Patient Survey — Before Treatment

Please mark answers with an “X” in the corresponding box. It is very important that the responses be recorded within the space allotted. Example: X

When recording numerical responses, such as amounts or dates, one number should be entered into each box. Example: 01 / 03 / 2010

Today’s Date mm dd y

Complete Questions 1 through 10 before the tooth is numbed.

1. Are you fearful about today’s appointment?
   a. □ Not at all
   b. □ A little
   c. □ Quite a lot
   d. □ Very much

2. I feel that the treatment outcome for my tooth will turn out (mark one):
   a. □ very good.
   b. □ good.
   c. □ fair.
   d. □ poor.

3. How many days in the past week have you had tooth pain? □ Days (If no pain, please write “0”)

4. Have you taken anything for the pain (over-the-counter or prescription medication, herbal, other) in the last 7 days?
   a. □ Yes
   b. □ No

IF PAIN WAS NOT PRESENT IN THE PAST 7 DAYS, SKIP TO QUESTION #11

5. Pain quality (mark all that apply)
   a. □ none
   b. □ dull
   c. □ sharp
   d. □ aching
   e. □ throbbing
   f. □ burning
   g. □ shooting
   h. □ electric

6. Does this pain? (mark all that apply)
   a. □ start all by itself for no known reason (spontaneous)
   b. □ start after the tooth is used or irritated (provoked)
7. What makes this pain worse? (mark all that apply)
   a. □ Nothing, never gets worse
   b. □ Nothing, gets worse all by itself
   c. □ Biting, chewing
   d. □ Cold and/or hot food or drink
   e. □ Stress

   Please CIRCLE ONE NUMBER when answering questions #8 – 10 below.

8. How would you rate your tooth pain on a 0 to 10 scale at the present time, that is right now, where 0 is "no pain" and 10 is "pain as bad as could be"?

   No Pain                               Pain as bad as could be
   0  1  2  3  4  5  6  7  8  9  10

9. In the past week, how intense was your worst tooth pain rated on a 0 to 10 scale where 0 is "no pain" and 10 is "pain as bad as could be"?

   No Pain                               Pain as bad as could be
   0  1  2  3  4  5  6  7  8  9  10

10. In the past week, on average, how intense was your tooth pain rated on a 0 to 10 scale where 0 is "no pain" and 10 is "pain as bad as could be"? (That is, your usual pain at times you were experiencing pain)

   No Pain                               Pain as bad as could be
   0  1  2  3  4  5  6  7  8  9  10

Please pause: Your dentist may now wish to numb the tooth before you answer #11-27

11. How many days in the past week have you been kept from your usual activities due to pain? (work, school or housework, etc.) □ days? (If none, please write "0")

   Please CIRCLE ONE NUMBER when answering questions #12 – 14 below.

12. In the past week, how much has tooth pain interfered with your daily activities rated on a 0 to 10 scale where 0 is "no interference" and 10 is "unable to carry on any activities"?

   No interference                           Unable to carry on any activities
   0  1  2  3  4  5  6  7  8  9  10
13. In the past week, how much has tooth pain interfered with your ability to take part in recreational, social and family activities where 0 is "no interference" and 10 is "unable to carry on any activities"?

<table>
<thead>
<tr>
<th>No interference</th>
<th>Unable to carry on any activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

14. In the past week, how much has tooth pain interfered with your ability to work (including housework) where 0 is "no interference" and 10 is "unable to carry on any activities"?

<table>
<thead>
<tr>
<th>No interference</th>
<th>Unable to carry on any activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

15. Has your tooth pain been present at least 8 hours a day, 15 days or more a month, over the last 3 or more months?
   a. ☐ Yes
   b. ☐ No

16. For at least the last 3 months, have you experienced pain in more than one area of your body during at least 4 days each week?
   a. ☐ Yes
   b. ☐ No

17. During your entire life, have you smoked at least 100 cigarettes?
   a. ☐ Yes
   b. ☐ No (if No, skip to question #20)

18. Do you smoke cigarettes now?
   a. ☐ Yes
   b. ☐ No

19. On average, how many cigarettes do you (or did you) usually smoke each day?
   ☐ cigarettes

20. Has a doctor ever told you that you had diabetes or high blood sugar? (For women, not during pregnancy.)
   a. ☐ Yes
   b. ☐ No

21. Your gender
   a. ☐ male
   b. ☐ female

22. Your age in years ☐ ☐
23. Your ethnicity
   a. ☐ Hispanic or Latino
   b. ☐ Not Hispanic or Latino

24. Your race
   a. ☐ White
   b. ☐ Black or African American
   c. ☐ American Indian or Alaska Native
   d. ☐ Asian
   e. ☐ Native Hawaiian or Pacific Islander
   f. ☐ Other (please specify) ______________________

25. Do you have dental insurance or third party coverage?
   a. ☐ Yes
   b. ☐ No

26. Indicate your household annual income
   a. ☐ < $10,000 per year
   b. ☐ $10,000 - $29,000 per year
   c. ☐ $30,000 - $49,999 per year
   d. ☐ > $50,000 per year

27. Indicate your highest level of education
   a. ☐ less than high school
   b. ☐ high school
   c. ☐ some college
   d. ☐ college degree
   e. ☐ advanced or graduate degree

Please complete contact information form now.