



Charlotte's Endodontists Since 1972

CHARLOTTE ENDODONTICS

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Patient Symptoms Questionnaire

Patient Name: _____

Date: _____

1) What is your chief complaint? _____

2) Are you experiencing pain right now? Yes__ No__

3) Do you know which tooth is the cause of the pain? Yes__ No__

4) When did the symptoms begin? _____

5) What is the level of the pain on a 1 – 10 scale? (10=most severe) _____

6) Describe the type of pain:

A) What is the character of the pain? Sharp__ Dull__ Ache__

B) How frequent is the pain? Constant__ Off/On__ Rare__

C) Have you had pain with: Cold__ Heat__ Chewing__

D) Does it wake you up at night? Yes__ No__

E) Does it hurt spontaneously (on its own)? Yes__ No__

F) Do you have to take medication for relief? Yes__ No__

7) Have you had any swelling? Are you taking antibiotics? _____

8) Have you had any recent dental work in the area? _____

9) Do you wear a nightguard? _____

10) Is there anything else to know about the symptoms? _____

Patient Signature: _____

