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: _________________________________________________________________________