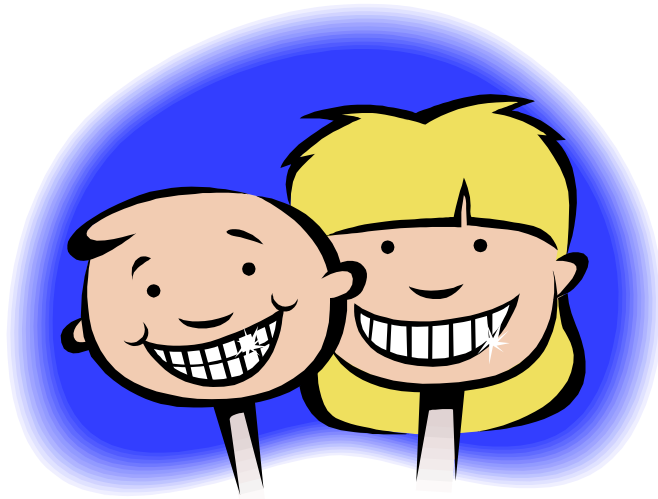


Questionnaire No:

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

TEETH AND THINGS



We'd really like to know the answers to these; you may have to ask someone for a bit of help with 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: Looking at your teeth

Please look in the mirror

A1.a) On the picture below draw an X on any teeth where you have a gap.

AND

b) Please draw any white or brown marks showing on your teeth. If you have a glued-on brace (train tracks) please draw this too.



A2. How many teeth do you have in your mouth all together?

--	--

A3. How many fillings are there in your mouth? (don't forget the front teeth!).

--	--

(If none, write 00 in the boxes)

A4. How many of these are silver fillings?

--	--

(If none, write 00 in the boxes)

A5. How many of these are white fillings?

(If none, write 00 in the boxes)

A6. Looking in the mirror and feeling with your tongue:

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

(If none, write 00 in the boxes)

A7. How many times a day do you usually clean your teeth?

Twice or
more a day

Once
a day

Not at all
some days

Never clean
my teeth

A8. Do you use an electric toothbrush? Yes

No

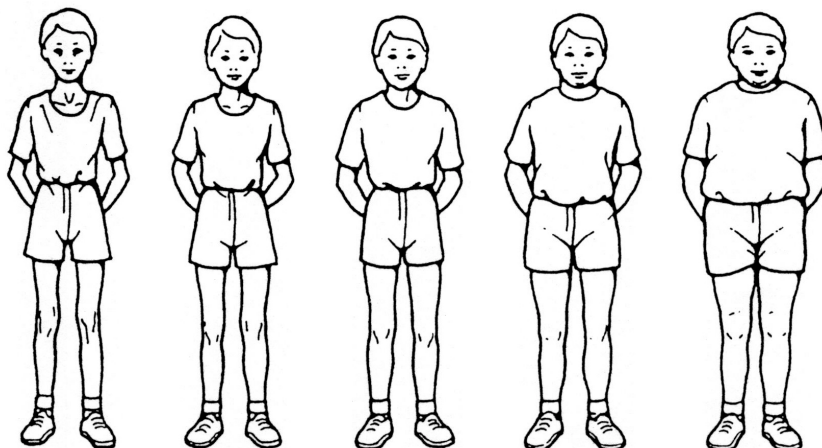
A9. What tooth-paste do you use? Write the whole name:

.....



Section B: Pictures of different boys (girls' pictures are different)

B1. Here are pictures of 5 boys. Please put a tick in the box under the drawing that is most like you:

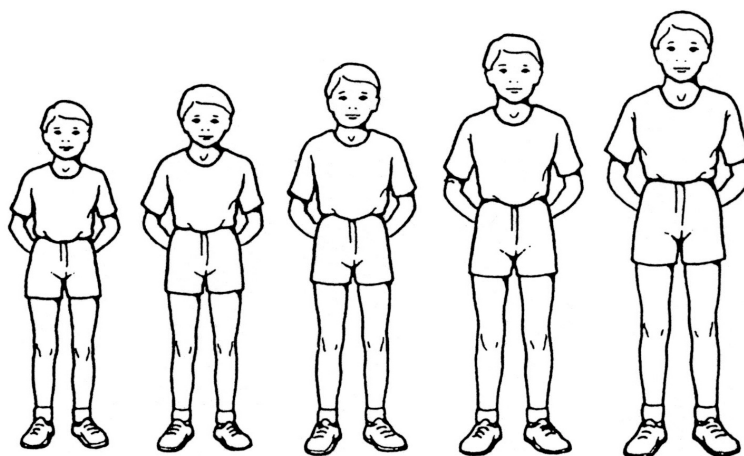


a) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

b) Now tick the box that you would most like to be. This can be the same one as in your answer above.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

B2. Here are some more pictures of boys. They are all the same age as you. Please put a tick in the box under the drawing that you think is most like you:



a) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

b) Now tick the box that you would most like to be. Again, this can be the same one as you ticked in your answer to part a).

