Thank you very much for agreeing to participate in this study. Let me read aloud a short paragraph to you that tells about how this interview is supposed to work. I have a set of questions that I have to ask exactly the way they are written. That way we know everyone in the study is answering the same questions and we can compare their answers. For most questions I will read a list of answers. Whenever possible you should choose one of the answers I read with the questions. It is important that your answers be as accurate as you can make them. So take time, if you need it, to think about your answers and please stop me if you have any questions about the kind of information we want. OK?

Interviewer: Read each question and each responses category aloud.

First, please tell me if you have avoided doing any of these things in the past 6 months.

IN THE PAST 6 MONTHS.....

1. Did you avoid laughing or smiling because of unattractive teeth, gums, or dentures?
   O No  O Yes  How often?  How much of a problem has it been?
   How often?
   O Almost every day
   O At least once each week
   O At least once each month
   O Less than once each month
   How much of a problem has it been?
   O Mild
   O Moderate
   O Severe

2. Did you avoid talking to someone because of unattractive teeth, gums, dentures, or bad breath?
   O No  O Yes  How often?  How much of a problem has it been?
   How often?
   O Almost every day
   O At least once each week
   O At least once each month
   O Less than once each month
   How much of a problem has it been?
   O Mild
   O Moderate
   O Severe
3. Did you avoid chewing hard things such as hard bread or apples, because of your teeth, mouth, or dentures?
   - No
   - Yes

   **How often?**
   - Almost every day
   - At least once each week
   - At least once each month
   - Less than once each month

   **How much of a problem has it been?**
   - Mild
   - Moderate
   - Severe

4. Did you avoid eating foods you would like to eat because of your teeth, mouth, or dentures?
   - No
   - Yes

   **How often?**
   - Almost every day
   - At least once each week
   - At least once each month
   - Less than once each month

   **How much of a problem has it been?**
   - Mild
   - Moderate
   - Severe

5. Did you avoid eating with other people because of problems with chewing?
   - No
   - Yes

   **How often?**
   - Almost every day
   - At least once each week
   - At least once each month
   - Less than once each month

   **How much of a problem has it been?**
   - Mild
   - Moderate
   - Severe

6. Did you cut food into small pieces because of mouth or chewing problems?
   - No
   - Yes

   **How often?**
   - Almost every day
   - At least once each week
   - At least once each month
   - Less than once each month

   **How much of a problem has it been?**
   - Mild
   - Moderate
   - Severe

7. Did you cook food longer or differently to make it softer, because of mouth or chewing problems?
   - No
   - Yes

   **How often?**
   - Almost every day
   - At least once each week
   - At least once each month
   - Less than once each month

   **How much of a problem has it been?**
   - Mild
   - Moderate
   - Severe
8. Did you reduce the total amount of food that you eat because of mouth or chewing problems?
   - No
   - Yes
   - How often?
     - Almost every day
     - At least once each week
     - At least once each month
     - Less than once each month
   - How much of a problem has it been?
     - Mild
     - Moderate
     - Severe

9. Did you lose any weight because of mouth or chewing problems?
   - No
   - Yes
   - How often?
     - Almost every day
     - At least once each week
     - At least once each month
     - Less than once each month
   - How much of a problem has it been?
     - Mild
     - Moderate
     - Severe

10. Were you uncomfortable eating in front of other people because of problems with your teeth, mouth, or dentures?
    - No
    - Yes
    - How often?
      - Almost every day
      - At least once each week
      - At least once each month
      - Less than once each month
    - How much of a problem has it been?
      - Mild
      - Moderate
      - Severe

11. Did you limit contact with other people because of the condition of your teeth, mouth, or dentures?
    - No
    - Yes
    - How often?
      - Almost every day
      - At least once each week
      - At least once each month
      - Less than once each month
    - How much of a problem has it been?
      - Mild
      - Moderate
      - Severe

