (2) ____Well (3) ____Very well (4)

DOMAIN 2. RESOURCES

2.1. Do you have a working phone?

___Yes ____ No

2.1a. If yes, can you be reached on that phone at any time?
___All the time ___Sometimes ___ Never

INTERVIEWER: If participant has a phone, skip to 2.3. If no, go to 2.2.

2.2. If you do not have a working phone, how often do you have access to a working phone?

___ All the time ___ Sometimes ___ Only for emergencies

2.2.a Can you be reached on that phone at any time?

___ Yes ___No

2.3. Do you have transportation whenever you need it?

____Yes ____ No

2.4. DAILY LIVING ACTIVITIES

The following questions ask about activities you might do during a **typical day**. For each activity, please tell me if you are able to do it without help (by yourself), with help, or not able to do it at all.

	No help	Help	Unable to do	Don't Know	Refused

Do you need help with…?					
a. Walking across a small room?	0	1	2	-7	-8
b. Bathing: either a sponge bath, tub bath, or shower?	0	1	2	-7	-8
c. Personal grooming, like brushing hair, or washing face?	0	1	2	-7	-8
d. Dressing, like putting on a shirt, buttoning and zipping, or putting on shoes?	0	1	2	-7	-8
e. Eating, like holding a fork, cutting food, or drinking from a glass?	0	1	2	-7	-8
f. Getting from a bed to a chair?	0	1	2	-7	-8
g. Using the toilet?	0	1	2	-7	-8
h. Brushing your teeth or cleaning your dentures	0	1	2	-7	-8

2.5. How often do you attend programs or activities in your building? (check all that apply)

Building Activity	**Never (0)**	**Sometimes (1)**	**Often (2)**	**Always (3)**	**Building does not sponsor (-7)**
a. Food access (Food Share; group meals in your building)					
b. Health related (blood pressure screenings; hearing examinations; health information, flu vaccinations, eye examinations, exercise programs)					
c. Tenant Association meetings					
d. Holidays or other social events					
e. Activities in the community (outside the building) arranged by the building manager or other organization					

2.6 BERKMAN SCALE OF SOCIAL SUPPORT/NETWORKING

	None (0)	**1 or 2 (1)**	**3 to 5 (2)**	**6 to 9 (3)**	**10 + (4)**	**Unknown (-7)**
a. How many close friends do you have, people that you feel at ease with, can talk to about private matters?						
b. How many of these close friends do you see at least once a month?						
c. How many relatives do you have, people that you feel at ease with, can talk to about private matters?						
d. How many of these relatives do you see at least once a month?						

2.6e Do you participate in any groups, such as a senior center, social or work group, religious-connected group, self-help group, or charity, public service, or community group?

___ No (0) ___ Yes (1)___ Unknown -7

2.6f About how often do you go to religious meetings or services?

___ Never or almost never 0
___ Once or twice a year 1

___ Every few months 2
___ Once or twice a month 3
___ Once a week 4
___ More than once a week 5
___ Unknown -7

	None (0)	1 or 2 (1)	3 to 5 (2)	6 to 9 (3)	10 + (4)	Unknown (-7)
g. Is there someone available to you whom you can count on to listen to you when you need to talk?						
h. Is there someone available to give you good advice about a problem?						
i. Is there someone available to you who shows you love and affection?						
j. Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)?						
k. Do you have as much contact as you would like with someone you feel close to, someone in whom you can trust and confide?						

2.7. BUILDING LEVEL SOCIAL SUPPORT

2.7a How many people who live in this building do you think other residents go to for information about health problems and how to handle them, not counting the manager or others who work here?

____ Number ____ DK

2.7b. Who do you go to for health information in this building?

_____Other Residents
_____ Managers
_____ People who come to provide services in the building
_____ No one

2.7c. How many people who live in the building do you talk to if you need information about health problems and how to handle them not counting the managers or others who work there?

____ Number ____DK

DOMAIN 3. HEALTH INSURANCE AND PHYSICAL HEALTH CARE

3.1. What type of <u>medical health insurance</u> coverage do you have? (ask each, check all that apply)

a. _____ Medicaid
b. _____ Medicare
c. _____ Private/Supplemental (AARP, BC/BS)
d. _____ None
e. _____Other (specify): _____

3.2. Where do you USUALLY go for medical health care? (check one)

a. ___ Hospital-based clinic
b. ___ Community health center
c. ___ Private doctor's office
d. ___ Emergency room
e. ___ Other (specify): _____

3.3. In general, how would you rate your overall physical health? (circle)

___ Poor (1) ___ Fair (2) ___ Good (3) ___ Very Good (4) ___ Excellent (5)

3.4. CES-D 10 ITEM

INTERVIEWER: Use the provided scoring criteria. Note that items d. and g. are reverse-scored.

