DATE	TEAM MEMBER	CHANGE
8/23/21	Julie Cusack & Neal Freedman	Draft of combined blood/urine/mouthwash
8/30/21	Julie Cusack & Neal Freedman	Updating name to research appointment Qx

Blood, Urine, and Mouthwash Data Collection Form

[SrvBlU_ModuleIntro] Thank you for being part of Connect and for donating your samples. We have some questions about you and your health history. This information will help us better understand your health status, and how it is related to the samples that you donated. If you are not sure of an answer, please make your best guess.

[SrvBlU_Sex_v1r0] Later questions in this survey will ask about your reproductive health, including your menstrual cycle (if you are menstruating) and your contraceptive use. We want to ask questions that make sense for you. What was your biological sex assigned at birth?

0 Female
1 Male
2 Intersex or other

[SrvBlU_SymptDay_v1r0] Did you have any of the following symptoms in the 24 hours before you donated your samples? Select all that apply.

0 [SrvBlU_CoughDay_v1r0] Cough
1 [SrvBlU_DiarrDay_v1r0] Diarrhea
2 [SrvBlU_NoseDay_v1r0] Stuffy nose (also known as nasal congestion)
3 [SrvBlU_VomitDay_v1r0] Feeling sick to your stomach or throwing up
4 [SrvBlU_FeverDay_v1r0] Fever
5 [SrvBlU_NoSymptDay_v1r0] No, I had none of these symptoms

[SrvBlU_EatDrinkBefore_v1r0] When did you last eat or drink anything other than water before donating your samples?

0 The same day
1 The day before
2 More than a day before **GO TO Q6**

[SrvBlU_EatDrinkTime_v1r0] At about what time did you last eat or drink anything other than water before donating your samples? Select your answer from the drop-down list below.

HH:MM AM/PM

[SrvBlU_SleepTime_v1r0] What time did you go to sleep on the night before donating your samples? Select your answer from the drop-down list below.

HH:MM AM/PM

[SrvBlU_WakeTime_v1r0] What time did you wake up on the day that you donated your samples? Select your answer from the drop-down list below.

HH:MM AM/PM

Ask, if SrvBlU_SelectSamp_v1r0 = 0 or 1:
Medications

[SrvBlU_Med_v1r0] Have you taken any of these medications in the **past month**? If so, please share the last time you took each type of medication before donating your samples. If you are not sure of an answer, please make your best guess.

[Radio button grid, select one each row]

Pain relievers	0 No	1 Yes, in the last day	2 Yes, in the last two days	3 Yes, in the last week	4 Yes, in the last month
[SrvBlU_Tylenol_v1r0] Tylenol					
[SrvBlU_NSAIDs_v1r0] NSAIDs [such as aspirin, Advil, Aleve]					
[SrvBlU_Acid_v1r0] Medications to lower stomach acid [such as Prilosec, Prevacid, Protonix, Acidphex, Omeprazole, Nexium, Tagamet, Zantac]					

[If SrvBlU_Sex_v1r0 = Male OR SrvBlU_Sex_v1r0 = Intersex or Other, GO TO COVIDINTRO**]**

[DISPLAY SrvBlU_MenstPrd_v1r0 IF SrvBlU_Sex_v1r0 = Female]

[SrvBlU_ReproIntro_v1r0] The following questions ask about your menstrual periods, if you are pregnant, and contraceptive use. Your answers will help us understand where your body was in your menstrual cycle when you donated your samples. You may have answered some questions like these on another survey, but the questions below ask about your status on the day that you donated your samples.

[SrvBlU_MenstPrd_v1r0] Have you had a menstrual period in the last **12 months**?

0 No **GO TO** SrvBlU_Pregnant_v1r0
1 Yes

[DISPLAY SrvBlU_MenstStart_v1r0 **IF** SrvBlU_MenstPrd_v1r0 **=YES]**

[SrvBlU_MenstStart_v1r0] When was the start date of your most recent period (the first day on which you saw menstrual blood)? If you are not sure or do not remember, please make your best guess.

MM/DD/YYYY

0 This does not apply to me

[SrvBlU_Pregnant_v1r0] Are you pregnant now?

