Patient Before Visit Questionnaire

English or Spanish Start Time: _____

Please answer the following questions before your treatment begins. Your responses are confidential and will not be shared with your dentist. Please answer as honestly as you can, there are no right or wrong answers.

To begin the survey, please hit the "next page" button below.

ADD SPANISH

1. How would you rate your tooth pain on a 0 to 10 scale at the present time, that is right now, where 0 is "no pain" and 10 is "pain as bad as it could be"?

◯ 0 (no pain)
◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10 (pain as bad as it could be)

ADD SPANISH

◯ 0
◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10

2. In the past 7 days, how intense was your worst tooth pain rated on a 0 to 10 scale, where 0 is "no pain" and 10 is "pain as bad as it could be"?

◯ 0 (no pain)
◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10 (pain as bad as it could be)

ADD SPANISH

◯ 0
◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10

3. In the past 7 days, on average, how intense was your tooth pain rated on a 0 to 10 scale, where 0 is "no pain" and 10 is "pain as bad as it could be"? (that is, your usual pain at times you were experiencing pain)

◯ 0 (no pain)
◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10 (pain as bad as it could be)

ADD SPANISH

◯ 0
◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10

4. I feel that the treatment outcome for my tooth will turn out:

◯ Poor
◯ Fair
◯ Good
◯ Very good

ADD SPANISH

5. To what degree are you afraid about receiving dental treatment today?

◯ Not at all afraid
◯ A little afraid
◯ Somewhat afraid
◯ Very afraid
◯ Extremely afraid

ADD SPANISH

6. Have you taken any of the following medications or supplements in the past 7 days for the tooth that was treated today?

	Yes	No
Prescription pain medications	◯	◯
Over-the-counter pain medications (a prescription was not needed)	◯	◯
Antibiotics prescribed by your dentist	◯	◯
Herbal medications	◯	◯

ADD SPANISH

	Sí	No
ADD SPANISH	◯	◯
ADD SPANISH	◯	◯
ADD SPANISH	◯	◯
ADD SPANISH	◯	◯

Questions 7-9 are related to any jaw or temple pain you may have had.

7. In the last 30 days, on average, how long did any pain in your jaw or temple area on either side last?

◯ No pain
◯ From very brief to more than a week, but it does stop
◯ Continuous

ADD SPANISH

8. In the last 30 days, have you had any pain or stiffness in your jaw on awakening?

◯ Yes
◯ No

ADD SPANISH

9. In the past 30 days, did the following activities change any pain (that is, make it better or make it worse) in your jaw or temple area on either side?

	Yes	No
Chewing hard or tough food	○	○
Opening your mouth or moving your jaw forward or to the side	○	○
Jaw habits such as holding teeth together, clenching, grinding, or chewing gum	○	○
Other jaw activities such as talking, kissing, or yawning	○	○

ADD SPANISH

	Sí	No
ADD SPANISH	○	○
ADD SPANISH	○	○
ADD SPANISH	○	○
ADD SPANISH	○	○

10. Everyone experiences painful situations at some point in their lives, such as headaches, tooth pain, joint or muscle pain. Please indicate the degree to which you have these thoughts/feelings when you're in pain:

	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
It is terrible and I think it is never going to get any better	○	○	○	○	○
I feel I can't stand it any more	○	○	○	○	○
ADD SPANISH					
ADD SPANISH	○	○	○	○	○
ADD SPANISH	○	○	○	○	○

11. Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed or hopeless	○	○	○	○
Feeling nervous, anxious or on edge	○	○	○	○
Not being able to stop or control worrying	○	○	○	○
ADD SPANISH				
ADD SPANISH	○	○	○	○
ADD SPANISH	○	○	○	○
ADD SPANISH	○	○	○	○
ADD SPANISH	○	○	○	○

12. The next questions ask about your experiences including feelings and thoughts during the past month. In each case, mark how often you felt or thought a certain way.

In the past month...

	Never	Almost never	Sometimes	Fairly often	Very often
How often have you felt that you were unable to control the important things in your life?	○	○	○	○	○
How often have you felt confident about your ability to handle your personal problems?	○	○	○	○	○
How often have you felt that things were going your way?	○	○	○	○	○
How often have you felt difficulties were piling up so high that you could not overcome them?	○	○	○	○	○

ADD SPANISH

ADD SPANISH	○	○	○	○	○
ADD SPANISH	○	○	○	○	○
ADD SPANISH	○	○	○	○	○
ADD SPANISH	○	○	○	○	○

Thank you. Once your treatment is finished, you will be asked to complete a few more questions. Please select "submit" to finish the survey.

ADD SPANISH

English or Spanish End Time: _____