Dental Symptom Worksheet

Patient: _____ Date: _____

- What brings you into the office today?

_____
_____

- When did you first notice these symptoms or problem?_____
- Did your symptoms or problem occur **suddenly** or **gradually**? (**CIRCLE ONE**)
- Are you having any pain at this time? Yes _____ No _____
    - If yes, where is the pain located? _____
- Intensity of pain (1 if you barely notice it, 10 if you are in tears)
    - 1____2____3____4____5____6____7____8____9____10____
- Frequency of pain
    a) _____ Constant
    b) _____ Occasional
    c) _____ waking you up at night
- Type of pain
    - _____Sharp shooting
    - _____Dull ache
    - _____ Throbbing/pulsing
- Have you noticed any swelling or pus? Yes _____ No _____
- When eating or drinking is your tooth/ problem area sensitive to
    - _____Hot
    - _____ Cold
    - _____ Sweets
    - _____ Biting/chewing
- Does anything help with the pain? Yes_____ No_____
    - If yes, what? _____

- Do you grind or clench your teeth? Yes ____ No_____

  If yes, do you wear a night guard? Yes ____ No_____