DENTAL QUESTIONAIRE

James P. Walker, DDS, PC

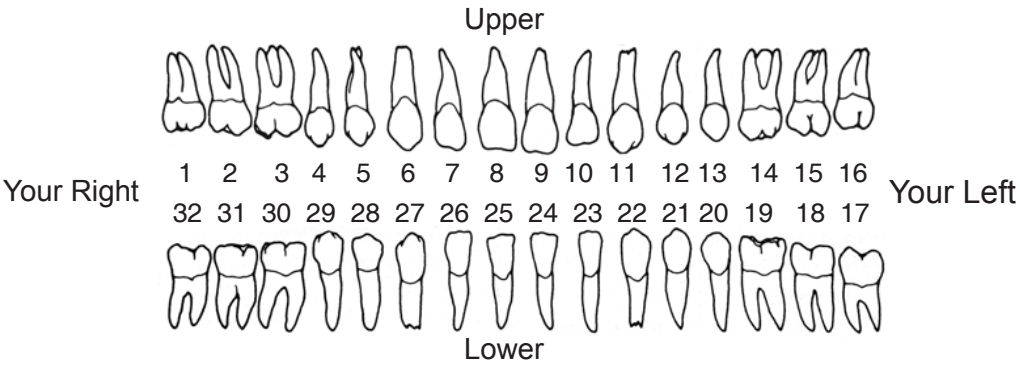
Your Name: _____ Date: _____

Your Dentist's Name: _____ Yes No

1. Are you experiencing any pain at this time? ..... ☐ ☐
   If No, please skip to question 13.

Pain History:

2. Can you locate the pain? ..... ☐ ☐
   If yes, please describe or outline below the approximate area(s):
   _____



3. When did you first notice the symptoms? _____
4. Did the symptoms start ☐ suddenly or ☐ gradually? _____
5. Since the start of your symptoms, has your pain:
   - ☐ Stayed at the same level.
   - ☐ Increased Slowly.
   - ☐ Fluctuated.
   - ☐ Increased greatly during the last _____ days.

6. Please check the best description of your level of pain now:
   0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
   (On a scale of 0 to 10, 1= Mild, 10 = Severe)

7. Please check the best description of your Maximum Level of Pain experienced:
   0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
   (On a scale of 1 to 10, 1= Mild, 10 = Severe)

8. Please check the **best descriptions** of your **pain frequency, quality and any stimulating factors:**

Frequency:		**Quality:**		**Stimulated by:**	
Constant	☐	Sharp/Stabbing	☐	Cold	☐
Intermittent	☐	Dull	☐	Hot	☐
Momentary	☐	Throbbing	☐	Pressure	☐
Occasional	☐	Deep Ache	☐	Sweets	☐
		Pressure	☐	Jaw Movement	☐
		Burning	☐	Nothing	☐
		Shooting	☐	Other _____	
		Other	☐		

(Over Please)

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	Yes	No
9. Is there anything you can do to relieve the pain?	☐	☐
If yes, what? _____		
10. Does your tooth hurt when you bite down or chew?	☐	☐
11. Does it hurt if you press on the gum tissue around this tooth?	☐	☐
12. Does a change in posture (lying down or bending over) cause your tooth to hurt?	☐	☐

Additional History:

13. Reason for appointment: _____

_____

	Yes	No
14. Have you taken any pain medications in the last 24 hours?	☐	☐
If yes, Medication, Dose and Time: _____		
_____		
15. Have you taken any antibiotics for this problem?	☐	☐
If yes, Medication, Dose and Time: _____		
_____		
16. Have you seen any other Dentists or Physician's regarding this problem?	☐	☐
If yes, Who and When: _____		
17. Do you grind or clench your teeth?	☐	☐
18. Do you wear a bite plane / night guard?	☐	☐
19. Has a restoration (filling or crown) been placed on this tooth recently?	☐	☐
20. Prior to this appointment, has root canal therapy been started on this tooth?	☐	☐
21. Are you or have you been under the care of a Periodontist (gum specialist)?	☐	☐
If yes, Name and Location: _____		
22. Any past trauma or injury to this tooth?	☐	☐
If yes, please describe: _____		
23. Is there anything else we should know about your teeth, gums or sinuses that would assist us in our diagnosis? _____		
24. Have you had difficulty getting numb in the past?	☐	☐
25. Do you have a strong gag reflex?	☐	☐

26. Rate your level of dental anxiety:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

(On a scale of 1 to 10, 1= Mild, 10 = Severe)

Signature of Patient (or Parent) _____ **Date:** _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally uncapable.

Relationship to the patient: _____

For Office Use:

Date: _____ 20___ Blood Pressure: _____ / _____ Pulse: _____ Tempurature: _____

Notes: