Orofacial function of persons having

Report from questionnaires | 12 questionnaires

Synonym	
ICD-10	
Estimated occurance	
General symptoms	
Oral symptoms	
Oral treatment	
Sources	The MHC database Rare diseases Dokumentation-Ågrenska

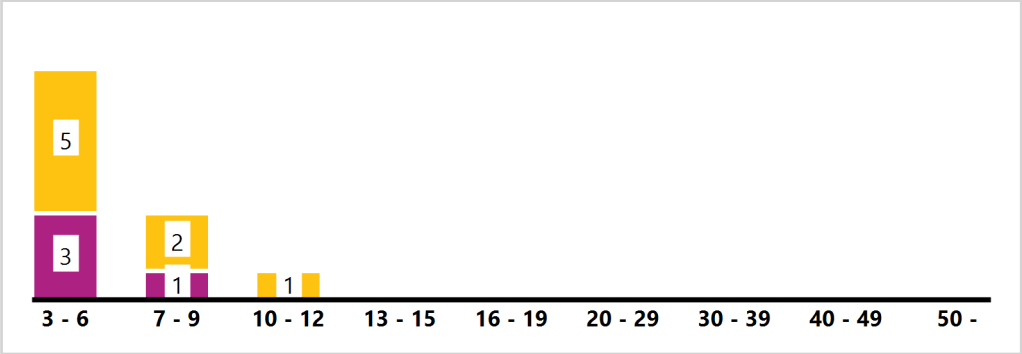
Age distribution

Number: 12

Ages: 3 - 10

♂ (4)

♀ (8)



Additional diagnoses

Medical impairment	Yes	No	Missing data
Inborn heart defect	1	10	1
Other cardiovascular disease	0	12	0
Epilepsy	1	11	0
Asthma	1	11	0
Need of respiratory support	1	11	0
Allergy	2	10	0

Neuropsychiatric diagnosis	Yes	No	Missing data
ADHD/ADD	1	10	1
Autism (Includes autism, Asperger syndrome and autistic traits)	8	2	2

General disability	Yes	No	Missing data
Intellectual disability	1	2	9
Motoric functional impairment	8	2	2
Visual impairment	2	9	1
Hearing loss	0	12	0
Communication difficulties	1	1	10

About dental care and oral health

Do you feel that you receive the dental care you need?	Number
Yes, very much so	7
Yes, somewhat	4
Missing data	1
Total:	**12**

How many times per year do you normally seek dental care?	Number
Less than once per year	3
One time per year	2
Two times per year	5
Three or more times per year	1
Missing data	1
Total:	**12**

When were your teeth last X-rayed?	Number
During the past two years	2
Never had my teeth X-rayed	10
Total:	**12**

Do you look after your teeth in a good way?	Number
Yes, very much so	5
Yes, somewhat	4
No, not really	1
No, not at all	1
Missing data	1
Total:	**12**

Who brushes your teeth?	Number
Someone else always helps me	9
Sometimes I brush myself	2
Missing data	1
Total:	**12**

How often are your teeth brushed?	Number
Not everyday	1
Once per day	1
Two times per day	10
Total:	**12**

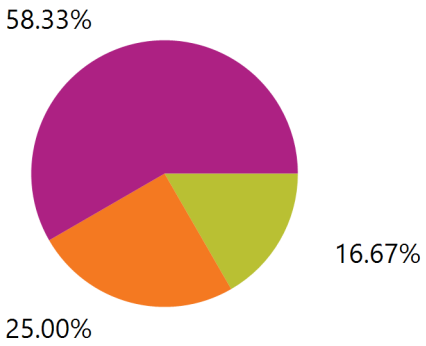
About dental care and oral health

	Yes	No	Missing data
Does your mouth hurt?	1	9	2
Does your mouth feel dry?	0	7	5
Have you ever taken a serious hit to your permanent front teeth?	2	9	1
Do you feel that you have a divergent bite?	2	9	1
Have you had a brace?	0	12	0
Do you feel that you need orthodontics/a brace?	1	10	1

Do you grind or press your teeth at night?	Number
Never	7
Once or twice per week	4
Every night	1
Total:	**12**

Do you grind or press your teeth during the day?	Number
Never	6
Once or twice per week	6
Total:	**12**

About eating



Do you have any problems with eating?	Number
Yes, somewhat	2
No, not really	3
No, not at all	7
Missing data	0
Total:	**12**

	Yes	No	Missing data
Do you cough daily in connection with meals?	0	12	0
Do you gag daily in connection with meals?	0	12	0
Do you get acid reflux daily?	0	11	1
Do you throw up often (at least twice per week)?	0	12	0
Do you have a poor appetite?	0	12	0
Does it take a long time before you can swallow a mouthful?	0	11	1
Do you press your tongue forward when you swallow so that food ends up outside the mouth?	0	10	2
Do you find it difficult to chew, i.e. grind food using your molars?	3	8	1
Do you find it difficult to take food from the spoon using your lips?	0	11	1
Have you had problems with food and drink leaking out through the corners of your mouth?	1	10	1
Does food tend to remain in your mouth after meals?	2	9	1
Do you get nutrition in any other way than through your mouth?	0	12	0

About drooling

Do you drool?	Number
Never drool	6
Drool sometimes – not every day	3
Drool often – every day	3
Missing data	0
Total:	**12**

How much do you drool?	Number
Slight drooling, only on the lips	1
Moderate drooling, on lip and chin	4
Profuse drooling	1
Total:	**6**

Is your drooling a problem for you?	Number
Yes, somewhat	1
No, not really	5
Total:	**6**

Is your drooling a problem for your family or people around you?	Number
Yes, very much so	1
Yes, somewhat	4
No, not at all	1
Total:	**6**