



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:**

When recording numerical responses, such as amounts or dates, one number should be entered into each box. **Example:** / / 20

Today's Date mm dd 20 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"?

| No interference | | | | | | | | | | Unable to carry on any activities |
|-----------------|---|---|---|---|---|---|---|---|---|-----------------------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

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"?

| No interference | | | | | | | | | | Unable to carry on any activities |
|-----------------|---|---|---|---|---|---|---|---|---|-----------------------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

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?

| | | |
|----------------------|----------------------|------------|
| <input type="text"/> | <input type="text"/> | 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

| | |
|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> |
|----------------------|----------------------|



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.