ENDODONTIC ASSOCIATES
EST 1964

Dental Symptom Form

Name: ____ Date : ________________________________

What name do you go by? ____

Who referred you to our office? ____

Who do you see for normal dental care (if different)? ____

1. Are you having pain? Yes No (skip to #9)
2. Where is it located? ____
3. How long ago did you notice symptoms? Days Weeks Months
4. What is the intensity of the pain? 1 2 3 4 5 6 7 8 9 10
5. Type/frequency of pain : Constant Intermittent Sharp Dull Throbbing
6. Does anything make it feel worse? Cold Heat Chewing
7. Does anything make it feel better? ____
8. Are you currently taking any medication specifically for the tooth pain? ______________________________
9. Has a filling or crown been placed on this tooth recently? Yes: When __________ No
10. Anything else you would like us to know about your visit?

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