# Breath History Questionnaire

**PATIENT NAME: _____ DATE: _____**

1. Do you think you have a breath problem? Yes No

If yes, describe it _____

2. Have you ever had treatment for halitosis/breath odor? Yes No

If yes, what kind of treatment(s) and when _____

3. Do you have a bad taste in your mouth? Yes No

4. Do notice a bad taste when you clean between your teeth? Yes No Sometimes

5. Do your gums bleed when you clean between your teeth? Yes No Sometimes

6. Does your mouth feel dry? Yes No Sometimes

7. Do you use gums, mints or mouthwash to mask your halitosis? Yes No Sometimes

8. What is your stress level on a scale of 1 to 10? _____

9. Has having bad breath affected your quality of life? Yes No

10. Are you on guard all the time because you worry about your breath? Yes No Sometimes

11. Does anyone in your family suffer from periodontal disease or breath odor? Yes No

If yes, who? _____

**Tell us about your daily routine:**

1. Do you use commercial mouthwashes? Yes No Which one? _____

2. Do you clean your tongue? Yes No Occasionally

3. Do you clean between your teeth? Yes No Occasionally

How're you doing it? _____

4. On average how many meals a day do you eat? _____

5. Do you drink at least 4 cups of water a day? Yes No Number of cups

6. Do you smoke? Yes No How much/often? _____

7. Do you drink alcohol? Yes No How much/often? _____

**Thank you for answering this questionnaire. Your answers will help us to prepare a specific plan for your individualized breath odor treatment.**