TELL US ABOUT YOUR SYMPTOMS

(Please complete this form as fully as possible.
This will assist us in diagnosing your dental problem.)

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? _____

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 the 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? _____

_____ _____
Signature (Parent or Guardian if patient is a minor) Date