INTERVIEWER: I'm going to read you a list of ways you may have felt or behaved *in the past week*. Please tell me, *during the past week*, have you felt or behaved in any of these ways? Please answer YES or NO

During the past week, …	**No**	**Yes**	**DK/Unsure**	**Refused**
a. Have you felt depressed?	0	1	-7	-8
b. Have you felt that everything you did was an effort?	0	1	-7	-8
c. Was your sleep restless?	0	1	-7	-8
d. Were you happy?	1	0	-7	-8
e. Have you felt lonely?	0	1	-7	-8
f. Were people unfriendly?	0	1	-7	-8
g. Have you enjoyed life?	1	0	-7	-8
h. Have you felt sad?	0	1	-7	-8
i. Have you felt that people disliked you?	0	1	-7	-8
j. Have you felt that you could not get "going"	0	1	-7	-8
Total CES-D Score (Total of "1s")				

DOMAIN 4. ORAL HEALTH CARE

4.1. Self-rating of oral health:
How would you rate the overall health of your teeth, gums and mouth ?

___ Excellent (4) ___ Good (3) ___ Fair (2) ___ Poor (1) ___ DK (-7)

4.2. Where do you USUALLY go for regular dental care? (Check one and indicate which)

a. ___ Hospital-based clinic Which? _____
b. ___ Community health center Which? _____
c. ___ Private dentist's office Which? _____
d. ___Hospital Emergency room Which? _____
e. ___ Other (specify): _____
f. ____Nowhere_____

4.3 If you have a dental/oral emergency, where do you go? (check one and indicate which)

a. ___ Hospital-based clinic Which? _____
b. ___ Community health center Which? _____
c. ___ Private dentist's office Which? _____

d. ___ Emergency room Which? _____

e. ___ Other (specify): _____

4.4. The last time you visited the dentist, was it for a checkup, a problem that was treated, a checkup and a problem that was treated at the same time, or an emergency? (Check one).

a. ___ a checkup (1)
b. ___ a problem that was treated (2)
c. ___ a checkup and a problem that was treated (3)
d. ____ an emergency (4)

4.5. Has your doctor or other health care provider ever asked you about your oral health, teeth, or gums or looked inside your mouth during a routine visit?

___Yes ___No

4.6. When was the last time you visited the dentist?

___in the past 6 months (5) ___ 6 months – 1 year ago (4) ___ 1-2 years ago (3)

___ more than 2 years (2) ___ Never been to a dentist (1)

4.7. INTERVIEWER: I'm going to read a list of possible reasons that prevent people from going to the dentist. For each reason, please tell me how true this is for you. (This gets around the previous wording that combines a yes/no question with the "how trus" scale.)

	Very True (1)	Somewhat True (2)	Not very true (3)	Not true at all (4)
a. You haven't had any problems with your teeth or gums				
b. You don't have dental insurance				
c. You can't afford to go to the dentist				
d. You don't have time to go to the dentist				
e. You don't have transportation or a way to get to the dentist				
f. You don't have a dentist				
g. You can't find a dentist who takes Medicaid				
h. You could not get an appointment				
i. You don't know why, you just haven't gone				
j. You can't find a dentist who speaks your language				
k. Going to the dentist is painful				
l. You're afraid they might not clean the instruments properly				
m. You're afraid they might pull out all your teeth				
n. You don't like the loud noise of the drill				
o. You think they won't take into consideration your other health problems or medications				
p. You think they will knock you out without your knowing it				
q. You think the dentist won't be careful enough				
r. You're afraid the dentist won't listen to your concerns				
s. You don't like needles				

4.8. Has a dentist or dental hygienist ever said you have gum disease (pyorrhea)?

___ Yes (1) ___ No (0) ___ DK/U (-7)

4.9. If yes, how long ago were you told that you have gum disease(pyorrhea)?

___ Less than 1 year ___ 1 – 2 years ___ 3 – 5 years ___ More than 5 years ago

4.10. Have you ever had any treatment specifically for gum disease (pyorrhea) called deep cleaning or scaling and root planing?