12. Did you avoid going outside your neighborhood because of the condition of your teeth, mouth, or dentures?
    - No
    - Yes
    - How often?
      - Almost every day
      - At least once each week
      - At least once each month
      - Less than once each month
    - How much of a problem has it been?
      - Mild
      - Moderate
      - Severe
13. Did you avoid going outside your house because of the condition of your teeth, mouth, or dentures?
   ○ No  ○ Yes  →  How often?  →  How much of a problem has it been?
   ○ Almost every day
   ○ At least once each week
   ○ At least once each month
   ○ Less than once each month
   ○ Mild
   ○ Moderate
   ○ Severe

14. Were you embarrassed by the appearance or bad condition of your teeth, gums, or dentures?
   ○ No  ○ Yes  →  How often?  →  How much of a problem has it been?
   ○ Almost every day
   ○ At least once each week
   ○ At least once each month
   ○ Less than once each month
   ○ Mild
   ○ Moderate
   ○ Severe

15. Did pain or discomfort from your teeth keep you from doing the things you normally do in a day?
   ○ No  ○ Yes  →  How often?  →  How much of a problem has it been?
   ○ Almost every day
   ○ At least once each week
   ○ At least once each month
   ○ Less than once each month
   ○ Mild
   ○ Moderate
   ○ Severe

16. Did you have trouble sleeping because you had pain or discomfort from your teeth, gums, mouth, or dentures?
   ○ No  ○ Yes  →  How often?  →  How much of a problem has it been?
   ○ Almost every day
   ○ At least once each week
   ○ At least once each month
   ○ Less than once each month
   ○ Mild
   ○ Moderate
   ○ Severe

17. Did you have difficulty speaking or pronouncing any words because of problems with your teeth, gums, mouth, or dentures?
   ○ No  ○ Yes  →  How often?  →  How much of a problem has it been?
   ○ Almost every day
   ○ At least once each week
   ○ At least once each month
   ○ Less than once each month
   ○ Mild
   ○ Moderate
   ○ Severe
18. Did you ever feel depressed because of problems with your teeth, gums, mouth, or dentures?

○ No  ○ Yes → How often? → How much of a problem has it been?
  ○ Almost every day
  ○ At least once each week
  ○ At least once each month
  ○ Less than once each month
  ○ Mild
  ○ Moderate
  ○ Severe

19. Did you ever feel stressed because of problems with your teeth, gums, mouth, or dentures?

○ No  ○ Yes → How often? → How much of a problem has it been?
  ○ Almost every day
  ○ At least once each week
  ○ At least once each month
  ○ Less than once each month
  ○ Mild
  ○ Moderate
  ○ Severe

Thank you -- Now we have some questions about the dryness of your mouth. Please tell me if mouth dryness affected you in the past 6 months.

IN THE PAST 6 MONTHS.....

20. Did mouth dryness limit the kinds of food that you eat?

○ No  ○ Yes → How often? → How much of a problem has it been?
  ○ Almost every day
  ○ At least once each week
  ○ At least once each month
  ○ Less than once each month
  ○ Mild
  ○ Moderate
  ○ Severe

21. Did mouth dryness cause you any discomfort or pain?

○ No  ○ Yes → How often? → How much of a problem has it been?
  ○ Almost every day
  ○ At least once each week
  ○ At least once each month
  ○ Less than once each month
  ○ Mild
  ○ Moderate
  ○ Severe

22. Did mouth dryness cause you any worry or concern?

○ No  ○ Yes → How often? → How much of a problem has it been?
  ○ Almost every day
  ○ At least once each week
  ○ At least once each month
  ○ Less than once each month
  ○ Mild
  ○ Moderate
  ○ Severe
23. Did mouth dryness keep you from socializing or going out?
   ○ No  ○ Yes ➔ How often? ➔ How much of a problem has it been?
          ○ Almost every day          ○ Mild
          ○ At least once each week     ○ Moderate
          ○ At least once each month    ○ Severe
          ○ Less than once each month

