

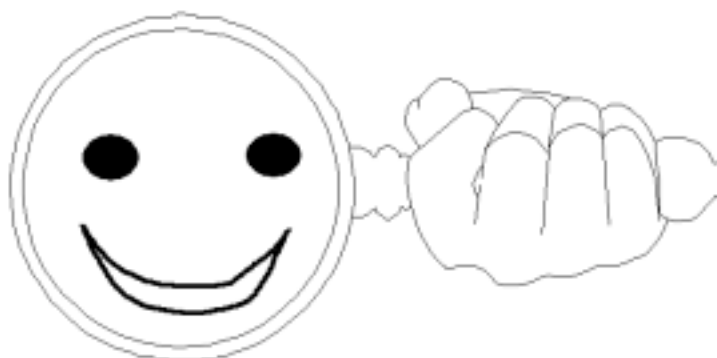
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# MY TEETH



We'd really like to know the answers to these; you may have to ask for a bit of help from a grown-up for some of them! You're going to need a mirror to help you as well.

OK - now you've got that, here we go!



## Section A: All about dentists

A1. Have you ever been to a dentist?

Yes ☐<sub>1</sub>      No ☐<sub>2</sub> → If no, go to B1 on page 4

A2. How old were you when you first went to a dentist?

☐ years old

A3. Why did you first go to a dentist?      **Tick 1 box**

because of tooth ache

☐<sub>1</sub>

for a check-up

☐<sub>2</sub>

with mum or dad when they went

☐<sub>3</sub>

for another reason

☐<sub>4</sub>

don't know

☐<sub>5</sub>

A4. Do you now go to a dentist?

**Tick 1 box**

regularly (for check-ups)

☐<sub>1</sub>

only when I have tooth-ache  
or some other problem

☐<sub>2</sub>

not ever, really

☐<sub>3</sub>

don't know

☐<sub>4</sub>

A5. How often do you go to the dentist?

every 4 months

1

every 6 months

2

once a year

3

don't go regularly

4

don't know

5

A6. Is your dentist a lady or a man?

lady

man

2

A7. Here is a space for you to write some things which  
you like about going to see your dentist.

.....

.....

.....

.....

A8. And here is a space for you to write some things you  
do not like about going to your dentist.

.....

.....

.....

.....

## Section B: All about your teeth

B1. Have you ever had a filling?

Yes ☐ No ☐ → If no, go to B4 below

B2. Space for you to write any nice things about having that done:

.....

.....

B3. Please write any not so nice things about having that done:

.....

.....

B4. a) Have you ever been given something to make your mouth go numb (sleepy, frozen, dead)?

Yes ☐ No ☐ → If no, go to B5 on page 5

b) How did you feel about that?

I liked it ☐ I hated it ☐ I wasn't sure ☐

B4. c) What did you have done to your teeth at that time?

A filling \_1\_ tooth pulled out \_2\_

something else \_3\_ (please say what) .....

.....

B5. a) Have you ever been given something to make you go to sleep (general anaesthetic) before the dentist did something to your teeth?

Yes \_1\_ No \_2\_ → If no, go to B6 on page 6

b) How did you feel about that?

I liked it \_1\_ I hated it \_2\_ I wasn't sure \_3\_

c) What did you have done to your teeth at that time?

tooth pulled out \_1\_ something else \_2\_  
(please say what)

.....

B6. a) Have you ever had a magic wind mixture that you breathe through a special nose-piece which makes you feel brave but lets you stay awake (sedation)?

Yes  No  → If no, go to B7 below

b) How did you feel about that?

I liked it  I hated it  I wasn't sure

c) What did you have done to your teeth at that time?

tooth pulled out  a filling   
something else  (please say what) .....

.....

B7. Do you like your teeth now?

Yes  No

a) If you don't - why not?

.....

.....

## Section C: Counting

Please look in the mirror or get someone else to help.

C1. How many teeth do you have in your mouth all together? 

--	--

C2. How many gaps have you got now where there used to be a tooth? 

--	--

C3. How many fillings are there in your mouth? (don't forget the front teeth!).

