TELL US ABOUT YOUR SYMPTOMS

Date:_______________

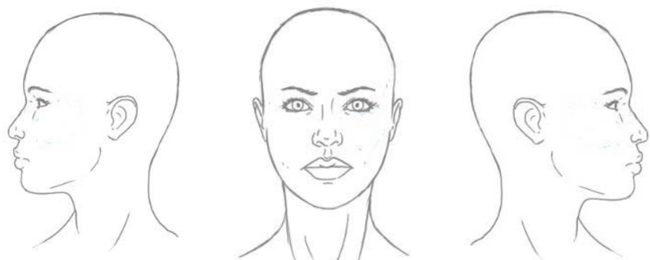
Name:_____________________________

What brought you here today?____
____

Do you have pain now?...**Yes** **No**

When you have pain, describe your pain:______________________________________
____
____

Circle the tooth or area of pain in the picture:



Right

Left

How often does the pain happen?
____

How bad is the pain when you have it? In the 10 scale circle one: **1 2 3 4 5 6 7 8 9 10**

What triggers the pain?____

What relieves the pain?____

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?_____________________________
____
____