24. Did mouth dryness make you uncomfortable when eating in front of other people?
   ○ No  ○ Yes ➔ How often? ➔ How much of a problem has it been?
          ○ Almost every day          ○ Mild
          ○ At least once each week     ○ Moderate
          ○ At least once each month    ○ Severe
          ○ Less than once each month

25. Did mouth dryness have a bad effect on how food tastes for you?
   ○ No  ○ Yes ➔ How often? ➔ How much of a problem has it been?
          ○ Almost every day          ○ Mild
          ○ At least once each week     ○ Moderate
          ○ At least once each month    ○ Severe
          ○ Less than once each month

Thank you for answering those questions about how things affected you in the past 6 months.
Next we have some questions about things that have to do with conditions that you might HAVE NOW.

26. Are you able to chew or bite raw carrots or celery sticks, or something very similar to that?
   ○ Yes
   ○ No
   ○ Have not tried
      Interviewer: Discourage this response by repeating "something very similar to that"

27. Are you able to chew or bite steak, chops, or firm meat, or something very similar to that?
   ○ Yes
   ○ No
   ○ Have not tried
      Interviewer: Discourage this response by repeating "something very similar to that"
28. Are you able to chew or bite a whole fresh apple without cutting it, or something very similar to that?
   - Yes ➔ Skip to question 31
   - No
   - Have not tried
     *Interviewer: Discourage this response by repeating "something very similar to that"

29. Are you able to chew or bite fresh lettuce or spinach salad, or something very similar to that?
   - Yes ➔ Skip to question 31
   - No
   - Have not tried
     *Interviewer: Discourage this response by repeating "something very similar to that"

30. Are you able to chew or bite boiled peas, carrots, or green or yellow beans or something similar to that?
   - Yes
   - No
   - Have not tried
     *Interviewer: Discourage this response by repeating "something very similar to that"

31. How would you rate your ability to chew food? Would you say that your ability to chew food is...?
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor

32. How satisfied are you with your ability to chew? Would you say...?
   - Completely satisfied
   - Somewhat satisfied
   - Neither satisfied nor dissatisfied
   - Somewhat dissatisfied
   - Completed dissatisfied

33. How would you rate the appearance of your teeth and/or dentures when you go out in public? Would you say that the appearance of your teeth and/or dentures is...?
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor
34. How satisfied are you with the appearance of your teeth and/or dentures when you go out in public? Would you say ...?
   - Completely satisfied
   - Somewhat satisfied
   - Neither satisfied nor dissatisfied
   - Somewhat dissatisfied
   - Completed dissatisfied

35. How would you rate the health of your mouth? Would you say the health of your mouth is...?
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor

36. How satisfied are you with the health of your mouth? Would you say...?
   - Completely satisfied
   - Somewhat satisfied
   - Neither satisfied nor dissatisfied
   - Somewhat dissatisfied
   - Completed dissatisfied

37. How would you rate your ability to smell food? Would you say that your ability to smell food is...?
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor

38. How would you rate your ability to taste food? Would you say that your ability to taste food is...?
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor
Next I would like to ask you about certain dental problems you may or may not have NOW.

39. Do you have infected or sore gums?
   ○ Yes  ➞  How long have you had this?  ➞  How bad has it been?
   ○ No
   ○ Days
   ○ Weeks
   ○ Months
   ○ Years
   ○ Mild
   ○ Moderate
   ○ Severe

40. Do you have pain or discomfort in your teeth or mouth when you chew food?
   ○ Yes  ➞  How long have you had this?  ➞  How bad has it been?
   ○ No
   ○ Days
   ○ Weeks
   ○ Months
   ○ Years
   ○ Mild
   ○ Moderate
   ○ Severe

41. Do you have sores or irritations in your mouth that are painful or uncomfortable?
   ○ Yes  ➞  How long have you had this?  ➞  How bad has it been?
   ○ No
   ○ Days
   ○ Weeks
   ○ Months
   ○ Years
   ○ Mild
   ○ Moderate
   ○ Severe

