

TELL US ABOUT YOUR SYMPTOMS

Date: _____

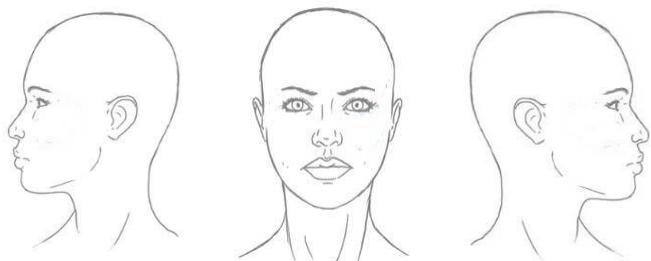
Name: _____

What brought you here today? _____

Describe any pain, discomfort, or sensitivity you have experienced on the tooth, or the area around:

Do you have pain, discomfort, or sensitivity **now**?..... Yes No

Circle the tooth or area of symptom/s in the picture:



Right



Left

How often do the symptom/s occur?

On a scale of 1-10, how bad are the symptom/s when they occur? 1 2 3 4 5 6 7 8 9 10

What triggers the symptom/s? _____

What relieves the symptom/s? _____

It is sensitive to: (Circle) HOT COLD SWEETS BITING/CHEWING

Does the tooth have any NEW FILLINGS?.....Yes No, NEW CROWN?.....Yes No
if you have NEW Fillings or Crown, how long ago was it done? _____

Is there anything that we need to know about the tooth? _____
