Precision Dental Care Emergency and Teledentistry Services – Patient Documentation

Patient name: _____ **Date of Birth:** _____

Please describe the symptoms:

_____ Pain 0-3 (none=0, mild=1, moderate=2, severe=3)

_____ Swelling 0-3 (none=0, mild=1, moderate=2, severe=3)

_____ Location (upper / lower / right / left / front / back)

_____ Duration of symptoms (hours/ days / weeks / months)

_____ Onset of symptoms (gradual / sudden)

_____ Stimulus and response: Does it cause discomfort only when provoked by something hot or cold or biting on the tooth? Describe:

_____ How long does the pain linger after the onset of symptoms? (none / seconds / minutes) *please be specific

_____ Are you currently taking any medicines or supplements? Please list:

_____ Have you had any significant changes to your health history?

_____ Are/were you currently scheduled for treatment of this problem?

_____Have you tested positive for COVID -19?

_____ Do you have any symptoms associated with a potential infection? (fever, cough, body aches, etc)

_____ Are you on medication to suppress your immune response? (eg Steroids, Humeira, Chemotherapy, etc)

_____ Are you allergic to any medication?

_____ Have you been diagnosed with diabetes, a bleeding disorder or respiratory disorder?

_____ Do you currently have a fever or have traveled more than 40 miles from your home or work?

_____ Have you been practicing social isolation to minimize your risk of exposure? (please describe)

_____ Is there anything else that you feel is important to know regarding your overall or dental health?