EMERGENCY TOOTHACHE QUESTIONNAIRE
(please skip questions that are unknown)

1. Which is the area of concern? (circle one)
   - Upper right
   - Upper Left
   - Lower Left
   - Lower Right
   - Upper Anteriors (front)
   - Lower Anteriors (front)

2. How long has the tooth been bothering you?___________________________

3. Please circle all that apply to this tooth.
   - Hot Sensitivity
   - Cold Sensitivity
   - Chewing Sensitivity
   - Swelling/Drainage
   - Broken
   - Cavity (hole)
   - Loose
   - Ache
   - Throb

4. Does the discomfort interrupt sleep or worsen with posture change?
   _____Yes   _____No

5. What would you rate your discomfort when at it’s worst on a pain scale of 1-10
   (10 being the most uncomfortable)?  (circle one)
   1  2  3  4  5  6  7  8  9  10

6. Have you been seen for this tooth in the past? _____Yes   _____No
   If Yes, please specify date, Dr.’s name, and treatment:
   ____________________________________________________________

7. Is there any history of the following?  (circle all that apply)
   - Grinding Teeth
   - TMJ related issues
   - Perio Issues
   - Sinus Issues

8. Are you taking any pain medication for the discomfort?  _____Yes   _____No
   If yes, what? ____________________

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Attention: Assistant please sign after entering information in the computer
_____________________________________________