

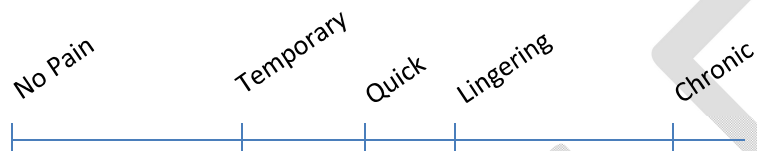




3. Now we would like you to describe the pain that you experienced in the past day (24 hours) related to your sensitive tooth or teeth. Please use a pen to mark a vertical **straight line** on the scales below to show how long your pain lasted (duration), how intense your pain was (intensity), how tolerable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

**DO NOT USE AN 'X' MARK.**

**Duration**



For official use only:

|\_|\_|\_|

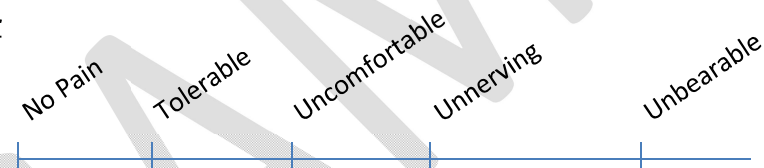
**Intensity**



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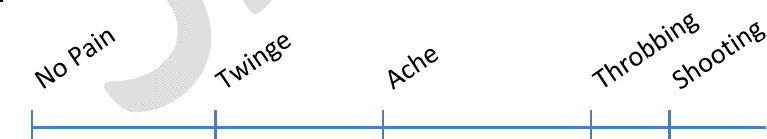
**Tolerability**



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**Description**



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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 -----> **Go to question 8**

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

8. Please make a mark (line) on the horizontal line below to indicate your satisfaction with treatment for dentin sensitivity since you began participating in the study.

**DO NOT USE AN 'X' MARK.**



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**Thank you for completing the form!**