___ Yes ___ No

4.11. Do you have natural teeth (including crowns or caps but not implants)?

___ Yes ___ No

___ If yes, how many do you have? _____

4.12. How many of your adult (permanent) teeth, including wisdom teeth, have been removed?

___ None (5) ___ Between 1 and 4 (4) ___ Between 5 and 8 (3)

___ More than 8 teeth but not all (2) ___ All (1) ___ DK/U (-7)

4.13. Do you have any partials or complete dentures?

___ Yes ___ No

4.12a. if yes, which: _____ partials _____ dentures

4.14. Do you have any dental implants?

___Yes ___ No

DOMAIN 5. PREVENTIVE DENTAL BEHAVIORS AND ORAL HYGIENE

For those with teeth (including those who have bridges or partial dentures)

5.1. How often do you brush your teeth?

___ Never (6) ___ Once a week (5) ___ A few times a week (4)

___ Once a day (3) ___ Twice a day (2) ___ More than 2 times/day (1)

5.2. Do you use toothpaste?

5.2a. ___Yes ___No

Type of toothpaste_____

5.2b. If no, what do you use?_____

5.2c. Do you use anything else to clean your teeth? _____

5.3. How often do you brush your teeth before you go to sleep?

___ Always ___ Sometimes ___ Never

5.4. How often do you floss your teeth (use dental floss)?

___ Never (1) ___Once a week (2) ___ A few times a week (3)

___ Once a day (4) ___ Twice a day (5) ___ More than 2 times/day (6)

5.4a. Do you clean between your teeth with something else? ___Yes ___No

5.4.b. If yes, what do you use?_____

5.5. How often do you use mouthwash or dental rinse?

___ Never (1) ___Once a week (2) ___ A few times a week (3)

___ Once a day (4) ___ Twice a day (5) ___ More than 2 times/day (6)

For people with dentures/partials:

5.6. How often do you clean your dentures/partials?

___ Never (1) ___Once a week (2) ___ A few times a week (3)

___ Once a day (4) ___ Twice a day (5) ___ More than 2 times/day (6)

5.7. What do you use to clean your dentures/partials most or all of the time (choose one)?

_____ Tablets
_____ Brush
_____ Brush and denture cleaning paste
_____ Baking soda
_____Soap and water
_____Other_____

5.8 How often in a typical week do you remove your dentures/partials before you go to sleep?

___ Never (1) ___ Once a week (2) ___ A few times a week (3) ___ every night (4)

5.9 How often in an average day do you:

	Never (0)	Only once (1)	2-3 times a day (2)	4-5 times a day (3)	more than 5 times a day (4)
a. Drink fruit juice					
b. Eat sweet snacks (cookies, pastries, candy)					
c. Eat starchy snacks (crackers, bread, chips)					
d. Suck on hard candies					
e. Drink or eat sweets, starch or fruit juice at night after you brush your teeth					

5.10 How important do you think the following behaviors are:

	Very important (1)	Somewhat important (2)	Not very important (3)	Not at all important (4)
For all participants:				
a. Visit the dentist once a year				
For people with teeth				
b. Brush your teeth at least once a day				
c. Brush with fluoride toothpaste				
d. Floss or clean between teeth at least once a day				
e. Check for sores in the mouth				
For people with partials/dentures				
f. Remove dentures/partials at night				
g. Soak dentures/partials in water over night				
h. Clean dentures/partials				
i. Clean gums with gauze or facecloth				

5.11 DRY MOUTH -

Please answer yes or no to the following questions.	Yes (1)	No (0)
a. Does your mouth feel dry at night or on wakening?		
b. Does your mouth feel dry at other times of the day?		
c. Do you keep a glass of water by your bed?		
d. Do you sip liquids to aid in swallowing dry foods?		
e. Does your mouth feel dry when eating a meal?		
f. Do you have difficulties swallowing any foods?		
g. Do you chew gum daily to relieve oral dryness?		
h. Do you use hard candies or mints daily to relieve oral dryness?		

5.12. Does the amount of saliva in your mouth seem to be:

____ Too little ____Too much ____ You don't notice

DOMAIN 6. ORAL HEALTH INFORMATION ACCESS

6.1. Where do you get most of your information about oral health ?

a. Newspapers/magazines		
b. TV/radio		
c. Building residents		
d. Family members		
e. Visiting nurses		
f. Dentist/hygienist		
g. Internet		
h. Health educators that visit the building		
i. Friends outside of the building		
j. Building staff		
k. Other _____		

6.2 . Have you ever advised anyone in the building to go to a dentist?

