"The Root Canal Guy"

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American Association of Endodontists Specialist Members

Name ____

1. Is your tooth **presently? A) Sensitive B) Uncomfortable C) Painful D) No Pain**

2. How bad is the pain level **now**, on a scale from 0(**no pain**) to 10(**severe pain**)? **0-1-2-3-4-5-6-7-8-9-10**

3. When did the pain start? _____________________________________

4. How long a period of time has it been sensitive/uncomfortable/painful?
   Hours:___ Days:___ Weeks:___ Months:___ Years:___

5. How does the pain affect your daily life/routine/behavior?_____________________

6. Can you describe the pain? **Dull, Throbbing, Pounding, Sharp, Stabbing, Other**_____________

7. What makes your tooth hurt? **Cold, Hot, Biting, Chewing, Pressure, Lying down, Other**_______

8. Does your tooth ever hurt by itself or only when it's stimulated? **Itself/Stimulated**

9. Is the pain continuous or intermittent(on/off)? **Continuous/Intermittent**

10. What makes your tooth feel better? **Cold, Hot, Biting, Chewing, Pressure, Lying down,**

    Pain medication (Ibuprofen or Tylenol), Other_______________________

11. Has any recent dental work been completed in the area where there is pain? **YES NO**

    If yes, what and when?____

12. Have you ever had a root canal before? **YES NO** By who **General Dentist/Root Canal Specialist**?

    When? _______________________

13. Did you have pain before the treatment? **YES NO** Did you have pain after the treatment? **YES NO**

    If you had pain after, how long did it last? _______________________________

14. Did any complications result such a **swelling** or **continued pain**?
____

15. Do you still have the tooth? **YES NO**

Signature:_______________________________________ Date:________________________

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