Precision Dental Care Emergency and Teledentistry Services – Patient Documentation

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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?