0 No > **GO TO** SrvBlU_Preg3Mon_v1r0
1 Yes > **GO TO** SrvBlU_Brstfd_v1r0

[SrvBlU_Preg3Mon_v1r0] Have you been pregnant in the last **three months**?

0 No
1 Yes

[SrvBlU_Brstfd_v1r0] Are you breastfeeding now?

0 No > **GO TO** SrvBlU_Brstfd3Mon_v1r0
1 Yes > **GO TO** SrvBlU_Contracept_v1r0

[SrvBlU_Brstfd3Mon_v1r0] Did you breastfeed in the last **three months**?

0 No
1 Yes

[DISPLAY SrvBlU_Contracept_v1r0 **IF** SrvBlU_Pregnant_v1r0 **=NO]**

[SrvBlU_Contracept_v1r0] Within the **last month**, have you used hormonal contraceptives? These types of contraceptives include oral contraceptives ("the pill"), injections, implants, skin patches, vaginal rings, and hormonal intrauterine devices (IUDs).

0 No
1 Yes

[DISPLAY SrvBlU_Hormone_v1r0 **IF** SrvBlU_Pregnant_v1r0 **=NO]**
[SrvBlU_Hormone_v1r0] Within the **last month**, have you used prescription hormone therapy to relieve common symptoms of perimenopause and menopause (for example, hot flashes and vaginal dryness), or to reduce bone loss due to lowering levels of estrogen and progesterone?

0 No
1 Yes

[COVIDINTRO] The COVID-19 pandemic has been going on since 2020 in the United States. We have some questions about whether you had COVID-19 and any symptoms, your experience during the pandemic, and if you have been vaccinated.

[SrvBlU_CovTst_v1r0] Have you ever been tested for the novel coronavirus COVID-19? Please include all types of tests (including nose or throat swabs, spit, blood, PCR, antigen, or antibody tests).

1 Yes
0 No > GO TO Question SrvBlU_CovRep_v1r0
77 Unsure > GO TO Question SrvBlU_CovRep_v1r0

[SrvBlU_CovTstPos_v1r0] Have you ever tested **positive** for COVID-19?

1 Yes
0 No > GO TO Question SrvBlU_CovRep_v1r0
77 Unsure > GO TO Question SrvBlU_CovRep_v1r0

[SrvBlU_CovTstDat_v1r0] When was the **first time** that you tested positive for COVID-19? If you are not sure, please make your best guess.

Month:____ Year_____

[Soft edit- cannot be before 2020 or past current year, drop down with month and year if possible]

[SrvBlU_CovTstTyp_v1r0] The **first time** that you tested positive for COVID-19, what type of test did you have?

0 Nose ("nasal", "nasopharyngeal") swab
1 Throat swab
2 Spit ("saliva") test
3 Blood test (either "blood draw," "tube," "dried blood spot," or "finger prick")
55 Other: _____

{NOTE- If test showed you had COVID-19 = YES > GO TO Question SrvBlU_CovSympt_v1r0*}*

[SrvBlU_CovRep_v1r0] We know that some people may have had COVID-19 without getting a test. Do you think that you may have had COVID-19?

0 Yes, definitely
1 Yes, I think so
2 Maybe
3 No > GO TO Question SrvBlU_CovPanSympt_v1r0

[SrvBlU_CovRepDt_v1r0] When do you think you **first** had COVID-19? If you are not sure, please make your best guess.

Month:____ Year_____

[Soft edit- cannot be before November 2019 or past current year, drop down with month and year if possible]

[SrvBlU_CovRepHlth_v1r0] Did a healthcare provider ever tell you they thought you had COVID-19?

0 No
1 Yes

[SrvBlU_CovSympt_v1r0] When you had COVID-19, did you have any symptoms?

1 Yes
0 No > GO TO SrvBlU_CovPanSympt_v1r0

[SrvBlU_CovDlyAct_v1r0] When you were experiencing your worst COVID-19 symptoms, did they interfere with or stop you from doing your daily activities?

