Patient's Name:_____ **Date:**_____

XEROSTOMIA

Normal • Refer to pretreatment nursing assessment or dental evaluation	
Onset • When did symptoms begin?	
Provoking / Palliating • What makes it better? Worse? • Is it worse at night? • Is it worse on CPAP?	
Quality (in last 24 hours) • Do you have a dry mouth? (e.g. decrease in amount or consistency of saliva) • Do you have any redness, blisters, ulcers, cracks, or white patchy areas? If so, are they isolated, generalized, clustered or patchy?	
Region / Radiation – NA	
Severity / Other Symptoms • How bothersome is this symptom to you? (0-10 scale, with 0 not at all – 10 being worst imaginable) • Have you been experiencing any other symptoms? • How does the surrounding skin look? • Foul breath?	
Treatment • Using any oral rinses? If so, what type? Effective? Using any salivary substitutes or stimulants? If so, what type? Effective? • Using any pain medications? If so, what type (topical, systemic)? Effective? • Any other medications or treatments? If so, what type (topical, systemic)? Effective?	
Understanding / Impact on You	

• Functional Alterations?	
Value • What is your comfort goal or acceptable level for this symptom (0 – 10 scale)?	