PALM BEACH ENDODONTICS

TELL US ABOUT YOUR DENTAL SYMPTOMS

First Name: _____ Last Name: _____

1.) Are you experiencing any pain at this time? If NOT, please go to question #5 Yes____ No____

2.) If yes, can you locate the pain? _____Yes____ No____

3.) When did you first notice the symptoms? _____

4.) Did 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

1___2___3___4___5___6___7___8___9___10___

FREQUENCY

____Constant

____Intermittent

____Momentary

QUALITY

____Sharp

____Dull

____Throbbing

Is there anything you can do to relieve this 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 when 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____

5.) Do you grind or clench your teeth? _____Yes____ No____

6.) If so, do you wear a night guard?_____Yes____ No____

7.) Has a restoration (filling or crown) been placed on this tooth recently?_____ Yes____ No____

8.) Prior to this appointment, has root canal therapy been started on this tooth?_____Yes____ No____

9.) Any past trauma or injury to this tooth? _____Yes____ No____

10.) If the answer to the preceding questions is yes, describe past trauma and state the occurrence date.

_____

11. Is there anything else we should know about your teeth, gums or sinuses that would assist us in our diagnosis?

_____

Does it hurt to open? _____Yes____ No____

Patient Signature _____ **Date**_____