RECALL: Customized Oral Hygiene Therapy Patient Survey - Copy

I Thank you for taking the time to fill out this survey about your thoughts concerning the Customized Oral Hygiene Therapy you received. All answers are anonymous and the results will only be reported on a group level.

1 Student or Faculty: Please enter the last 4 digits of patient ID

2 What was the date of the initial session?

3 Please rate how well you think your home care habits Were Prior the Customized Oral Hygiene Therapy session you had with your student provider.

* Deficient (1)
* Poor (2)
* OK (3)
* Good (4)
* Excellent (5)

4 After the Customized Oral Hygiene Therapy session, how would you rate your home care habits?

* Much better (1)
* Somewhat better (2)
* About the same (3)
* Somewhat worse (4)
* Much worse: Why? (5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5 After the Customized Oral Hygiene Therapy session how often are you now brushing your teeth?

* 2-3 times per week (1)
* 4-5 times per week (2)
* 1 time per day (3)
* 2 times per day (4)
* More than 2 times per day (5)
* Other (6) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6 After the Customized Oral Hygiene Therapy session, how long did you brush your teeth each time?

* less than 30 secs (1)
* 30 secs to 1 min (2)
* 1 - 2 mins (4)
* 2 - 3 mins (5)
* More than 3 mins (6)

7 After the Customized Oral Hygiene Therapy session do you feel you have a better understanding of how often/ long you should be brushing your teeth?

* Much better (1)
* Somewhat better (2)
* About the same (3)
* Somewhat worse (4)
* Much worse: Why? (5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8 After the Customized Oral Hygiene Therapy session, do you understand the areas you need to focus and how to reinforce it with the correct tool and methods?

* Yes (1)
* Maybe (3)
* No (4)

9 Prior to the oral hygiene session, how would you rate your mouth odor?

* Very bad odor (1)
* Bad odor (2)
* Moderate odor (3)
* Light odor (4)
* No odor (5)

10  After using the techniques described in the session do you feel your mouth odor is:

* Much better (18)
* Somewhat better (19)
* About the same (20)
* Somewhat worse (21)
* Much worse (22)

11 Rate how much you agree with this statement: I feel my mouth odor has gotton better since I began using the techniques taught to me by my student in the customized oral hygiene session.

* Strongly agree (12)
* Somewhat agree (13)
* Neither agree nor disagree (14)
* Somewhat disagree (15)
* Strongly disagree (16)

12 How satisfied are you with the outcomes of your work?

* Extremely satisfied (12)
* Somewhat satisfied (13)
* Neither satisfied nor dissatisfied (14)
* Somewhat dissatisfied (15)
* Extremely dissatisfied (16)

13 Do you believe the customized oral hygiene therapy  session helped you achieve better oral health?

* A great deal (1)
* A lot (2)
* Somewhat (3)
* A little (4)
* Not at all (5)

14 Did you receive the custom made video

* Yes (1)
* No (2)
* I don't know (3)

15 How did you view your video?

* phone (1)
* tablet (2)
* other (3)

16 On average how often did you watch your video since your initial appointment?

* 1 time (1)
* 2 times (2)
* 3 times (3)
* 4 times (4)
* More than 4 times (5)
* I have not watched the video (6)

Answer If On average how often did you watch your video since your initial appointment? I have not watched the video Is Selected

17 Please explain why you have not watched the video.

18 How useful has having the video for you to watch been for you?

* Extremely useful (1)
* Very useful (2)
* Moderately useful (3)
* Slightly useful (4)
* Not at all useful (5)

19 Are you using the techniques found in the video?

* Yes (23)
* No (24)

20 Do you feel the session helped with your brush and flossing techniques?

* Yes (6)
* Maybe (7)
* No (8)

21 Would you recommend this form of instruction to a friend or family member?

* Yes (1)
* Maybe (2)

22 Do you frequently feel fatigue or have sleep disorders?

* Yes (1)
* No (2)

Answer If Do you frequently feel fatigue or have sleep disorders? Yes Is Selected

23 Do you feel your fatigue or sleep disorder has gotten better since the session?

* Yes (1)
* No (2)

24 Do you smoke?

* Yes (1)
* No (2)

If No Is Selected, Then Skip To

Did the therapy and ...

25 Are you interested in quitting smoking?

* Yes (1)
* No (2)

Answer If Are you interested in quitting smoking? Yes Is Selected

26 Do you believe that an increase in oral hygiene at home can help you reduce your smoking?

* Yes (1)
* No (2)

27 Please rate how much you agree with this statement : Toothpaste could help assist in quitting smoking.

* Strongly agree (1)
* Somewhat agree (2)
* Neither agree nor disagree (3)
* Somewhat disagree (4)
* Strongly disagree (5)

28 Please rate how much you agree with this statement : Brushing my teeth more often could help assist with quitting smoking.

* Strongly agree (1)
* Somewhat agree (2)
* Neither agree nor disagree (3)
* Somewhat disagree (4)
* Strongly disagree (5)

29 Please rate how much you agree with this statement: A toothpick type device could help assist with quitting smoking.

* Strongly agree (1)
* Somewhat agree (2)
* Neither agree nor disagree (3)
* Somewhat disagree (4)
* Strongly disagree (5)

30 Did the therapy and improved oral hygiene positively impact
the following issues?

(Please check all that apply)

* Sleep Quality (1)
* Feeling more energetic (2)
* Feeling more comfortable in social situations (3)
* Feeling more confident (4)
* Better appearance (5)
* Increased self esteem (6)
* Overall better mood or happiness (7)
* Increased smiling and laughing (8)
* Increased social life (9)
* Increases in successes at work (10)
* Increased attendance to activities (11)
* Better romantic relationship (12)
* Appetite (13)
* Weight change (14)
* Other (15)

31 Please provide any feedback you feel could help the Customized Oral Hygiene Therapy Program. Please hand the IPAD back to your student.