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 which tooth 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? _____

   Is there anything that causes the pain to increase? _____

   When eating or drinking, is your tooth sensitive to: ☐ COLD ☐ HEAT ☐ SWEETS

   Does your tooth/teeth 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? _____