

TELL US ABOUT YOUR SYMPTOMS

LAST NAME _____ FIRST NAME _____

1. Are you experiencing any pain at this time? If not, please go to question 6. Yes _____ No _____
2. If yes, can you locate the tooth that is causing the pain? Yes _____ No _____
3. When did you first notice the symptoms? _____
4. Did your symptoms occur suddenly or gradually? _____
5. Please check the frequency and quality of the discomfort, and the number that most closely reflects the intensity of your pain:

LEVEL OF INTENSITY
(On a scale of 1 to 10)
1 = Mild 10 = Severe

1____2____3____4____5____6____7____8____9____10____

FREQUENCY

_____ Constant
_____ Intermittent
_____ Momentary
_____ Occasional

QUALITY

_____ Sharp
_____ Dull
_____ Throbbing

Is there anything you can do to relieve the pain? Yes _____ No _____

If yes, what? _____

Is there anything you can do to cause the pain to increase? Yes _____ No _____

If yes, what? _____

When eating or drinking, is your tooth sensitive to: Heat _____ Cold _____ Sweets _____

Does your tooth hurt when you bite down or chew? Yes _____ No _____

Does it hurt if you press the gum tissue around this tooth? Yes _____ No _____

Does a change in posture (lying down or bending over) cause your tooth to hurt? Yes _____ No _____

6. Do you grind or clench your teeth? Yes _____ No _____

7. If yes, do you wear a night guard? Yes _____ No _____

8. Has a restoration (filling or crown) been placed on this tooth recently? Yes _____ No _____

9. Prior to this appointment, has root canal therapy been initiated on this tooth? Yes _____ No _____

10. Is there anything else we should know about your teeth, gums, or sinuses that would assist us in our diagnosis? _____