42. Do you have any teeth that look bad or do you wear a denture that looks bad?
   ○ Yes  ➞  How long have they looked bad?  ➞  How bad has it been?
   ○ No
   ○ Days
   ○ Weeks
   ○ Months
   ○ Years
   ○ Mild
   ○ Moderate
   ○ Severe

43. Do you have bad breath that you are aware of?
   ○ Yes  ➞  How long have you had this?  ➞  How bad has it been?
   ○ No
   ○ Days
   ○ Weeks
   ○ Months
   ○ Years
   ○ Mild
   ○ Moderate
   ○ Severe
44. Do you think you need to see a dentist now or in the next couple of weeks?
   ○ Yes  $\Rightarrow$  Is that for...
      ○ A routine check-up
      ○ A dental problem  $\Rightarrow$  What problem?  Specify:
      
   ○ No  $\Rightarrow$  Is that because...
      ○ You have a problem that can wait  $\Rightarrow$  What problem?  Specify:
      
   ○ Your mouth is in good shape now/no problems now
   ○ You believe you never need to see a dentist

45. Have you ever had any dentures or plates regardless of whether or not you wear them?
   ○ Yes
   ○ No  $\Rightarrow$  If no, skip to question 52

46. Have you ever had a full denture for your upper jaw?
   ○ Yes  $\Rightarrow$  How often do you wear it now?
      ○ Never
      ○ All the time
      ○ All the time during the day
      ○ Only when eating
      ○ All during the day except when eating
      ○ All the time except when eating

47. Have you ever had a full denture for your lower jaw?
   ○ Yes  $\Rightarrow$  How often do you wear it now?
   ○ No  $\Rightarrow$  
   ○ Never
   ○ All the time
   ○ All the time during the day
   ○ Only when eating
   ○ All during the day except when eating
   ○ All the time except when eating
48. Have you ever had a partial denture for your upper jaw?
   - Yes  ➔ How often do you wear it now?
     - Never
     - All the time
     - All the time during the day
     - Only when eating
     - All during the day except when eating
     - All the time except when eating
   - No

49. Have you ever had a partial denture for your lower jaw?
   - Yes  ➔ How often do you wear it now?
     - Never
     - All the time
     - All the time during the day
     - Only when eating
     - All during the day except when eating
     - All the time except when eating
   - No

50. Do you currently use a denture that makes your mouth sore?
   - Yes  ➔ How long have you had denture soreness?  ➔ How bad has it been?
     - No
     - Days
     - Weeks
     - Months
     - Years
     - Mild
     - Moderate
     - Severe

51. Do you currently use a denture that is broken?
   - Yes  ➔ How long has this denture been broken?  ➔ How bad has it been?
     - No
     - Days
     - Weeks
     - Months
     - Years
     - Mild
     - Moderate
     - Severe

*Interviewer: If the participant has no teeth (has both an upper and a lower full denture) then skip to question 55.*

52. Do you have a toothache in any of your teeth?
   - Yes  ➔ How long have you had this toothache?  ➔ How bad has it been?
     - No
     - Days
     - Weeks
     - Months
     - Years
     - Mild
     - Moderate
     - Severe
53. Are any of your teeth sensitive to hot or cold fluids?
   O Yes  How long have you had this sensitive tooth?  How bad has it been?
   O No    O Days  O Mild
          O Weeks  O Moderate
          O Months  O Severe
          O Years

54. Are any of your teeth sensitive to sweets?
   O Yes  How long have you had this sensitive tooth?  How bad has it been?
   O No    O Days  O Mild
          O Weeks  O Moderate
          O Months  O Severe
          O Years

INTERVIEWER PLEASE NOTE: INFORMATION ON THIS FORM WAS PROVIDED BY
   O Subject
   O Mostly by subject with minimal proxy assistance
   O Subject and proxy
   O Proxy
Before we go to the dental exam, do you have any questions?