___Yes ___ No

6.3. Have you ever advised anyone in the building about brushing and flossing?

___Yes ___ No

DOMAIN 7. ORAL HEALTH AND QUALITY OF LIFE
Geriatric Oral Health Assessment Index – GOHAI;

In the past three months	**Never (0)**	**Seldom (1)**	**Sometimes (2)**	**Often (3)**	**Always (4)**
a. How often did you limit the kinds or amounts of food you eat because of problems with your teeth, mouth, or dentures?					
b. How often did you have trouble biting or chewing any kinds of food, such as firm meat or apples?					
c. How often were you able to swallow comfortably?					
d. How often have your teeth or dentures prevented you from speaking the way you wanted?					
e. How often were you able to eat anything without feeling discomfort?					
f. How often did you limit contacts with people because of the condition of your teeth or denture?					
g. How often were you pleased or happy with the looks of your teeth, gums or dentures?					
h. How often did you use medication to relieve pain or discomfort in your mouth or around your mouth?					
i. How often were you worried or concerned about the problems with your teeth, gums or dentures?					
j. How often did you feel nervous or self-conscious because of problems with your teeth, gums or dentures?					
k. How often did you feel uncomfortable eating in front of people because of problems with your teeth or dentures?					
l. How often were your teeth or gums sensitive to hot, cold, or sweets?					

DOMAIN 8. PERCEIVED RISK OF ORAL HEALTH DISEASE

What are the chances that you will… (Check box for each response.)

	Very Unlikely (4)	**Unlikely (3)**	**Likely (2)**	**Very likely (1)**
a. Get cavities?				
b. Get a toothache?				
c. Have problems with your gums?				
d. Develop oral cancer?				
e. Have to go to the hospital for problems related to your teeth, gums or mouth?				

DOMAIN 9. ORAL HEALTH EFFICACY / LOCUS OF CONTROL

9.1. I am going to read a list of statements. Please tell me how much you agree with each statement.

	Strongly Agree (4)	Partly agree (3)	Partly Disagree (2)	Strongly Disagree (3)
a. If you brush and floss correctly, you expect fewer dental problems				
b. You believe that you know how mouth sores can be treated				
c. You believe teeth should last a lifetime				
d. Only the dentist can prevent cavities and gum disease				
e. You believe cavities can be prevented				
f. If someone showed you how to clean your teeth and mouth, you would be able to practice better oral health care				
g. If both parents have had bad teeth, brushing and flossing your teeth will not help to keep them healthy				
h. You believe that dentures don't have to be removed during the night				
i. You believe you know how to floss correctly				
j. It is not possible to prevent sickness and medicines from destroying teeth				
k. You believe flossing teeth can help prevent gum disease				
l. You believe tooth loss is a normal part of growing old				
m. You believe brushing can prevent cavities				
n. If you knew the facts about dental disease, you would be able to practice better oral care				
o. You believe you can remove most of plaque to help prevent cavities and gum disease				
p. You believe that one way of brushing is just as good as any other				
q. You believe gum diseases can be prevented				
r. You believe that you can eat better if you have a healthy, clean mouth				
s. Even if you take good care of your teeth, they are only going to fall out as you get older				

DOMAIN 10. DENTAL KNOWLEDGE

Please answer true or false to each of the following statements.	True (1)	False (2)	DK/U (-7)
a. Sugary foods and drinks may cause cavities			
b. Cavities and gum disease are caused by an infection in the mouth			
c. Fluoride disinfects water and makes it safe to drink			
d. Gum disease that is not treated can cause teeth to fall out			
e. Fluoride helps prevent cavities			
f. Dentures need to be removed before going to sleep			
g. Gum disease is caused by germs in the mouth			
h. Oral cancer is contagious			

DOMAIN 11. SELF-MANAGEMENT FEAR SCALE

11.1. How worried or embarrassed are you that…

	Very 1	Somewhat 2	Not Much 3	Not at All 4
a. You cannot clean your dentures properly				
b. You can't control your bad breath				
c. The medications you are taking may be affecting your teeth				
d. If you brush your teeth your gums might get irritated				
e. You don't brush your teeth enough				
f. When you floss there is bleeding				
g. You don't brush your teeth properly				
h. You are not using the correct toothbrush to clean your teeth				
i. You don't know how to clean your tongue				
j. You don't know when is the best time to go to the dentist				
k. If you use mouthwash it might dry out your mouth				
l. Your mouth feels dry all the time				
m. If you take your dentures out you could lose them				
n. You might have to get dentures ir false teeth made from dead men's teeth so you keep your bad teeth				
o. If you go to the dentist you might get a mouth or tooth infection or cancer				
p. You can't clean the teeth in the back of your mouth and they might rot				
q. Your teeth may keep you from having friends or socializing				
r. Your bad teeth are keeping you from eating foods that will keep you healthier				
s. Your teeth get discolored and you can't keep them white				
t. When you try to brush you feel pain				
u. When you put your dentures in it hurts				
v. When you brush your teeth you feel your tooth hurts				
w. You avoid brushing your teeth because they are sensitive				

11.2. Fears of Oral Health

You are afraid…

	Very 1	Somewhat 2	Not Much 3	Not at All 4
a. That bleeding gums may be a serious problem				
b. You cannot clean your dentures properly				
c. Of losing your teeth				
d. Of oral cancer				
e. That problems with your teeth and gums might affect your general health				

DOMAIN 12. HEALTH STATUS AND HOSPITALIZATIONS

Now I'm going to ask you about your physical health. What health problems do you have that have been DIAGNOSED BY A DOCTOR OR HEALTH PROFESSIONAL.

