



SENSITIVE TEETH STUDY

Patient Pain Assessment – (2nd Line Treatment Visit)

Date Completed: |__|__|/|__|__|/| 2 | 0 || 1 |__|
 m m d d y y y y

We would like you to describe the pain from your sensitive tooth or teeth by answering the following questions. Please review the scale labels and then use a pen to mark the appropriate point on the scale that best describes your pain. Please use a vertical straight line.

DO NOT USE AN 'X' MARK.

Example below:

Not painful |-----| Most intense pain imaginable

1. Please describe the pain from your sensitive tooth or teeth that you have experienced in the past day (24 hours).

Not painful |-----| Most intense pain imaginable

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|_|_|_|

2. Please describe the sensation you have felt from your sensitive tooth or teeth in the past day (24 hours).

Not unpleasant |-----| Most unpleasant sensation imaginable

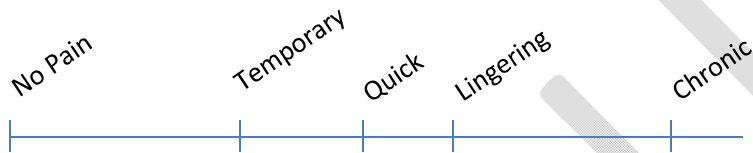
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3. Now we would like you to describe the pain that you experienced in the past day (24 hours) related to your sensitive tooth or teeth. Please use a pen to mark a vertical **straight line** on the scales below to show how long your pain lasted (duration), how intense your pain was (intensity), how tolerable your pain was (tolerability) and what type of pain you had (description).

DO NOT USE AN 'X' MARK.

Duration



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||_||_||_||_||

Intensity



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||_||_||_||_||

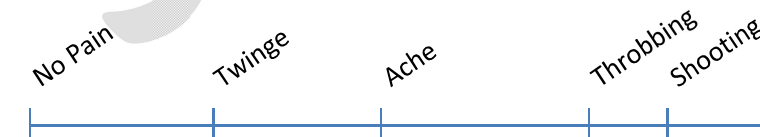
Tolerability



For official use only:

||_||_||_||_||

Description



For official use only:

||_||_||_||_||

Thank you for completing the form!