

NAME _____ AGE _____ SEX: M F Patient # _____
Last First MI Social Security #

DENTAL HISTORY

Referring Dentist _____ City _____
First Name Last Name

Briefly describe your problem: _____

How long have you had this problem? _____ Day(s) _____ Weeks(s) _____ Months(s) _____ Years(s)

Check (X) all that apply:

PAIN: Never (If checked, go to SWELLING) **LOCATION:** Upper Left Upper Right Upper Front
 In the Past Today Lower Left Lower Right Lower Front

DURATION: Seconds Minutes Hours Constant **QUALITY:** Dull pain Throbbing pain Sharp Pain

PAIN SCALE (check (X) 0-10):

Mild *Severe*

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|

0 1 2 3 4 5 6 7 8 9 10

PROVOKED BY: Cold Hot Biting Sweet Spontaneous (unprovoked) Other _____

SWELLING: None In the Past Today

Today's Anxiety Level: (0-10) _____

Do you use Nitrous Oxide (Laughing Gas)? Yes No (50.00 fee)