TELL US ABOUT YOUR SYMPTOMS

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	FREQUENCY	QUALITY
1___2___3___4___5___6___7___8___9___10___	_____ Constant	_____ Sharp
	_____ Intermittent	_____ Dull
	_____ Momentary	_____ Throbbing
	_____ Occasional	

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? _____

Signed: Patient or Parent _____ Date _____