Emergency Patient Information with Pain

First & Surname: Mr / Mrs / Miss / Ms: _____

Where is the pain? : Right ☐ Left ☐ Top Jaw ☐ Bottom Jaw ☐

Rate your pain out of 10 (1 being slight and 10 severe pain):_____

How long have you had the pain for?: _____

Have you ever had a swollen face from it?: _____

Have you ever had any discharge from it?: _____

How would you describe the pain?:

1) Constant pain? Yes ☐ No ☐ 2) Intermittent Pain? Yes ☐ No ☐ If so:

If Intermittent Pain: 1) Initiating Reason: Hot ☐ Cold ☐ Bite (eating) ☐

Throbbing ☐ Sweet ☐

2) Starts without any initiation: During the Day ☐ During the Night ☐ When sleeping ☐ Awake ☐

Sensitive to Temperature?: Hot ☐ Cold ☐

Are you having trouble sleeping because of the pain? Yes ☐ No ☐

Duration of pain when it occurs?: _____
(eg: seconds, hours or days)

Is there anything you can do to relieve the pain?:_____

Are you taking pain medication for this pain?: Yes ☐ No ☐

If yes, details: _____

Is there anything else you want to let us know about your pain?:

_____

Parent/Guardian Signature: _____Date: _____