Dental History

How long has it been since you have been to the dentist? _____

Who was your former dentist? _____ City/State: _____

When did the pain/discomfort first start? _____

Have you had pain/discomfort in this same area before? ..... ☐ Yes ☐ No

Does the pain **wake you up** in the middle of the night? ..... ☐ Yes ☐ No

Where is the pain/discomfort you are having? (Please circle) Upper Left Upper Front Upper Right

Lower Left Lower Front Lower Right

On a scale of 0 to 10 (0 being no pain and 10 being the worst), where would you rate the pain you have?

0 1 2 3 4 5 6 7 8 9 10

Please describe the pain/discomfort you are having……. (please circle as many as needed)

Ache Burn Throb Tender Nagging

Sharp Dull Radiating Stabbing Pressing

Pounding

What causes the pain/discomfort to happen? Eating Air Hot Cold Nothing/Spontaneous

Other: _____