

**University of British Columbia**  
**Breath Testing Clinic**  
**Questionnaire**

Clinical Record No. \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

1. When did you first become aware that you had bad breath?  
\_\_\_\_\_ years/months/weeks ago
2. How did you find out you had bad breath?
  - a. By yourself. If so, how? \_\_\_\_\_
  - b. Someone pointed it out to you. Who? \_\_\_\_\_
  - c. Other \_\_\_\_\_
3. What measures do you employ to reduce the condition? Describe precisely (e.g. name of mouthwash/gum product).  
\_\_\_\_\_

- 4-1. Have you ever had an examination for bad breath by your dentist? Yes / No
- a. If so, when? \_\_\_\_\_
  - b. Name and address of your dentist.  
\_\_\_\_\_
  - c. What kind of examination did you receive (e.g. instrumental assessment of intensity of bad breath, gingival examination, etc.)?  
Describe below.  
\_\_\_\_\_

- 4-2. Have you ever had an examination for conditions associated with bad breath by your physician? Yes / No
- a. If so, when? \_\_\_\_\_
  - b. Name and address of your physician.  
\_\_\_\_\_
  - c. Describe the examination that you received (e.g. X-ray, endoscope).  
\_\_\_\_\_

5. Have you had any treatments for bad breath by either a physician or a dentist (e.g. medication, mouthwash, tooth extraction, etc.)? Yes/ No  
If so, describe below.  
\_\_\_\_\_

6. Have you had any treatments for bad breath from an alternative or holistic practitioner (chiropractor, homeopath, etc.)? Yes / No  
If so, please describe: \_\_\_\_\_

7. Do you brush your teeth every day? Yes / No  
How many times a day? \_\_\_\_\_times /day
8. Do you floss your teeth every day? Yes / No  
How many times a day? \_\_\_\_\_times /day
9. Do you use mouthwash every day? Yes / No  
a. How many times a day? \_\_\_\_\_times /day  
b. Name of the product \_\_\_\_\_  
c. Why did you choose the product you use (e.g. TV commercial, other people's recommendation, etc.)?  
\_\_\_\_\_
10. Do your gums bleed during tooth brushing? Yes / No
11. Do you have a loose tooth or teeth? Yes / No
12. Do you have dry mouth? Yes / No
13. Do you have dry eyes? Yes / No
14. Do you have canker sores? Yes / No  
If so, how frequently (e.g. once a week)? \_\_\_\_\_
15. Do you notice a bad taste in your mouth? Yes / No  
a. If so, how frequently (e.g. once a day)? \_\_\_\_\_  
b. When you wake up in the morning, do you notice bad taste in your mouth? Yes / No
16. Is your tongue frequently coated with white or yellowish deposits? Yes / No
17. What time during the day do you find your breath worst? Please circle.  
after waking up            when hungry            when tired            when thirsty  
morning                      afternoon            whole day            during work  
when talking with other people            other \_\_\_\_\_
18. In the past month did your breath interfere with your ability to function at your workplace or with your social life? Yes / No
19. Did your bad breath interfere with your family life in the past month? Yes / No
20. Have you had any of the dysfunctions listed below in your medical history? Please circle those that apply.
- |                                    |                             |                     |
|------------------------------------|-----------------------------|---------------------|
| sinusitis or other nasal condition | lung and bronchial diseases | stomach dysfunction |
| diabetes                           | liver dysfunction           | anemia              |
| autoimmune disease                 | cancer                      | HIV positive/AIDS   |
| emotional                          | others _____                |                     |

21. Are you on a special diet? Yes / No  
If so, please describe: \_\_\_\_\_

22. Do you take (list them):  
Vitamins: \_\_\_\_\_  
Laxative: \_\_\_\_\_  
Antacids: \_\_\_\_\_  
Health medicines: \_\_\_\_\_

23. Do you have any other health concerns? Yes / No  
If so, please describe: \_\_\_\_\_

24. Do you have any of the problems listed below because of your bad breath?  
Please circle those that apply.

- a. None
- b. I hesitate to talk to other people.
- c. I am uneasy whenever someone is nearby.
- d. I do not like to meet other people.
- e. I cannot be close to people socially.
- f. Other people avoid me.
- g. Other \_\_\_\_\_

25. Do you lead what might be considered an ordinary life? Yes / No

26. Are you a smoker? Yes / No

27. Have you asked other persons other than a health care professional Yes / No  
to judge your bad breath?  
What response did you receive? \_\_\_\_\_

28. How many times during the day do you drink beverages, including water?  
\_\_\_\_\_ times a day

29. Are you concerned about other people's behavior toward yourself on account  
of your breath?  
a. If so, describe the behavior that concerns you? \_\_\_\_\_  
b. Are you certain that the behavior was caused by the offensiveness Yes / No  
of your breath?

30. What do you think causes your bad breath?  
\_\_\_\_\_

31. How did you hear about our Breath Testing Clinic?  
\_\_\_\_\_