RIVERSIDE DENTAL CENTRE

EMERGENCY PATIENT CARE

PLEASE TELL US ABOUT YOUR SYMPTOMS AS THIS WILL ASSIST THE DENTIST TO BEGIN HIS EXAMINATION

Patient Last Name ..... First Name .....

Please circle the applicable words to your complaint

1. Are you experiencing any pain at this time? If not please go to question 6 YES NO

2. If yes, can you locate the tooth that is causing the pain? YES NO

3. When did you first notice the symptoms? .....

4. Did your symptoms occur **suddenly** or **gradually**? .....

5. For the table below, please write a number for the intensity of pain.
   Then tick the frequency and quality of pain which is relevant for you.

LEVEL OF INTENSITY	**FREQUENCY** (how often)	**QUALITY** (type of pain)
On a scale from 1-10,	Constant	Sharp
1 = mild, 10 = severe	Intermittent	Dull
	Momentary	Throbbing
	Occasional	

6. Is there anything that you can do to relieve the pain? YES NO

If yes, what? .....

7. Have you taken any medication at all, regularly or for this complaint YES NO

8. When eating or drinking, is your tooth sensitive to: HEAT COLD SWEETNESS

9. Does your tooth hurt when you bite down, or chew? YES NO

10. Does it hurt if you press the gum tissue around this tooth? YES NO

11. Does a change in posture (lying down or bending over) cause your tooth to hurt? YES NO

12. Do you grind, or clench your teeth? YES NO

13. If yes, do you wear a night guard? YES NO

14. Has a restoration (filling or crown) been placed on the tooth recently? YES NO

15. Prior to this appointment, has root canal therapy been initiated on this tooth? YES NO

16. Is there anything else we should know about your teeth, gums or sinuses that would assist us in our diagnosis?

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Signed by Patient/Parent/Guardian ..... Date ...../...../.....