0 Not at all
1 A little bit
2 Somewhat
3 Quite a bit
4 Very much

[SrvBlU_CovSympt_v1r0] When you had COVID-19, did you have any of the following symptoms? Please mark yes for any symptom that **started or got worse** when you had COVID-19.

[Radio button grid, select one each row]

Part one

Symptoms	1 **Yes**	2 **No**
Fever [SrvBlU_CovFever_v1r0]	O	O
Body chills (feeling cold, shivering)[SrvBlU_CovChill_v1r0]	O	O
Body or muscle aches [SrvBlU_CovAche_v1r0]	O	O
Weakness or fatigue (tiredness) [SrvBlU_CovWeak_v1r0]	O	O
Confusion [SrvBlU_CovConf_v1r0]	O	O
Trouble sleeping [SrvBlU_CovTrSlp_v1r0]	O	O

Part two

Symptoms	1 **Yes**	2 **No**
New loss of taste or smell [SrvBlU_CovTsteSmll_v1r0]	O	O
Stuffy nose (nasal congestion) [SrvBlU_CovNasal_v1r0]	O	O
Sore throat [SrvBlU_CovSorThrt_v1r0]	O	O
Cough [SrvBlU_CovCgh_v1r0]	O	O
Shortness of breath (trouble breathing) [SrvBlU_CovBrth_v1r0]	O	O
Chest tightness [SrvBlU_CovTightCh_v1r0]	O	O

Part three

Symptoms	1 **Yes**	2 **No**
Stomach pain [SrvBlU_CovAbPain_v1r0]	O	O
Diarrhea or watery stool (poop) [SrvBlU_CovDiarr_v1r0]	O	O
Nausea (being sick to your stomach) [SrvBlU_CovNaus_v1r0]	O	O
Vomiting (throwing up) [SrvBlU_CovVom_v1r0]	O	O
Rashes or other skin changes [SrvBlU_CovSkinC_v1r0]	O	O
Conjunctivitis (pink eye) [SrvBlU_CovConjun_v1r0]	O	O
Other [Free text box] [SrvBlU_CovSymptOth_v1r0]	O	O

[SrvBlU_CovSeptic_v1r0] Did you ever have septic shock (a condition with symptoms like difficulty breathing, chills, peeing less, and confusion) as a complication of COVID-19?

1 Yes
0 No
77 Unsure

[SrvBlU_CovPneum_v1r0] Were you ever diagnosed with pneumonia (a lung or respiratory infection) as a complication of COVID-19?

1 Yes
0 No

77 Unsure

Were you ever diagnosed with blood clots as a complication of COVID-19?

1 Yes
0 No
77 Unsure

[SrvBlU_CovHsp_v1r0] Did you ever stay in a hospital overnight for any symptoms or illness related to COVID-19?

1 Yes
0 No > GO TO Question SrvBlU_CovLngSympt_v1r0
77 Unsure> GO TO Question SrvBlU_CovLngSympt_v1r0

[SrvBlU_CovHspNum_v1r0] How many nights did you stay in the hospital? If you had multiple overnight hospital stays, please add up all of the nights from each of your stays.

_____ nights

[SrvBlU_CovHspTrt_v1r0] While you were in the hospital, did you ever have any of the following treatments? If you are not sure, please make your best guess.

[Radio button grid, select one each row]

Treatment	1 **Yes**	0 **No**	77 **Do not know**
Oxygen (by mask or nose) [SrvBlU_CovHspOxy_v1r0]	O	O	O
A breathing tube or ventilator [SrvBlU_CovHspVent_v1r0]	O	O	O
"Intensive care unit" or ICU monitoring [SrvBlU_CovHspICU_v1r0]	O	O	O
Dialysis [SrvBlU_CovHspDial_v1r0]	O	O	O

{NOTE- If all NO or DON'T KNOW or did not answer > GO TO Question

Treatment	**#Days needed**
Oxygen (by mask or nose) [SrvBlU_CovHspOxyD_v1r0]	___
A breathing tube or ventilator [SrvBlU_CovHspVentD_v1r0]	___
"Intensive care unit" or ICU monitoring [SrvBlU_CovHspICUD_v1r0]	___
Dialysis [SrvBlU_CovHspDialD_v1r0]	___

[SrvBlU_CovLngSympt_v1r0] Some people who have had COVID-19 reported long-term effects from their illness and from living through the COVID-19 pandemic. Since your COVID-19 diagnosis, have you experienced any of the following symptoms?

