Dental practice	
Patient ID	
Outcome assessment	**DENTAL MEASURES** **Date: ………………………** **Dental pain/problems over the study period: Yes ☐ No ☐ If yes, please give details:** **Number of teeth remaining (excluding implants): ………………………** **Number of new decayed and filled teeth: ………………………** **Number of sites*: ………………………** **Number of sites* with BoP: ………………………** **Number of sites* with plaque: ………………………** **Number of sites with a probing depth that now exceed Code 2 of the Basic Periodontal Examination periodontal probe:** **Number of sites* exceed BPE Code 2: ………………………** ***Six sites per tooth** **ORAL HEALTH IMPACT PROFILE (as a separate form)** **1. Have you had trouble pronouncing any words because of problems with your teeth, mouth or dentures? Yes ☐ No ☐** **If yes, HOW OFTEN have you had the problem during the last three months?** Very often ☐ Fairly often ☐ Occasionally ☐ Hardly ever ☐ Never ☐ Don't know ☐ **2. Have you felt that your sense of taste has worsened because of problems with your teeth, mouth or dentures? Yes ☐ No ☐** **If yes, HOW OFTEN have you had the problem during the last three months?** Very often ☐ Fairly often ☐ Occasionally ☐ Hardly ever ☐ Never ☐ Don't know ☐ **3. Have you had painful aching in your mouth? Yes ☐ No ☐** **If yes, HOW OFTEN have you had the problem during the last three months?** Very often ☐ Fairly often ☐ Occasionally ☐ Hardly ever ☐ Never ☐ Don't know ☐

4. Have you found it uncomfortable to eat any foods because of problems with your teeth, mouth or dentures? Yes ☐ No ☐

If yes, HOW OFTEN have you had the problem during the last three months?

Very often ☐
Fairly often ☐
Occasionally ☐
Hardly ever ☐
Never ☐
Don't know ☐

5. Have you been self conscious because of your teeth, mouth or dentures? Yes ☐ No ☐

If yes, HOW OFTEN have you had the problem during the last three months?

Very often ☐
Fairly often ☐
Occasionally ☐
Hardly ever ☐
Never ☐
Don't know ☐

6. Have you felt tense because of problems with your teeth, mouth or dentures? Yes ☐ No ☐

If yes, HOW OFTEN have you had the problem during the last three months?

Very often ☐
Fairly often ☐
Occasionally ☐
Hardly ever ☐
Never ☐
Don't know ☐

7. Has your diet been unsatisfactory because of problems with your teeth, mouth or dentures? Yes ☐ No ☐

If yes, HOW OFTEN have you had the problem during the last three months?

Very often ☐
Fairly often ☐
Occasionally ☐
Hardly ever ☐
Never ☐
Don't know ☐

8. Have you had to interrupt meals because of problems with your teeth, mouth or dentures? Yes ☐ No ☐

If yes, HOW OFTEN have you had the problem during the last three months?

Very often ☐
Fairly often ☐
Occasionally ☐
Hardly ever ☐
Never ☐
Don't know ☐

9. Have you found it difficult to relax because of problems with your teeth, mouth or dentures? Yes ☐ No ☐

If yes, HOW OFTEN have you had the problem during the last three months?

Very often ☐
Fairly often ☐
Occasionally ☐
Hardly ever ☐
Never ☐
Don't know ☐

10. Have you been a bit embarrassed because of problems with your teeth, mouth or dentures?
Yes ☐ No ☐

If yes, HOW OFTEN have you had the problem during the last three months?

Very often ☐
Fairly often ☐
Occasionally ☐
Hardly ever ☐
Never ☐
Don't know ☐

11. Have you been a bit irritable with other people because of problems with your teeth, mouth or dentures? Yes ☐ No ☐

If yes, HOW OFTEN have you had the problem during the last three months?

Very often ☐
Fairly often ☐
Occasionally ☐
Hardly ever ☐
Never ☐
Don't know ☐

12. Have you had difficulty doing your usual jobs because of problems with your teeth, mouth or dentures? Yes ☐ No ☐

If yes, HOW OFTEN have you had the problem during the last three months?

Very often ☐
Fairly often ☐
Occasionally ☐
Hardly ever ☐
Never ☐
Don't know ☐

13. Have you felt that life in general was less satisfying because of problems with your teeth, mouth or dentures? Yes ☐ No ☐

If yes, HOW OFTEN have you had the problem during the last three months?

Very often ☐
Fairly often ☐
Occasionally ☐
Hardly ever ☐
Never ☐
Don't know ☐

14. Have you been totally unable to function because of problems with your teeth, mouth or dentures? Yes ☐ No ☐

If yes, HOW OFTEN have you had the problem during the last three months?

Very often ☐
Fairly often ☐
Occasionally ☐
Hardly ever ☐
Never ☐
Don't know ☐

OHIP ADDITIONAL QUESTIONS
15. Have you had difficulty chewing any foods because of problems with your teeth, mouth, dentures or jaw? Yes ☐ No ☐

If yes, HOW OFTEN have you had the problem during the last three months?

Very often ☐
Fairly often ☐
Occasionally ☐
Hardly ever ☐
Never ☐
Don't know ☐

	16. Have you felt uncomfortable about the appearance of your teeth, mouth, dentures or jaws? **Yes ☐ No ☐** **If yes, HOW OFTEN have you had the problem during the last three months?** Very often ☐ Fairly often ☐ Occasionally ☐ Hardly ever ☐ Never ☐ Don't know ☐ **17. Have you felt that there has been less flavour in your food because of problems with your teeth, mouth, dentures or jaws?** **Yes ☐ No ☐** **If yes, HOW OFTEN have you had the problem during the last three months?** Very often ☐ Fairly often ☐ Occasionally ☐ Hardly ever ☐ Never ☐ Don't know ☐ **BEHAVIOUR CHANGE AT THE END OF THE STUDY** **Since entering the study, have you been doing anything differently?** **Diet Yes ☐ No ☐ If yes, please give details:** **Brushing Yes ☐ No ☐ If yes, please give details:** **Toothpaste Yes ☐ No ☐ If yes, please give details:** **Flossing Yes ☐ No ☐ If yes, please give details:** **Other Yes ☐ No ☐ If yes, please give details:** **DENTAL ANXIETY** **On a scale of 1 to 10 (10 is very anxious), how anxious have you been about your check-ups in the study period? ……………………..**
Investigator's signature	