M Street Dental
EMERGENCY TOOTHACHE QUESTIONNAIRE

(please skip questions that are unknown)

NAME_____ DATE_____

1. Where is the area of concern? (please 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:

   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. Please rate your discomfort or pain on a scale of 1-10 (10 being the most uncomfortable):

   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? _____

OFFICE USE ONLY

Attention: Assistant please sign after entering information in the computer

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