



Healthy Finland study oral health: questionnaire

Perceived oral health

1 . During the last 12 months, have you experienced any tooth pain or other problems with your mouth, teeth or dentures?

- no
- yes

2 . Is your mouth dry?

- regularly, and almost every day or night
- from time to time
- never

3 . Are you able to chew hard or tough food, such as apple, rye bread or meat?

- yes, without difficulty
- yes, but chewing is difficult
- no, I can't do it at all

4 . Do you have removable dentures?

- full dentures on both jaws

- full denture on one jaw and either a partial denture on the other jaw or my own teeth
- a partial denture on either one or both jaws and my own teeth as well
- only my own teeth, no dentures , → *You can proceed to question 9*
- neither dentures nor my own teeth , → *You can proceed to question 9*

5 . Have you had removable dentures repaired or rebased during the last five years?

- no
- yes, the upper denture
- yes, the lower denture
- yes, both dentures

6 . Do you think that your current removable denture(s) are in need of repair?

- no
- yes, the upper denture
- yes, the lower denture
- yes, both dentures

7 . When do you use your UPPER denture?

- rarely or never
- most of the time when awake
- all the time

8 . When do you use your LOWER denture?

- rarely or never
- usually when awake
- all the time

9 . Do you feel pain in your temples, jaw joints, face, or jaws at least once a week?

- no
- yes

10 . Does chewing or opening your mouth cause you pain at least once a week?

- no
- yes

11 . Has a dental splint been made for you?

- no
- yes, but I don't use it at the moment
- yes, I use it regularly
- yes, I use it irregularly

12 . Do you gums bleed?

- no
- yes, when I chew food
- yes, when brushing teeth
- yes, for no visible reason
- yes, I have blood in my mouth when I wake up in the morning

Temporomandibular Functions (OBC-FIN)

Based on the last month, how often do you do the following activities?

If the amount of activity varies, select the higher option. Answer each point and do not skip over any point.

Activities while asleep

13 . Based on whatever evidence you have, do you press your teeth firmly together or grind your teeth while asleep?

- never
- less than 1 night/month
- 1-3 nights/month
- 1-3 nights/week
- 4-7 nights/week

Activities while awake

14 . Do you grind your teeth together when you are awake?

- never
- rarely
- sometimes
- often (most of the time)
- all the time

15 . Do you press your teeth firmly together when you are awake?

- never
- rarely
- sometimes
- often (most of the time)
- all the time

Oral self-care

16 . How often do you usually brush your teeth?

- more often than twice a day
- twice a day

- once a day
- less frequently than every day
- never

17 . Are you able to clean your own teeth and mouth?

- yes, without difficulty
- yes, but with some difficulty
- yes, but the process is very difficult
- cannot do at all

18 . How often do you clean your removable denture(s)? (answer the question if you have a denture or dentures)

- more often than twice a day
- twice a day
- once a day
- less frequently than every day
- never

19 . How often do you use the following for oral care of your mouth and teeth?

	daily	weekly	less often	not at all
an ordinary toothbrush	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
an electric toothbrush	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
dental floss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
interdental brushes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
fluoride toothpaste	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
mouthwash	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Service use

20 . Do you visit the dentist

- regularly, e.g. according to the recommended regularity for dental check-ups and care
- only when you have toothache or some other problem
- never

21 . How often do you go for a dental check-up?

- around once a year
- around once every two years
- around once every three years
- less often
- never

22 . When did you last receive dental care?

Dental care visits include visits to a dentist, dental hygienist, dental nurse and/or dental technician.