This is the last of the questions before the dental exam. Thank you for answering them.

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<tr>
<th>LIFE-SPACE 5</th>
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<tbody>
<tr>
<td>BEEN TO PLACES OUTSIDE YOUR TOWN?</td>
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<th>LIFE-SPACE 4</th>
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<tr>
<td>BEEN TO PLACES OUTSIDE YOUR NEIGHBORHOOD, but within your town?</td>
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<th>LIFE-SPACE 3</th>
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<tbody>
<tr>
<td>BEEN TO PLACES IN YOUR NEIGHBORHOOD, building? other than your own yard or apartment</td>
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<th>LIFE-SPACE 2</th>
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<tr>
<td>BEEN TO AN AREA OUTSIDE YOUR HOME, or driveway? or apartment building, or garage, in your own yard or in your porch, deck or patio, hallway (or in such a manner that one cannot see such a building), or in your home</td>
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<tr>
<th>LIFE-SPACE 1</th>
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<tr>
<td>BEEN TO OTHER ROOMS OF YOUR HOME</td>
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**Subject Status**

**DURING THE PAST FOUR WEEKS HAVE YOU . . .**

The next questions refer to your activities.

### Date:

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0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
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### Subject Number:

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0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
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**DENTAL STUDY - LIFE SPACE ASSESSMENT**

---

**Subject Status**

---

**DURING THE PAST FOUR WEEKS HAVE YOU . . .**

The next questions refer to your activities.

### Date:

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0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
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### Subject Number:

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0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
```
CLINICAL EXAMINATION

Recorder Number □ 1=Love; 2=Mathews; 3=Other1; 4=Other2; 5=Other3

Dentist Number □ 1=Boykin; 2-Bradford; 3=Fisher; 4=Gilbert; 5=Mathews; 6=Other1

Exam Location □ Participant’s home
□ Other Specify below

Before we do the dental examination, I need to ask one medical question:

Are you allergic to latex or rubber gloves, which we will use during the dentalexmination?

□ Yes
□ No
□ Don’t know

1. STABILITY OF DENTURES

IF REMOVABLE DENTURES ARE PRESENT AND THE PARTICIPANT WEARS THE DENTURE WHILE EATING, THE STABILITY OF EACH REMOVABLE DENTURE IS NOTED NEXT.

IF THE PARTICIPANT DOES NOT WEAR ANY GIVEN DENTURE WHILE EATING, IT SHOULD BE REMOVED FOR THE EXAMINATION.

Placing the index finger on the denture’s premolar area (if applicable), apply mild apical force to assess stability. Do this for each premolar area (if applicable), and record the worse score.

Upper Denture
□ Not present
□ No stability, extreme rocking
□ Moderate rocking
□ Satisfactory, slight rocking
□ No rocking

Lower Denture
□ Not present
□ No stability, extreme rocking
□ Moderate rocking
□ Satisfactory, slight rocking
□ No rocking
2. RETENTION OF DENTURES

IF REMOVABLE DENTURES ARE PRESENT AND THE PARTICIPANT WEARS THE DENTURE WHILE EATING, THE STABILITY OF EACH REMOVABLE DENTURE IS NOTED NEXT.

IF THE PARTICIPANT DOES NOT WEAR ANY GIVEN DENTURE WHILE EATING, IT SHOULD BE REMOVED FOR THE EXAMINATION.

Placing the index finger and thumb on either side of the denture, apply mild vertical force to assess retention.

**Upper Denture**
- ☐ Not present
- ☐ No retention, displaces itself
- ☐ Minimum, slight resistance to vertical pull
- ☐ Moderate resistance to vertical pull
- ☐ Maximum resistance to vertical forces

**Lower Denture**
- ☐ Not present
- ☐ No retention, displaces itself
- ☐ Minimum, slight resistance to vertical pull
- ☐ Moderate resistance to vertical pull
- ☐ Maximum resistance to vertical forces
### 3. TYPE AND LOCATION OF TEETH

If removable dentures are present and the participant wears the denture while eating, the presence and replacement of teeth are noted with the denture still in place.

For each tooth or tooth space, record:

PP = Present (regardless of whether the crown of the tooth is broken down)
BB = Bridge, pontic, cantilever (fixed bridge or implant) replaces the tooth
DD = Denture replaces the tooth (either a full or partial removable denture)
MO = Missing, and the tooth space is open
MC = Missing, but more than half the tooth space is closed due to drifting or orthodontic correction

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4. TOOTH MOBILITY

IF REMOVABLE DENTURES ARE PRESENT AND THE PARTICIPANT WEARS THE DENTURE WHILE EATING, THEN ASSESS MOBILITY WITH DENTURES STILL IN MOUTH.

For each tooth that is mobile, darken the circle where...

O = the tooth has bucco-lingual mobility of 1 or more mm in either the buccal or lingual direction, then record the tooth as being mobile.

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5. ROOT FRAGMENTS

NEXT REMOVE ANY REMOVABLE DENTURES.

Record any present teeth that are actually root fragments. For each root fragment, darken the circle where...

O = clinically visible root fragments, defined as missing more than 3/4 of the anatomic crown (not clinical crown)

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6. RECORD ANY FINAL COMMENTS ABOUT THE OVERALL CLINICAL EXAMINATION BELOW:

1. 

2. 

3. 
PHYSICAL MEASUREMENTS

Arm circumference.
To determine the midpoint of the participant's upper arm; bend the arm at the elbow to form a right degree angle. Place the tape at zero on the tip of the shoulder. Pull the tape straight down along the back of the arm past the tip of the elbow. Do not bend the tape around the elbow. Locate the tip of the elbow bone and read the number. Divide by two. The result is the midpoint. Mark the midpoint. Wrap the tape around the arm at the midpoint mark. Make sure that the tape is flat on the skin. Adjust tension on tape, record measurement.

Mid-arm circumference
(Measure to the nearest centimeter)

Reading 1: [ ] [ ] Centimeters

Waist circumference.
Measure waist at narrowest point.

Waist circumference [ ] [ ] Centimeters

Hip circumference.
Measure hips at widest point.

Hip circumference [ ] [ ] Centimeters

Triceps skin fold measurement
Along the midline on the back of the triceps of the right arm, determine the midpoint located between the top of the acromial process (top of the shoulder) to the bottom of the olecranon process of the ulna (elbow). Pinch the skin so that the fold is running vertically. Grab the skin with the thumb and forefinger about 0.5 inch from the measurement site following the natural fold of the skin. Lift the skin up from the muscle, apply the calipers. Record measurement. Repeat for three measurements.

Reading 1 [ ] [ ] Millimeters
Reading 2 [ ] [ ] Millimeters
Reading 3 [ ] [ ] Millimeters

Measured height without shoes:
Have subject stand against wall, measure height

[ ] [ ] Height in Inches
CAUTION -- IF PARTICIPANT HAS A PACEMAKER, USE THE REGULAR SCALE TO GET WEIGHT, RECORD BELOW AND STOP. LEAVE BODY FAT MEASURE BOXES BLANK. MARK PACEMAKER IN USE.

- Pacemaker in use

If no pacemaker is in use, proceed as follows:

1. Wipe Tanita scale surface with sanitized wipe
2. Input age
3. Input female/standard or male/standard
4. Input height
5. Note three readings for accuracy
6. Ask participant to remove shoes/socks and wipe bottom of participant's feet with second sanitized wipe.
7. Ask participant to stand on scale.
8. Request participant to remain as still as possible.
9. Record weight reading
10. Record body fat measure reading

Measured weight without shoes: □□□□ □ Pounds

Body fat measure: □□□□ □ Percent