ARIZONA MICROSCOPIC ENDODONTICS

American Association
of Endodontists
Specialist Members

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Tell us about your tooth and why you are here

Name____ Date___________________

1. Is your tooth **presently** (please circle):
   A)Sensitive B)Uncomfortable C)Painful D)No pain

2. How bad is the pain level **now**, on a scale from 0(no pain) to 10(severe pain)?
   (Please circle) **0—1—2—3—4—5—6—7—8—9—10**

3. When did the pain start?____

4. How long a period of time has it been sensitive/uncomfortable/painful?
   Hours:___ Days:___ Weeks:___ Months:___ Years:___

5. How does the pain affect your daily life/routine/behavior?_______________________

6. Can you describe the pain?
   (Please circle) **Dull, Throbbing, Pounding, Sharp, Stabbing, Other**_______________

7. What makes your tooth hurt?
   (Please circle) **Cold, Hot, Biting, Chewing, Pressure, Lying down, Other**________

8. What makes your tooth feel better?
   (Please circle) **Cold, Hot, Biting, Chewing, Pressure, Lying down,**
   Pain medication (Ibuprofen or Tylenol), Other___________________

9. Does your tooth ever hurt spontaneously? **YES NO**

10. Is the pain continuous or intermittent(on/off)? **Continuous/Intermittent**

11. Has any recent dental work been completed in the area where there is pain? **YES NO**

    If yes, what and when?____

12. If the tooth that hurts has had a root canal done previously, when was it done and by whom?____

13. Is there any other information that would be helpful about your current condition?
    ____

Signature:____ Date:_________________________

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