

ORAL HEALTH IMPACT PROFILE

Name

Date

HOW OFTEN have you had the problem during the last year?
(circle your answer)

- | | VERY OFTEN | FAIRLY OFTEN | OCCASIONALLY | HARDLY EVER | NEVER | DON'T KNOW |
|---|------------|--------------|--------------|-------------|-------|------------|
| 1. Have you had trouble <u>pronouncing any words</u> because of problems with your teeth, mouth or dentures? | VERY OFTEN | FAIRLY OFTEN | OCCASIONALLY | HARDLY EVER | NEVER | DON'T KNOW |
| 2. Have you felt that your <u>sense of taste</u> has worsened because of problems with your teeth, mouth or dentures? | VERY OFTEN | FAIRLY OFTEN | OCCASIONALLY | HARDLY EVER | NEVER | DON'T KNOW |
| 3. Have you had <u>painful aching</u> in your mouth? | VERY OFTEN | FAIRLY OFTEN | OCCASIONALLY | HARDLY EVER | NEVER | DON'T KNOW |
| 4. Have you found it <u>uncomfortable to eat any foods</u> because of problems with your teeth, mouth or dentures? | VERY OFTEN | FAIRLY OFTEN | OCCASIONALLY | HARDLY EVER | NEVER | DON'T KNOW |
| 5. Have you been <u>self conscious</u> because of your teeth, mouth or dentures? | VERY OFTEN | FAIRLY OFTEN | OCCASIONALLY | HARDLY EVER | NEVER | DON'T KNOW |
| 6. Have you <u>felt tense</u> because of problems with your teeth, mouth or dentures? | VERY OFTEN | FAIRLY OFTEN | OCCASIONALLY | HARDLY EVER | NEVER | DON'T KNOW |
| 7. Has your <u>diet been unsatisfactory</u> because of problems with your teeth, mouth or dentures? | VERY OFTEN | FAIRLY OFTEN | OCCASIONALLY | HARDLY EVER | NEVER | DON'T KNOW |
| 8. Have you had to <u>interrupt meals</u> because of problems with your teeth, mouth or dentures? | VERY OFTEN | FAIRLY OFTEN | OCCASIONALLY | HARDLY EVER | NEVER | DON'T KNOW |
| 9. Have you found it <u>difficult to relax</u> because of problems with your teeth, mouth or dentures? | VERY OFTEN | FAIRLY OFTEN | OCCASIONALLY | HARDLY EVER | NEVER | DON'T KNOW |
| 10. Have you been a bit <u>embarrassed</u> because of problems with your teeth, mouth or dentures? | VERY OFTEN | FAIRLY OFTEN | OCCASIONALLY | HARDLY EVER | NEVER | DON'T KNOW |

HOW OFTEN have you had the problem during the last year?

(circle your answer)

- | | | | | | | |
|---|-----------------------|-------------------------|---------------------------|----------------|-------|---------------|
| 11. Have you been a bit <u>irritable with other people</u> because of problems with your teeth, mouth or dentures? | VERY
OFTEN | FAIRLY
OFTEN | OCCAS-
IONALLY | HARDLY
EVER | NEVER | DON'T
KNOW |
| 12. Have you had <u>difficulty doing your usual jobs</u> because of problems with your teeth, mouth or dentures? | VERY
OFTEN | FAIRLY
OFTEN | OCCAS-
IONALLY | HARDLY
EVER | NEVER | DON'T
KNOW |
| 13. Have you felt that life in general was <u>less satisfying</u> because of problems with your teeth, mouth or dentures? | VERY
OFTEN | FAIRLY
OFTEN | OCCAS-
IONALLY | HARDLY
EVER | NEVER | DON'T
KNOW |
| 14. Have you been <u>totally unable to function</u> because of problems with your teeth, mouth or dentures? | VERY
OFTEN | FAIRLY
OFTEN | OCCAS-
IONALLY | HARDLY
EVER | NEVER | DON'T
KNOW |

CARE PLANNING: *If the person answered very often, fairly often or occasionally on any question, determine the Oral Health-Related Quality of Life most appropriate oral and general health intervention(s):*

Completed by
(name & professional designation)

INSTRUCTIONS

THE QUESTIONNAIRE.

This questionnaire asks how troubles with your teeth, mouth or dentures may have caused problems in your daily life. We would like you to complete the questionnaire even if you have good dental health. We would like to know how often you have had each of the 14 listed problems during the LAST YEAR.

HOW TO ANSWER THE QUESTIONS.

Each question on the left hand side of the page asks you about a particular dental problem. You should think about each question in turn, and circle the answer to the right of the question, to indicate how often you have had the problem during the last year.

EXAMPLES

If you occasionally had painful aching in your mouth, you would circle the answer as shown in this example.

- | | | | | | | |
|--|---------------|-----------------|-------------------|----------------|-------|---------------|
| 3. Have you had <u>painful aching</u> in your mouth? | VERY
OFTEN | FAIRLY
OFTEN | OCCAS-
IONALLY | HARDLY
EVER | NEVER | DON'T
KNOW |
|--|---------------|-----------------|-------------------|----------------|-------|---------------|

OHIP Development: Slade GD. Derivation and validation of a short-form oral health impact profile. *Community Dentistry & Oral Epidemiology* 1997; 25:284-90.

OHIP Summary Scoring: Slade GD, Nuttall N, Sanders AE, Steele JG, Allen PF, Lahti S. Impacts of oral disorders in the United Kingdom and Australia. *Br Dent J.* 2005 Apr 23;198(8):489-93.

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For additional information and resources: www.rgpc.ca
Primary Care Oral Health of Older Adults Resource Kit
ML van der Horst, D Scott & D Bowes 2008 September