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Section C: About the look of your teeth

C1. Do you like the way your teeth look now?

Yes ☐ ₁ No ☐ ₂

↓

If Yes, go to C4 on page 6

If No

C2. What don't you like about them? (You can tick more than one box)

My teeth are:

- | | | | |
|--------------|---------------------------------------|------------------------------|---------------------------------------|
| a) too white | <input type="checkbox"/> ₁ | g) my top teeth stick out | <input type="checkbox"/> ₁ |
| b) too brown | <input type="checkbox"/> ₁ | h) my bottom teeth stick out | <input type="checkbox"/> ₁ |
| c) blotchy | <input type="checkbox"/> ₁ | i) my teeth are gappy | <input type="checkbox"/> ₁ |
| d) too small | <input type="checkbox"/> ₁ | j) my teeth are crooked | <input type="checkbox"/> ₁ |
| e) too big | <input type="checkbox"/> ₁ | k) I don't like my brace | <input type="checkbox"/> ₁ |
| f) pointy | <input type="checkbox"/> ₁ | | |

l) Something else (please say what) ☐ ₁

.....

.....

C3. If you don't like your teeth, do you worry about them?

Tick one box only please

Yes, all of the time ☐ ₁ Yes, sometimes ☐ ₂ No, not at all ☐ ₃

C4. Do other people ever make fun of your teeth?

Often ☐

Sometimes ☐

Never ☐

C5. Do you think braces look cool on other people's teeth?

Yes ☐

No ☐

C6. Have any of your friends got a brace?

Yes ☐

No ☐

C7. Have you got a brace?

Yes ☐

No ☐

➔ If **no**, go to C9 below

C8. How are you getting on with your brace?

I like it ☐

Its OK ☐

I hate it ☐

C9. If you haven't got a brace at the moment, would you like a brace? (Tick one box only)

Yes

☐

Maybe, when I'm older

☐

Never

☐

Not sure

☐

I've already had a brace

☐

In the next section, don't worry if you can't answer a question, just leave it out and go on to the next one.

Section D: All about dentists

D1. Have you ever been to a dentist?

Yes ☐
1

No ☐
2



If no, go to F1 on page 11

D2. How old were you when you first went to visit a dentist?
(If you are not sure, ask someone)

years old

D3. Why did you first go to the dentist?
(If you are not sure, ask someone)

Tick 1 box

because I had toothache

☐
1

for a check-up

☐
2

with a grown-up when they went

☐
3

for another reason

☐
4

don't know

☐
5

D4. Do you now go to the dentist?

Tick 1 box

regularly (for check-ups)

☐
1

only when I have tooth-ache
or some other problem

☐
2

not ever, really

☐
3

don't know

☐
4

D5. How often do you go to the dentist?

- | | |
|--------------------|--------------------------|
| every 4 months | <input type="checkbox"/> |
| every 6 months | <input type="checkbox"/> |
| once a year | <input type="checkbox"/> |
| don't go regularly | <input type="checkbox"/> |
| don't know | <input type="checkbox"/> |

D6 When was the last time you went to the dentist?

- | | |
|---------------------------------|--------------------------|
| During the last 6 months | <input type="checkbox"/> |
| Between 6 months and a year ago | <input type="checkbox"/> |
| More than a year ago | <input type="checkbox"/> |
| Can't remember | <input type="checkbox"/> |

D7. Is your dentist a woman or a man? woman ☐ man ☐

D8. Here is a space for you to write some things which you like about going to see your dentist.

.....

.....

D9. And here is a space for you to write some things you do not like about going to your dentist.

.....

.....

Section E: All about your teeth

E1. Have you ever had a filling?

Yes ☐ ₁

No ☐ ₂ →

If no, go to E4 below

E2. Space for you to write any nice things about having that done:

.....
.....

E3. Please write any not so nice things about having that done:

.....
.....

E4. a) Have you ever been given something to make your mouth go numb (sleepy, frozen, dead)?

Yes ☐ ₁

No ☐ ₂ →

If no, go to E5 below

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?

a filling ☐ ₁

a tooth pulled out ☐ ₂

something else ☐ ₃

(please say what)

.....

E5. 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 E6 on page 10



E5. If yes

b) How old were you the last time this happened?

years old

c) How did you feel about it?

I liked it ₁

I hated it ₂

I wasn't sure ₃

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

tooth pulled out ₁

something else ₂
(please say what)

.....

E6. 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 ₁

No ₂



If no, go to F1 on page 11

b) How old were you the last time you had the "magic wind" mixture?

years old

c) How did you feel about it?

I liked it ₁

I hated it ₂

I wasn't sure ₃

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

tooth pulled out ₁

a filling ₂

something else ₃ (please say what)

.....

Section F: Accidents to your teeth

Can you remember...:

F1. a) Have you ever banged any of your grown-up top front teeth?

Yes

No



If no, go to Section G on page 13

If yes

b) How old were you? years old

c) How many teeth did you bang?

