#_______

Name: ____________________________________

Pain Scale 1 2 3 4 5 6 7 8 9 10

What is your main reason for coming to the dentist today?

____

Describe the pain:

____

What makes the pain worse?

____

How long have you had this pain?

____

Throbbing? Yes No

Sensitive to Hot? Yes No

Sensitive to Cold? Yes No

Sensitive to Pressure? Yes No

What have you been taking to relieve the pain?

____

Has this tooth ever had dental work? Yes No

Are you allergic to any medications? Yes No

Which ones? ____

Have you ever been pre-medicated before a dental appointment? Yes No