[Radio button grid, select one each row]

Part one

Symptoms	0 **Yes, I have this**	1 **Yes, I have had**	2 **No, I never had**

	symptom now.	**this in the past, but I do not have it now.**	**this symptom.**
Loss of taste or smell			
Appetite changes[SrvBlU_CovLngApp_v1r0]			
Feeling generally more tired than you used to feel [SrvBlU_CovLngTrd_v1r0]			
Trouble remembering things [SrvBlU_CovLngMem_v1r0]			
Trouble paying attention [SrvBlU_CovlngAttn_v1r0]			
Trouble thinking or making decisions [SrvBlU_CovLngDec_v1r0]			

Part two

Symptoms	0 **Yes, I have this symptom now.**	1 **Yes, I have had this in the past, but I do not have it now.**	2 **No, I never had this symptom.**
Shortness of breath			
Not able to exercise at your usual level [SrvBlU_CovLngExer_v1r0]			
Not able to return to work or school [SrvBlU_CovLngWk_v1r0]			
Not able to return to your usual activities [SrvBlU_CovLngAct_v1r0]			
Feeling weak, tired and/or sick 24-48 hours after physical activity or exercise [SrvBlU_CovLngPhysAct_v1r0]			

Part three

Symptoms	0 **Yes, I have this symptom now.**	1 **Yes, I have had this in the past, but I do not have it now.**	2 **No, I never had this symptom.**
Feeling lightheaded or dizzy [SrvBlU_CovLngLght_v1r0]			
Periods of racing heart rate [SrvBlU_CovLngRace_v1r0]			
Trouble sleeping [SrvBlU_CovLngSlp_v1r0]			
Changes in your mood and emotions (such as feeling sad, anxious, or annoyed more than usual) [SrvBlU_CovLngMood_v1r0]			
Muscle Aches			

Other [Free text box] [SrvBlU_CovLngOthr_v1r0]			

[DISPLAY *insert* if *responses from* SrvBlU_CovLngSympt_v1r0=0 or =1. How long did you experience the following symptoms?

Symptom	0 **less than 1 month**	1 **Between 1-3 months**	2 **over 3 months**
Loss of taste or smell			
Feeling generally more tired than you used to feel			
Trouble remembering things			
Trouble paying attention			
Trouble thinking or making decisions			
Appetite changes			
Feeling lightheaded or dizzy			
Periods of racing heart rate			
Shortness of breath			
Not able to exercise at your usual level			
Not able to return to work or school			
Not able to return to your usual activities			
Feeling weak, tired and/or sick 24-48 hours after physical activity or exercise			
Trouble sleeping			
Changes in your mood and emotions (such as feeling sad, anxious, or annoyed more than usual)			
Muscle Aches			
Other [Free text box]			

[SrvBlU_CovRecov_v1r0] Following your COVID-19 infection in [FILL IN DATES FROM SrvBlU_CovTstDat_v1r0], do you feel that you have fully recovered to your usual state of health?

0 Yes, completely
1 Yes, mostly
2 No> GO TO Question SrvBlU_CovVax_v1r0

[SrvBlU_CovRecovDt_v1r0] How long did it take you to recover to your usual state of health from the date you first realized you had COVID-19?

____ months _____ days

> GO TO Question SrvBlU_CovVax_v1r0

[SrvBlU_CovPanSympt_v1r0] Many people have reported challenges related to living during the COVID-19 pandemic that have affected their health. Since the beginning of 2020, have you experienced any of the following health problems?