Because of the bang:

F2. Did you chip any teeth?

Yes

No

If yes

a) How many did you chip?

F3. Did any teeth come loose because of the bang?

Yes

No

F4. Did you knock any teeth out?

Yes

No

If no, go to F5 on page 12

If yes,

a) How many did you knock out?

b) Were any teeth put back in after they were knocked out?

Yes

No

F5. Did any of the teeth you banged change colour after the bang?

Yes ☐

No ☐

F6. Did you get a gum-boil on any tooth (or teeth) after the bang?

Yes ☐

No ☐

F7. Have you had any of the banged tooth (teeth) taken out?

Yes ☐

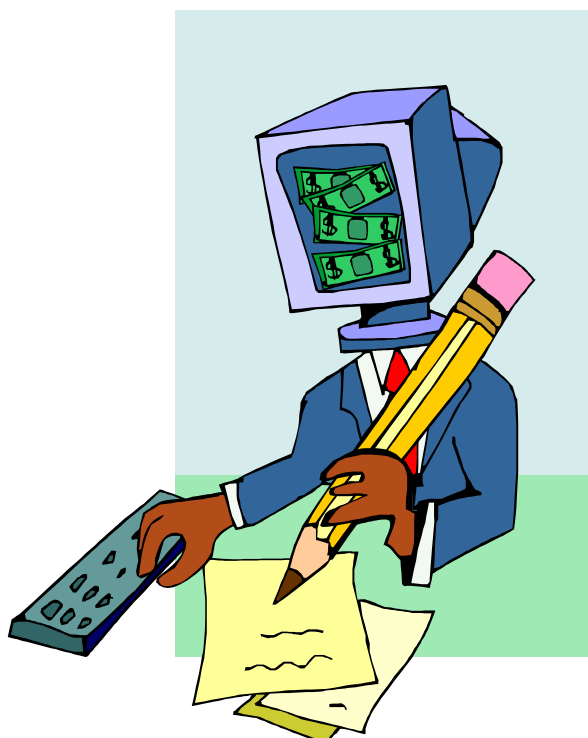
No ☐

If yes,

a) How many were taken out? ☐

Did you know? Children of the 90s families have sent us back about half a million questionnaires!!

Our computers are really busy!



Section G: All about drinks

G1. When do you drink these different kinds of drink?

	I don't drink it ↓	I only drink it on special occasions	I drink it at mealtimes only ↓	I drink it at any time of day	(i) Tick this if you often drink it at bedtime
a) Cola (any type)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div> →	<div>1</div>
b) Other fizzy fruit drinks including flavoured fizzy water, or lemonade	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div> →	<div>1</div>
c) Plain water	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div> →	<div>1</div>
d) Plain fizzy water	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div> →	<div>1</div>
e) Pure fruit juices from a carton or freshly squeezed	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div> →	<div>1</div>
f) Sweetened fruit drinks, for example Sunny Delight, Orange C	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div> →	<div>1</div>
g) Drinks with water added, for example Ribena, orange squash etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div> →	<div>1</div>
h) Ribena Toothkind	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div> →	<div>1</div>
i) Flavoured milk drinks, for example Horlicks, Ovaltine, milkshakes	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div> →	<div>1</div>

Nearly finished this one! Now turn over for just a few more drinks

G1.

	I don't drink it ↓	I only drink it on special occasions	I drink it at mealtimes only ↓	I drink it at any time of day	(i) Tick this if you often drink it at bedtime
j) Plain milk	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	→ <div>1</div>
k) Tea	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	→ <div>1</div>
l) Coffee	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	→ <div>1</div>
m) Others (Please tick and say what they are)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	→ <div>1</div>

.....

G2. Do you add sugar to any of your drinks?

Yes

1

No

2

If yes,

a) Which drinks?

G3. How do you drink these different kinds of drink?

Drink	I drink it all in one go ↓	I sip it a little at a time ↓	I froth and swish it around my mouth for a while	I usually use a straw ↓	Don't have it ↓
a) Cola (any type)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
b) Other fizzy fruit drinks including flavoured fizzy water, or lemonade	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

Drink	I drink it all in one go ↓	I sip it a little at a time ↓	I froth and swish it around my mouth for a while	I usually use a straw ↓	Don't have it ↓
c) Plain water	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d) Plain fizzy water	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
e) Pure fruit juices from a carton or freshly squeezed	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
f) Sweetened fruit drinks, for example Sunny Delight, Orange C	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
g) Drinks with water added, for example Ribena, orange squash etc.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
h) Ribena Toothkind	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
i) Flavoured milk drinks, for example Horlicks, Ovaltine, milkshakes	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
j) Plain milk	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
k) Tea	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
l) Coffee	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
m) Others (Please tick and say what they are)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

.....

H1. This questionnaire was completed with help from:

mother or father

brother or sister

someone else

no-one helped me

H2. When were you born?

Date

Month

Year

1	9		
---	---	--	--

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**