- during the past 12 months
- 1 to 2 years ago
- 2 to 5 years ago
- over 5 years ago
- I have never received dental care

23 . Where did you last receive dental care? *Such care may include only one visit, such as a normal dental check-up, or may include several visits, such as for a check-up, filling, and scaling. You may select more than one option.*

- a dentist at a health centre
- a dentist in a private practice
- at my own expense (either with Kela support or without)

- with a service voucher or as a purchase service
- a dentist elsewhere (Finnish Student Health Service, Defense Forces, university, hospital etc.)
- a specialist dental technician or dental technician
- a dental hygienist at a health centre
- a dental hygienist in a private practice
- at my own expense (either with Kela support or without)
- with a service voucher or as a purchase service
- a dental practice abroad

24 . What was the reason for your last dental appointment? *You can select more than one option*

oral and dental health check-up	<input type="checkbox"/>
I received an invitation to go for a dental check-up	<input type="checkbox"/>
the visit was scheduled at the end of my previous care period	<input type="checkbox"/>
scaling	<input type="checkbox"/>
chipped tooth	<input type="checkbox"/>
tooth cavity	<input type="checkbox"/>
toothache	<input type="checkbox"/>
other pain or discomfort related to the face, mouth or teeth and/or dentures	<input type="checkbox"/>
an accident	<input type="checkbox"/>
matters related to my outer appearance	<input type="checkbox"/>
some other reason what? <input type="text"/>	<input type="checkbox"/>

25 . During your most recent dental care period, how many visits have you had to the following? (The care period includes all the dental visits during which you were treated for the dental conditions and problems that had been identified.)

	times
a dentist at a health centre	<input type="text"/>
a dentist in a private practice	<input type="text"/>

	times
a dentist elsewhere (Finnish Student Health Service, Defense Forces, university, hospital etc.)	<input type="text"/>
a dental technician	<input type="text"/>
a dental hygienist at a health centre	<input type="text"/>
a dental hygienist in a private practice	<input type="text"/>
other dental care	<input type="text"/>
dental care abroad	<input type="text"/>

Dental care customer

26 . What treatments were you given during your last treatment period? Do you receive:

	no	yes	do not know
an oral and dental health examination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
an X-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
a filling or filling replacement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
root canal treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
manufacture or repair of a crown or bridge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
insertion of a dental implant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
manufacture or repair of removable dentures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
tooth or root extraction (incl. tooth extraction surgery)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
other oral surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
treatment of problems with the jaw joint or the masseter, e.g. with a dental splint	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
scaling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
fluoride varnish or other fluoride treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
a saliva test	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
guidance for brushing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
nutritional guidance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	no	yes	do not know
guidance on the use of fluoride	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
teeth whitening	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

27 . Have any of following factors prevented you from getting dental care? *You may select more than one option.*

Long queues for dental care	<input type="checkbox"/>
Poor transport connections to the care facility	<input type="checkbox"/>
Excessive service fees and prices	<input type="checkbox"/>
Fear	<input type="checkbox"/>
Inappropriate treatment received at the care facility	<input type="checkbox"/>
Some other reason	<input type="checkbox"/>

28 . If you consider your last visit to the dentist, how much do you agree with the following statements?

	completely agree	somewhat agree	disagree
I received care quickly enough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I received enough information about my health situation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The care personnel listened to me and showed interest in me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was able to influence the decisions made about my treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The care received was helpful for me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I did not receive the care I needed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

29 . Do you think you are currently in need of dental care?

no

yes

what kind of treatment? _____

	very often	fairly often	sometimes	very rarely	not at all	cannot say
Have you felt tense because of problems with your teeth or mouth?	<input type="radio"/>					
Have you diet been unsatisfactory because of problems with your teeth of mouth?	<input type="radio"/>					
Have you had to interrupt meals because of problems with your teeth or mouth?	<input type="radio"/>					
Have you found it difficult to relax because of problems with your teeth or mouth?	<input type="radio"/>					
Have you been a bit embarrassed because of problems with your teeth or mouth?	<input type="radio"/>					
Have you been a bit irritable with other people because of problems with your teeth or mouth?	<input type="radio"/>					
Have you had difficulty doing your usual jobs because of problems with your teeth or mouth?	<input type="radio"/>					
Have you felt that life in general was less satisfying because of problems with your teeth or mouth?	<input type="radio"/>					
Have you been totally unable to function because of problems with your teeth or mouth?	<input type="radio"/>					

HEALTHY FINLAND STUDY'S TOLL-FREE NUMBER TEL. +358 (0)800 97730 (AT 8.00-11.00 AND 15.00-17.00 ON WEEKDAYS)

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