--	--

 (If none, write 00 in the boxes)

C4. How many of these are silver fillings? 

--	--

  
(If none, write 00 in the boxes)

C5. How many of these are white fillings ? 

--	--

  
(If none, write 00 in the boxes)

C6. Looking in the mirror and feeling with your tongue:

How many teeth can you see or feel which have a hole in them?

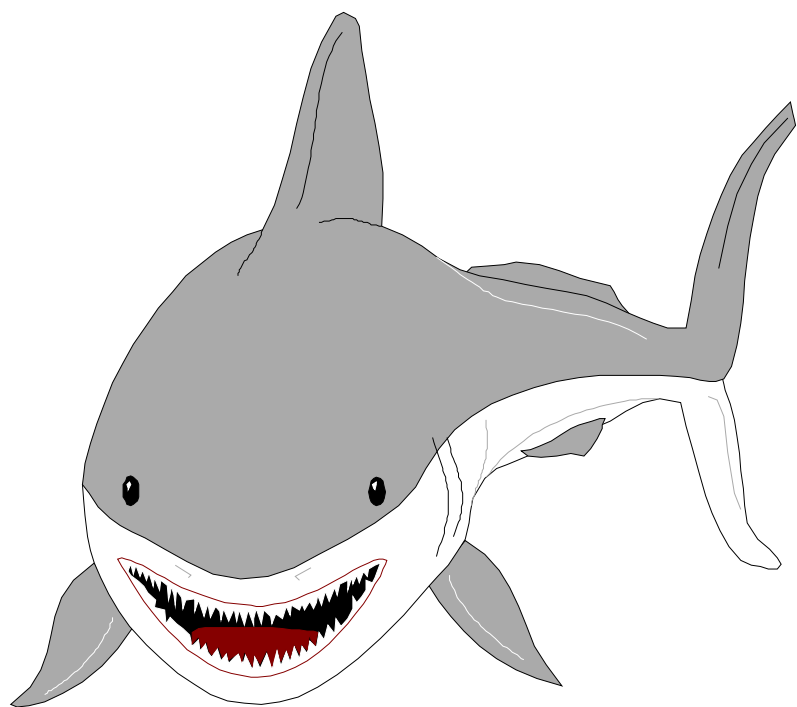
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 (If none, write 00 in the boxes)

We expect that you may be growing your new, back, grown-up teeth.

C7. Right at the back of your mouth, one in each corner, you may have grown your new “six year molars”. Which of these have grown?

	Yes	No
a) YOUR top right? (the one on YOUR right hand side!)	<div><div>1</div><div></div></div>	<div><div>2</div><div></div></div>
b) YOUR top left?	<div><div>1</div><div></div></div>	<div><div>2</div><div></div></div>
c) YOUR bottom right?	<div><div>1</div><div></div></div>	<div><div>2</div><div></div></div>
d) YOUR bottom left?	<div><div>1</div><div></div></div>	<div><div>2</div><div></div></div>





C8. Sometimes, these teeth **come through** LOOKING brown. It could be that your teeth have been through for a while. We want to know how these back teeth looked when they FIRST CAME THROUGH.

Which of your six year molars **came through** LOOKING brown?

	Yes	No	Hasn't come through
a) YOUR top right?	<div>1</div>	<div>2</div>	<div>3</div>
b) YOUR top left?	<div>1</div>	<div>2</div>	<div>3</div>
c) YOUR bottom right?	<div>1</div>	<div>2</div>	<div>3</div>
d) YOUR bottom left?	<div>1</div>	<div>2</div>	<div>3</div>

- C9. a) Look in a mirror, then put a **T** on the picture on each tooth that is a grown-up tooth. Then put a **B** on each tooth that is a baby tooth.

Cross out any teeth where you have a gap



- b) On this picture, please draw any white or brown marks showing in your **grown-up teeth only**.





## Section D: Accidents to your teeth

We expect that you have probably lost your **top baby teeth** now, but can you remember..

D1. Did you ever bang your top baby teeth?

Yes ☐<sub>1</sub>      No ☐<sub>2</sub> → If no, go to Section E  
on page 12

Because of the bang:

a) Did you chip any?    Yes ☐<sub>1</sub>                      No ☐<sub>2</sub>

b) Did any come loose because of the bang?