[Radio button grid, select one each row]

Part one

Health Problems	0 **Yes, I am experiencing this now.**	1 **Yes, I experienced this, but I am not experiencing it now.**	2 **No, I never experienced this.**
Loss of taste or smell			
Appetite changes [SrvBlU_CovPanApp_v1r0]			
Feeling generally more tired than you used to feel [SrvBlU_CovPanTrd_v1r0]			
Trouble remembering things [SrvBlU_CovPanMem_v1r0]			
Trouble paying attention [SrvBlU_CovPanAttn_v1r0]			
Trouble thinking or making decisions [SrvBlU_CovPanDec_v1r0]			

Part two

Health Problems	0 **Yes, I am experiencing this now.**	1 **Yes, I experienced this, but I am not experiencing it now.**	2 **No, I never experienced this.**
Feeling lightheaded or dizzy [SrvBlU_CovPanLght_v1r0]			
Periods of racing heart rate [SrvBlU_CovPanRace_v1r0]			
Shortness of breath			
Feeling weak, tired and/or sick 24-48 hours after physical activity or exercise [SrvBlU_CovPanPhysAct_v1r0]			
Trouble sleeping [SrvBlU_CovPanSlp_v1r0]			
Changes in your mood and emotions (such as feeling sad, anxious, or annoyed more than usual) [SrvBlU_CovPanMood_v1r0]			
Muscle aches			
Other [Free text box] [SrvBlU_CovPanOthr_v1r0]			

[DISPLAY *insert* if *responses from* SrvBlU_CovPanSympt_v1r0 =0 or =1. How long did you experience the following symptoms?

Health Problems	0	1	2

	less than 1 month	Between 1-3 months	over 3 months
Loss of taste or smell			
Appetite changes			
Feeling generally more tired than you used to feel			
Trouble remembering things			
Trouble paying attention			
Trouble thinking or making decisions			
Feeling lightheaded or dizzy			
Periods of racing heart rate			
Shortness of breath			
Feeling weak, tired and/or sick 24-48 hours after physical activity or exercise			
Trouble sleeping			
Changes in your mood and emotions (such as feeling sad, anxious, or annoyed more than usual)			
Muscle aches			
Other [Free text box]			

[SrvBlU_CovVax_v1r0] Did you get a COVID-19 vaccination?

0 Yes
1 No > GO TO end
77 Do not know > GO TO end

[SrvBlU_CovVaxDos_v1r0] How many shots of vaccine did you get?

0 One
1 Two
2 Three
3 Other, please specify [please have drop down (numeric)]

For each vaccination based on [SrvBlU_CovVaxDos_v1r0], [can we include an indicator of which shot?] i.e. for your first shot, for your second shot, for your third shot...

[SrvBlU_CovVaxDt_v1r0] When were you vaccinated?

____ month _____ year

[Soft edit- cannot be before 2020 or past current year, drop down with month and year if possible]

[SrvBlU_CovVaxTyp_v1r0] Which COVID-19 vaccine shot did you get?

0 Moderna
1 Pfizer
2 Johnson & Johnson
3 AstraZeneca
55 Other _____ [SrvBlU_CovVaxOthr_v1r0]

77 Do not know

Repeat up to total number of vaccinations reported above.

Note, this is the beginning of the mouthwash collection section of questions.

1. [BioMwQ_OralHlth_v1r0] Overall, how would you rate the health of your teeth and gums?

0 Excellent
1 Very Good
2 Good
3 Fair
4 Poor
77 Don't know

2. [BioMwQ_MwBefore_v1r0] In the **1 hour before** you donated your mouthwash (saliva) sample, did you brush your teeth?

1 Yes
0 No

2a. [BioMwQ_RinseBefore_v1r0] In the **1 hour before** you donated your mouthwash (saliva) sample, did you rinse out your mouth?

1 Yes
0 No

2b. [BioMwQ_GumBefore_v1r0] In the **1 hour before** you donated your mouthwash (saliva) sample, did you chew gum?

1 Yes
0 No

2d. [BioMwQ_TobaccoBefore_v1r0] In the **1 hour before** you donated your mouthwash (saliva) sample, did you smoke, vape, or chew any products (including tobacco)?

1 Yes
0 No

Next, we have a few questions about your oral health and routine that will help us better understand your mouthwash (saliva) sample.

