BRADFORD ENDODONTICS
FOCUSED ON THE TOTAL PATIENT EXPERIENCE

TELL US ABOUT YOUR SYMPTOMS

LAST NAME_____ FIRST NAME_____

1.) Are you experiencing any pain at this time? **If NO, please go to questions 10.** 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
	__ Spontaneous	

a. Is there anything you can do to relieve the pain? Yes___ No___
If yes, what?_____
b. Is there anything you can do to cause the pain to increase? Yes___No___
If yes, what?_____

6.) When eating or drinking, is your tooth sensitive to: Heat___Cold___Sweets___
7.) Does your tooth hurt when you bite down or chew? Yes___No___
8.) Does it hurt if you press the gum tissue around this tooth? Yes___No___
9.) Does a change in posture (lying down or bending over) cause your tooth to hurt? Yes___No___
10.) Do you grind or clench your teeth? Yes___No___
11.) If yes, do you wear a night guard? Yes___No___
12.) Has a restoration (fillings or crown) been placed on this tooth recently? Yes___No___
13.) Prior to this appointment, has root canal therapy been initiated on this tooth? Yes___No___
14.) Is there anything else we should know about your teeth, gums, or sinuses that would assist us in our diagnosis?_____

_____

Signature: Patient or Parent _____Date:_____