Yes ☐<sub>1</sub>                      No ☐<sub>2</sub>

c) Did you knock any out?      Yes ☐<sub>1</sub>                      No ☐<sub>2</sub>

d) Did they change colour after the bang?

Yes ☐<sub>1</sub>                      No ☐<sub>2</sub>

e) Did you get a gum-boil on the tooth (or teeth)  
after the bang?

Yes ☐<sub>1</sub>                      No ☐<sub>2</sub>

f) Did you have to have the banged teeth taken  
out?

Yes ☐<sub>1</sub>                      No ☐<sub>2</sub>

## Section E:

### Some questions about teeth that go bad.

E1. What do you think is the MOST IMPORTANT reason for teeth going bad?

.....

.....

.....

E2. Do you know ANOTHER reason for teeth going bad?

.....

.....

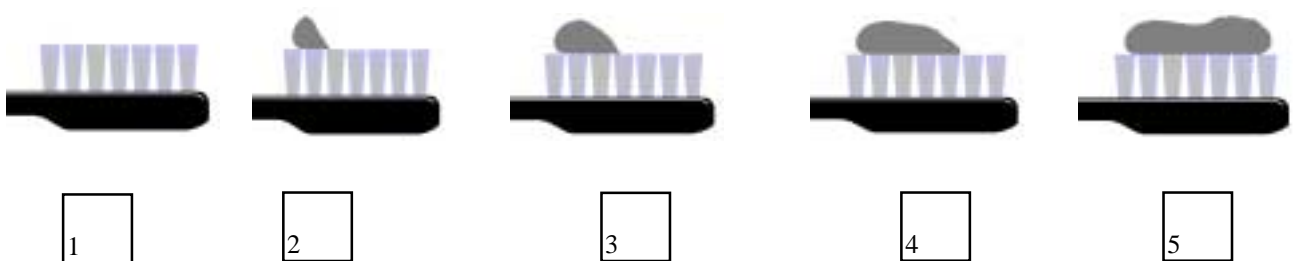
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E3. How many times a day do you clean your teeth?   
(If not at all, put 0 in the box)

E4. What tooth-paste do you use?

Write the whole name: .....

E5. Put a tick in the box below the brush that looks like the amount of tooth-paste you use:



E6. Do you swallow the tooth-paste after brushing?

Yes  No  Don't use tooth-paste

Some silly questions now which are helpful for us but may seem daft to you!

E7. Do you eat the tooth-paste straight from the tube?

Yes  Yes  No   
often sometimes



E8. Do you ever get "heart-burn" (a sort of sore, burny kind of hurt just under your ribs in the middle)?

Yes ☐\_1\_ No ☐\_2\_

E9. Do you ever get a sour taste (like after being sick) in your mouth when you haven't been sick?

Yes ☐\_1\_ No ☐\_2\_

E10. Do you ever make yourself sick "just because you can"?

Yes ☐\_1\_ No ☐\_2\_

## Section F: Drinks.

Ask a grown-up to help you with these.

HOW do you drink these different kinds of drink?

Drink	Sip it a little at a time?	Drink it all in one go? ↓	Froth and swish it around your mouth for a while?	Don't have it ↓
a) Cola (any type)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
b) Lemonade (fizzy)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
c) Other fizzy drinks	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
d) Tooth Kind	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
e) Real orange juice	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
f) Squash	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
g) Water	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
h) Tea with sugar	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
i) Tea without sugar	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
j) Coffee with sugar	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
k) Coffee without sugar	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
l) Others	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>



If others, what are they? .....

G1. This questionnaire was completed with help from:

mother or father

brother or sister

someone else

no-one helped me

G2. When were you born?

Date	Month	Year
<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Thank you VERY much.

Love from the Children of the Nineties Dental Team

When completed, please send this back to:

**Professor Jean Golding**  
**Children of the Nineties - ALSPAC**  
**Institute of Child Health**  
**24 Tyndall Avenue**  
**Bristol BS8 1BR**      **Tel: Bristol 928 5007**