PAIN HISTORY QUESTIONAIRE

Please circle your responses

1. Have you experienced pain in this tooth any time in the past? **Yes / No**

2. Are you in pain now? **Yes / No**

3. If you are in pain now, how long have you been in pain? **1 day / 2 days / 3 days / 4 days / 5 days / 6 days / 1 week 2 weeks / 3 weeks / > 3 weeks**

4. Did this pain either keep you awake or awaken you last night? **Yes / Yes, and I have been up all night in pain / No / No, but it has before**

5. Can you locate the tooth that is causing the pain? **Yes / No / Not sure / There may be more than one tooth**

6. Does the pain radiate to other parts of your jaw or down your neck and shoulders? **Yes / No / Not now but has in the past**

7. Is the pain spontaneous or does it always require some stimulus to become painful**? I have spontaneous pain / It always takes some stimulus to make it hurt / I don't have spontaneous pain now, but have in the past with this tooth**

8. Do you feel swollen now? **Yes / No** Has there been a history of prior swelling? **Yes / No**
   Are you running a fever? **Yes / No**

9. How would you rate the severity of your pain today (as a number and description, 10 being unbearable and 1 being very slight)? **1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10**

10. Please check the frequency and nature of pain that most closely describes your discomfort? **Sharp / Dull / Radiating / Throbbing / Migrating / Constant / Aching / Intermittent / Momentary / Gnawing / Variable / Enlarging to other areas / Shooting / Tingling / Itching / Burning / Only when chewing or biting**

11. Do you have lingering pain (more then a few seconds)? **Yes / No / No but I have in the past**

12. Is the tooth sensitive to temperature? **No / No, but there is a history of temperature in the past / More to hot than cold / Equally to hot and cold / Neither / Not sure / More sensitive to cold than hot**

13. What relieves the pain**? Nothing / Cold / Hot / Massage / Vicodin / Non-biting / Aspirin / NSAIDS / Codeine / Advil/Aleve / Antibiotics / Darvocet / Tylenol / Other: _____**

14. If you don't touch the tooth or bite, does it still hurt? **Yes / No / Sometimes / Only if I bite in a certain way/ Not now, but it has in the past**

15. What increases the pain? **Touching / Biting / Cold / Hot / Eating / Cold air / Lying down / Pressing on gum/ Flossing / Nothing / Sweet**

16. What is the course of the pain? **Increasing / Decreasing / Constant / Variable / None now**

17. Has there been any recent restorative work done on this area? **Yes / No / Not sure**

18. Prior to this appointment has endodontic treatment been started by any doctor? **Yes / No / Not sure**

19. Have you had recent periodontal (gum) surgery in the area or a tooth cleaning? **Yes / No /**

20. Have you ever had any endodontic surgery (apicoectomy) on this tooth? **Yes / No / Not sure**

21. Are you numb now (been given anesthesia earlier today)? **Yes / No / Slightly / Not sure**

22. Have you take any antibiotic for this problem? **No / Today / Last 2 days / Last 3 days / Last 4 days / Last week/ Last month / Other: _____**

23. Have you take any pain killer for this problem**? No / Today / Last night / Last 2 days / Last 3 days / Last 4 days/ Last 5 days / Last 6 days / Various times**

24. Did you explicit request this referral? **Yes / No**

25. Did your Doctor recommend this referral? **Yes / No**