SOUTHWEST Endodontics

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HISTORY & SYMPTOMS

Patient Name: _____ **Date**:_____

Chief Complaint in Your Own Words:_____

When Did You First Notice the Pain? _____

What Medications have you taken to Relieve the pain? Has this Worked? _____

What is your Pain Level?

- ☐ None
- ☐ Mild
- ☐ Moderate
- ☐ Severe

Type of Pain:

- ☐ Spontaneous (unprovoked)
- ☐ Sharp
- ☐ Dull
- ☐ Radiating (spreading)
- ☐ Constant
- ☐ Throbbing

Location of Pain:

- ☐ Upper Left
- ☐ Lower Left
- ☐ Upper Right
- ☐ Lower Right
- ☐ Upper Front
- ☐ Lower Front

Aggravating Factors:

- ☐ Cold
- ☐ Heat
- ☐ Biting
- ☐ Chewing
- ☐ Pain on bite release
- ☐ Hard Foods
- ☐ Lying Down

Frequency:

- ☐ Multiple Times per Day
- ☐ Daily
- ☐ Weekly
- ☐ Occasional