

DRY MOUTH SYMPTOM & RELIEF TRACKER

Use this page for several days, then bring it to your dentist or healthcare provider.

Name: _____ Dates tracked: _____

1. When and How Dry Does Your Mouth Feel?

Date	Morning 0-3	Daytime 0-3	Meals 0-3	Night 0-3	What did you notice? (sticky mouth, burning, trouble eating, etc.)

Dryness scale: 0 = none 1 = mild 2 = moderate 3 = severe

2. What Did You Try—and Did It Help?

Strategy	Tried	Helped	Notes
Small sips of water	☐	☐ Yes ☐ No	
Sugar-free gum or lozenge	☐	☐ Yes ☐ No	
Moisturizing spray, gel, or rinse	☐	☐ Yes ☐ No	
Moist foods / added sauce or broth	☐	☐ Yes ☐ No	
Cool-mist humidifier at night	☐	☐ Yes ☐ No	
Other: _____	☐	☐ Yes ☐ No	

3. Changes and Concerns

☐ New or changed medication ☐ Repeated cavities ☐ Mouth sores or burning

☐ Trouble chewing or swallowing ☐ White patches ☐ Denture discomfort

Medication or dose changes: _____

Other concerns: _____

4. Questions for My Dentist or Healthcare Provider

- _____
- _____
- _____

Important: Do not stop or change a prescription medication on your own. Persistent dry mouth, difficulty swallowing, repeated cavities, mouth sores, white patches, or worsening symptoms should be discussed with a dentist or healthcare provider.

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