INTERVIEWER: If resident says "yes" – ask "b" and "c" before moving to next health problem.

Health Problem	**Diagnosed with? A**	**Does the problem keep you from doing Normal daily activities? b**	**Have you been hospitalized because of the problem? c**
a. Diabetes	Yes No	Yes No	Yes No
b. Arthritis	Yes No	Yes No	Yes No
c. Heart disease	Yes No	Yes No	Yes No
d. High blood pressure	Yes No	Yes No	Yes No
e. Lung or breathing problems	Yes No	Yes No	Yes No
f. Glaucoma, cataracts, other serious eye problems	Yes No	Yes No	Yes No
g. Hearing loss	Yes No	Yes No	Yes No
h. Cancer (any)	Yes No	Yes No	Yes No
i. Problems from stroke	Yes No	Yes No	Yes No
j. Serious problems with digestion/stomach problems	Yes No	Yes No	Yes No
k. Long term sadness or depression	Yes No	Yes No	Yes No
l. Pneumonia	Yes No	Yes No	Yes No
m. Joint replacement (knee, hip, shoulder)	Yes No	Yes No	Yes No
n. Mental Health	Yes No	Yes No	Yes No
o. Any heart procedures? Please specify_____	Yes No		Yes No

13. SUBSTANCE USE

13.1. ALCOHOL

Days	**0**	**1-2**	**3-5**	**6-9**	**10-19**	**20-29**	**30**	**Ref**	**DK**
Code	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**-7**	**-8**
a. During the past 30 days, on how many days did you have at least one drink of alcohol?									
b. During the past 30 days, on how many days did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours?									

TOBACCO USE

13.3. Have you ever used any of the following tobacco products?
(INTERVIEWER: Ask "if ever", "in the past 6 months", and "right now".)

	EVER		**IN PAST 6 MOS.**		**RIGHT NOW**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
a. Cigarettes	1	0	1	0	1	0
b. Cigars	1	0	1	0	1	0
c. Pipe/Pipe tobacco	1	0	1	0	1	0
d. Chewing tobacco	1	0	1	0	1	0
e. Marijuana	1	0	1	0	1	0
f. Other:	1	0	1	0	1	0

DOMAIN 14. INTENTION

What is the possibility that…	Very Good Possibility (4)	Good Possibility (3)	Slight Possibility (2)	No Possibility (1)
For those with natural teeth				
a. You will brush your teeth at least twice a day?				
b. You will floss your teeth or clean between your teeth at least once a day?				
c. You will check your mouth for loose teeth?				
d. You will check your mouth for sores and broken teeth at least once a week?				
e. You will visit the dentist in the next year for a check-up and screening for oral cancer?				
For denture wearers				
f. You will remove your dentures every night before you go to sleep?				
g. You will place your dentures in a container of water when you are not wearing them?				
h. You will check your mouth for sores at least once a week?				
i. You will clean your mouth daily?				
j. You will clean your dentures with denture paste or a tablet and a brush every day?				
k. You will visit the dentist in the next year for a check-up and screening for oral cancer?				
l. You will check your dentures to see if they fit comfortably?				

DOMAIN 15.MEDICATIONS

We are almost finished. The last thing I would like to do is write down a list of all the medications you are currently taking, including any over-the-counter or non-prescription medications, vitamins, herbal remedies or supplements. [Interviewer: Ask to see all medication containers and document below. One medication per row]

Medication	Type (tablet, capsule, etc.)	Dosage (amount and times/day)	Expiration date

THANK YOU FOR YOUR TIME.

INTERVIEWER NOTES:

_____

_____

_____

_____

_____

_____

DOMAIN 16. POST CAMPAIGN QUESTIONS

18.1. How much do you know about the Project GOH campaign about oral health that has taken place in your building.

___ A great deal (4) ____ Some (3) ____ A little (2) ___ Never heard of it (1)

18.2. How many sessions did you participate in:

____ None (1) ____ 1 (2) ____ 2 (3)

18.3. How many activities did you participate in during the campaign events?

____ None (1) ____ 1-2 (2) ____ 3-4 (3) ____ 5+ (4)