Symptoms Questionnaire

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

Name _____ Date_____

1. Are you experiencing any pain at this time? YES NO If "NO" then go to question 6
2. If YES, can you locate the tooth that is causing 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 (1 = Mild 10 = Severe)	Frequency	Quality
1 2 3 4 5 6 7 8 9 10 (please circle)	____ Constant ____ Intermittent ____ Momentary ____ Occasional	____ Sharp ____ Dull ____ Throbbing

Is there any relief to the pain? YES NO

If YES, what relieves the pain? _____

Is there anything you can do that causes the pain to increase? YES NO
If YES, then what causes the pain to increase? _____

When eating or drinking, is your tooth sensitive to: HEAT COLD SWEETS
(Circle all that apply)

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 (lying down or bending over) cause you tooth to hurt? YES NO

6. Do you grind or clench your teeth? YES NO
   If YES, do you wear a night guard? YES NO
7. Has a restoration (filling or crown) been placed on this tooth recently? YES NO
   If YES, then when? _____
8. Prior to this appointment, has this tooth ever had a root canal? YES NO
9. 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