Pre-printed SID number

GREEN

The National Dental Practice-Based Research Network
The nation's network

SENSITIVE TEETH STUDY

Patient Pain Assessment – 4 Week (1st Line Treatment)

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).

For official use only:
|___|___|___|

Not painful — Most intense pain imaginable

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

For official use only:
|___|___|___|

Not unpleasant — Most unpleasant sensation imaginable

SEE REVERSE

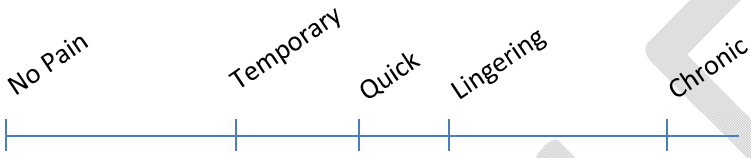
Pre-printed SID number

GREEN

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

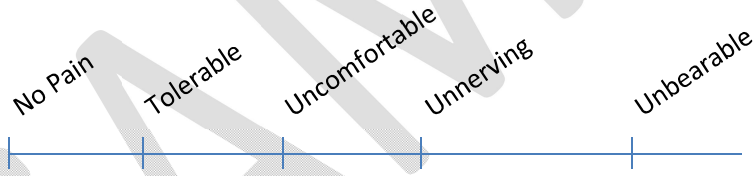


For official use only:
|___|___|___|

Intensity

For official use only:
|___|___|___|

Tolerability



For official use only:
|___|___|___|

Description

For official use only:
|___|___|___|

Pre-printed SID number

GREEN

4. Are you using the product(s) recommended by your dentist at home?

☐ Yes
☐ No ------> **Go to question 6**
☐ My dentist did not recommend any product(s) to use at home -----> **Go to question 6**

5. If yes, how often are you using them?
☐ Weekly
☐ Daily
☐ Twice a day
☐ More than twice a day

6. Did your dentist recommend you stop or decrease any products and/or habits/activities?
☐ Yes-----> **Go to question 7**
☐ No ------> T**his form is completed**

7. If yes, to what extent have you stopped or decreased these products or habits/activities?
☐ 100% of the time
☐ 50% of the time
☐ 25% of the time
☐ I have not stopped or decreased these products or habits at all

Thank you for completing the form!