3. [BioMwQ_Hygeine_v1r0] In the last **month**, which of these oral hygiene products have you used? Select all that apply.

0 [BioMwQ_Brush1_v1r0] Toothbrush
1 [BioMwQ_Mw1_v1r0] Mouthwash
2 [BioMwQ_Floss1_v1r0] Floss

3 [BioMwQ_WtrPick1_v1r0] Water-based flosser or pick/jet
4 [BioMwQ_Tongue1_v1r0] Tongue Cleaner or Scraper
5 [BioMwQ_White1_v1r0] Teeth-whiteners (strips, etc.)

[DISPLAY Q3B IF Q3 =1 Mouthwash]

3B. [BioMwQ_MwUse_v1r0] In the last **month**, which of these mouthwash products have you used? Select all that apply. [BioMwQ_MwAlc1_v1r0] Alcohol-based mouthwash (such as Scope® or LISTERINE®)

0 [BioMwQ_MwAlcFree1_v1r0] Alcohol-free mouthwash (such as LISTERINE® Zero)
1 [BioMwQ_MwChlor1_v1r0] Chlorhexidine mouthwash (such as Peridex™, PerioGard®, or Paroex®)
2 [BioMwQ_MwFlouride1_v1r0] Flouride mouthwash (such as ACT®)
3 [BioMwQ_MwPerox1_v1r0] Peroxide mouthwash (such as Colgate® Peroxyl® Mouth Sore Rinse)
4 [BioMwQ_MwCetyl1_v1r0] Cetylpyridinium chloride mouthwash (such as Crest® Pro-Health)
5 [BioMwQ_MwSensitive1_v1r0] Mouthwash for sensitive teeth (such as Sensodyne®)
6 [BioMwQ_MwDry1_v1r0] Mouthwash for dry mouth (such as biotène®)

[DISPLAY Q4 FOR EACH PRODUCT SELECTED IN Q3 EXCEPT MOUTHWASH USE Q3B. DISPLAY QUESTION IF PRODUCT SELECTED IN Q3 AND Q3B]

4a. [BioMwQ_Brush2_v1r0] In the last **month**, how often did you use a toothbrush?

0 Never
1 Less than once a week
2 Once or twice a week
3 Three to five times a week
4 Once a day
5 Two times a day or more

4b. [BioMwQ_Floss2_v1r0] In the last **month,** how often did you use floss?

0 Never
1 Less than once a week
2 Once or twice a week
3 Three to five times a week
4 Once a day
5 Two times a day or more

4c. [BioMwQ_WtrPick2_v1r0] In the last **month**, how often did you use a water-based flosser or pick/jet?

0 Never
1 Less than once a week
2 Once or twice a week

3 Three to five times a week
4 Once a day
5 Two times a day or more

4d. [BioMwQ_Tongue2_v1r0] In the last **month**, how often did you a tongue cleaner or scraper?

0 Never
1 Less than once a week
2 Once or twice a week
3 Three to five times a week
4 Once a day
5 Two times a day or more

4e. [BioMwQ_White2_v1r0] In the last **month**, how often did you use teeth-whiteners (such as whitening strips)?

0 Never
1 Less than once a week
2 Once or twice a week
3 Three to five times a week
4 Once a day
5 Two times a day or more

4f. [BioMwQ_MwAlc_v1r0] In the last **month**, how often did you use alcohol-based mouthwash (such as Scope® or LISTERINE®)?

0 Never
1 Less than once a week
2 Once or twice a week
3 Three to five times a week
4 Once a day
5 Two times a day or more

4g. [BioMwQ_MwAlcFree_v1r0] In the last **month**, how often did you use alcohol-free mouthwash (such as LISTERINE® Zero)?

0 Never
1 Less than once a week
2 Once or twice a week
3 Three to five times a week
4 Once a day
5 Two times a day or more

4h. [BioMwQ_MwChlor_v1r0] In the last **month**, how often did you use chlorhexidine mouthwash (such as Peridex™, PerioGard®, or Paroex®)?

