The Endodontic Center of Southern Indiana

PATIENT SYMPTOMS

Date: _____

Have you experienced any discomfort recently? ☐ YES ☐ NO

If yes, can you locate the tooth that is causing the discomfort? ☐ YES ☐ NO

When did you first notice symptoms? _____

Please circle the words below that best describe the frequency and type of discomfort.

☐ Constant ☐ Sharp ☐ Intermittent ☐ Dull ☐ Throbbing ☐ Occasional

Is there anything you can do to relieve your discomfort? ☐ YES ☐ NO

If yes, what? _____

When eating or drinking, is your tooth sensitive to: ☐ HOT ☐ COLD ☐ SWEETS

Does your tooth hurt when you bite down or chew? ☐ YES ☐ NO

Do you grind or clench your teeth? ☐ YES ☐ NO

If yes, do you wear a nightguard? ☐ YES ☐ NO

Has a filling or crown been placed on this tooth recently? ☐ YES ☐ NO

Prior to today, has root canal therapy been started on this tooth? ☐ YES ☐ NO

Is there anything else we should know about your teeth, gums or sinuses that would assist us in our diagnosis today?

Please explain:

_____

_____

_____

_____

Assistant Notes:

_____

_____