

ENDODONTIC HISTORY

NAME _____ AGE _____ DATE _____

PLEASE CIRCLE

1. Do you have a toothache? YES NO

2. If so, can you locate the specific tooth? YES NO

3. Does anything specific cause pain? HOT COLD PRESSURE SWEET CHEWING

4. Is the pain SHARP or DULL ACHE?

5. Does the pain last for SECONDS, MINUTES, or is it CONTINUOUS?

6. Does the tooth in question feel high or swollen? YES NO

7. When did the toothache start? _____

8. When did the swelling start? _____

9. Did you suffer a blow to the mouth or bite on something hard? YES NO
When?

10. Do you think you are exceptionally apprehensive in regard to your dental care and treatment?
YES NO