0 Never
1 Less than once a week
2 Once or twice a week
3 Three to five times a week

4 Once a day
5 Two times a day or more

4i. [BioMwQ_MwFlouride_v1r0] In the last **month**, how often did you use fluoride mouthwash (such as ACT®)?

0 Never
1 Less than once a week
2 Once or twice a week
3 Three to five times a week
4 Once a day
5 Two times a day or more

4j. [BioMwQ_MwPerox_v1r0] In the last **month**, how often did you use peroxide mouthwash (such as Colgate® Peroxyl® Mouth Sore Rinse)?

0 Never
1 Less than once a week
2 Once or twice a week
3 Three to five times a week
4 Once a day
5 Two times a day or more

4k. [BioMwQ_MwCetyl_v1r0] In the last **month**, how often did you use cetylpyridinium chloride mouthwash (such as Crest® Pro- Health)?

0 Never
1 Less than once a week
2 Once or twice a week
3 Three to five times a week
4 Once a day
5 Two times a day or more

4l. [BioMwQ_MwSensitive_v1r0] In the last **month**, how often did you use mouthwash for sensitive teeth (such as Sensodyne®)?

0 Never
1 Less than once a week
2 Once or twice a week
3 Three to five times a week
4 Once a day
5 Two times a day or more

4m. [BioMwQ_MwDry_v1r0] In the last **month**, how often did you use mouthwash for dry mouth (such as biotène®)?

0 Never
1 Less than once a week
2 Once or twice a week
3 Three to five times a week

4 Once a day
5 Two times a day or more

5. [BioMwQ_PermTthLost_v1r0] Have you lost any of your permanent adult teeth, not including your wisdom teeth?

1 Yes, from accident or injury **GO TO Q6**
2 Yes, from tooth decay or disease **GO TO Q7**
0 No **GO TO Q8**

6. [BioMwQ_TeethLost_v1r0] How many teeth have you lost from accident or injury? Do not include wisdom teeth.

0 1
1 2-4
2 5-9
3 10 or more
4 More than one, but not sure how many
5 Don't know

GO TO Q8, unless Q5=2

7. [BioMwQ_TeethLost_v1r0] How many teeth have you lost from tooth decay or disease? Do not include wisdom teeth.

0 1
1 2-4
2 5-9
3 10 or more
4 More than one, but not sure how many
5 Don't know

[DISPLAY Q8 IF Q6 ≠ NO]

8. [BioMwQ_Dentures_v1r0] Do you currently use any type of dentures or dental appliance? Please select all you have.

1 Dental Bridge
2 Partial denture
3 Full denture
4 Dental Implants
5 Other
0 No
77 Don't know

9. [BioMwQ_DentalClean_v1r0] When did you last have a professional dental cleaning by a dentist or hygienist?

0 In the past month
1 More than a month ago, but in the past 6 months
2 More than six months ago, but in the past year

3 Between one year and two years ago
4 More than 2 years ago
77 Don't know

10. [BioMwQ_Cavity_v1r0] Have you ever had a cavity in any of your permanent adult teeth? Please include root caries, which are cavities on the root of the tooth.

1 Yes
0 No
77 Don't know

11. [BioMwQ_GumDisease_v1r0] Has a dentist ever told you that you have gum disease (periodontal disease)?

1 Yes
0 No
77 Don't know

12. [BioMwQ_GumTx_v1r0] Have you ever had treatment for gum disease, such as scaling or root planing, sometimes called "deep cleaning"?

1 Yes
0 No
77 Don't know

13. [BioMwQ_Antibio_v1r0] In the **past two months**, have you taken any antibiotic medicine? Common antibiotics include Azithromycin (such as Zithromax®/Z-Paks®), Penicillin (such as Pfizerpen® or Pen-Vee K®), and Amoxicillin (such as Amoxil®) and are generally used to treat infections.

1 Yes **GO TO Q14**
0 No **GO TO END**
77 Don't know **GO TO END**

14. [BioMwQ_AntibioTime_v1r0] When did you last take antibiotic medicine?

0 Within the last 24 hours
1 More than 24 hours ago but within the last week
2 1-4 weeks ago
3 More than 4 weeks ago

[Same thank you message as other modules]