Supplementary Material

Participant Survey

Pre-Testing Survey

Gender: **Male** **Female**

Age:__________

Did you eat, drink, chew gum, brush teeth or suck on candies in the past 15 minutes? **Yes / No**

Do you currently take any prescription medication? **Yes / No**

How many hours since you last ate food? **Less than 1 hour 1 2 3 4+ hours**

Do you think you have dry mouth? **Yes / No**

Have you ever been diagnosed by a dentist or doctor with Dry Mouth? **Yes / No**

Do you think you have healthy saliva flow – **Yes / No / I don't know**

Please note the frequency of the following statements:

	Not at all	A little	Quite a bit	Very Much
My mouth feels dry	☐	☐	☐	☐
My mouth feels dry when eating	☐	☐	☐	☐
I have difficulty in eating dry food	☐	☐	☐	☐
I have difficulties swallowing certain foods	☐	☐	☐	☐
I sip liquids to aid in swallowing food	☐	☐	☐	☐
I have difficultly talking due to dry mouth	☐	☐	☐	☐
I drink more during the day due to dry mouth	☐	☐	☐	☐
I have difficulty sleeping due to dry mouth	☐	☐	☐	☐
My lips feel dry	☐	☐	☐	☐

Using the same scale, have had any of the following issues **during the last 12 months:**

	Not at all	A little	Quite a bit	Very Much
Bleeding gums	☐	☐	☐	☐
Cavities	☐	☐	☐	☐
Bad breath	☐	☐	☐	☐
Frequent cough	☐	☐	☐	☐
Frequent colds	☐	☐	☐	☐
Tooth sensitivity	☐	☐	☐	☐