SC ENDODONTICS, INC. 2900 Bristol St, D105 Costa Mesa, CA 92704 714-668-1620

DIAGNOSTIC QUESTIONNAIRE

NAME: _____ DATE: _____

(Please check the appropriate box)

Current or past problem(s) relating to:

❑Tooth/Teeth: #_____ ❑Gum around tooth ❑Area near tooth
❑ Sinuses ❑ Ear ❑ T.M.J (Joint where the jaw hinges) ❑ Upper jaw ❑ Lower Jaw ❑ Head ❑ Neck ❑ Eyes
❑Findings by your referring dentist: _____

Any **prior root canal treatment** on related tooth/teeth: ❑Yes ❑No. If Yes, when? _____

_____

When and **how** did the problem begin and/or reoccur? _____

_____

How long did it usually last for? ❑Seconds: _____ ❑Minutes: _____ ❑Hours: _____ ❑Days: _____
❑Months: _____ ❑Years: _____ When did it stop? _____

Any **recent dental treatment** provided by your dentist to treat the symptoms? ❑Yes ❑No. If Yes, please describe:

_____

Description of Symptoms (current or past):
Do you still have pain, aching, or swelling at this time? ❑Yes ❑ No

Location:
❑Localized ❑Diffused ❑Referred to what area: _____
❑Upper Right ❑Upper Left ❑Lower Right ❑Lower Left ❑Upper Front ❑Lower Front

Severity: ❑Mild ❑Moderate ❑Severe **or** Level of pain: 1 to 10 (10 is most painful): _____

Progression: ❑Increasing with time ❑Decreasing with time ❑Staying the same ❑Intermittent / Comes and goes
❑Began after a dentist has worked on - Describe: _____

Frequency: ❑Spontaneous (occurs on its own) ❑Momentary (brief, short)
How often (times/day or week): _____ What part of the day is the worst? _____

Quality: ❑Sharp ❑Throbbing ❑Dull ❑Electrical ❑Steady ❑Radiating ❑Aching ❑Other: _____

Worsening Factors:
❑Biting/chewing on:_____ ❑Release or open after biting down
❑Cold food/drink ❑Hot food/drink ❑Inhaling air ❑Finger manipulation ❑When opening jaw wide ❑Bending over
❑Lying down at night ❑Jumping ❑Lifting ❑Is reproducible by:_____

Lessening Factors:
❑Ice ❑Heat ❑Clove oil ❑Pain Med's: _____ ❑Antibiotics:_____ ❑Other: _____

Swelling:
❑None ❑Presently ❑On & Off ❑In the past, when started? _____
❑Gum boil (sinus tract or fistula) ❑Gland tenderness or soreness under jaw or on neck area
❑Feel feverish, when? _____

Miscellaneous:
❑History of a blow to the mouth or accident in the past. Describe: _____
_____

❑Sinus problems are currently aggravating
❑History of wearing night guard or splint
❑History of clenching and grinding teeth
❑History of Temporal Mandibular Disorder
❑History of neuralgia (nerve pain) in head or neck
❑Sore jaw muscles
❑Headaches, type: _____
❑Recent bad taste in mouth _____