TELL US ABOUT YOUR SYMPTOMS

Date_____

1. Are you experiencing any pain at this time? If no, 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)	***FREQUENCY***	***QUALITY***
1__2__3__4__5__6__7__8__9__10__	☐Constant ☐Intermittent ☐Momentary ☐Occasional	☐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 the tooth? Yes☐ No☐
Does a change in posture cause your tooth to hurt? Yes☐ No☐
(lying down or bending over)

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 today, has root canal therapy been started 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? Please explain:_____

Assistant Notes:_____

Name