SENSITIVE TEETH STUDY

Patient History Form

Today's Date: [___] / [___] / 2[0] 1 [___]
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Please complete the following questions after the patient’s baseline visit has been completed

1. In the PAST, have you or your office staff done any treatment, provided prescriptions or recommended over the counter (OTC) products for any previous episode(s) of your patient’s sensitive tooth/teeth? Note: Previous sensitive tooth/teeth episode does not have to be in the same location as current episode.
   - [ ] Yes------> Go to the next question
   - [ ] No------> Go to question 4
   - [ ] I don’t know/I did not ask------> Go to question 4

2. Did your patient follow you or your office staff’s instructions for the recommended treatment for sensitive tooth/teeth?
   - [ ] Yes------> Go to the next question
   - [ ] No -------> Go to question 4
   - [ ] I don’t know/I did not ask -------> Go to question 4

3. What effect did the recommended treatment have on your patient’s previous episode(s) of sensitive teeth?
   - [ ] Symptoms went away
   - [ ] Symptoms decreased and were comfortable
   - [ ] Symptoms decreased but were uncomfortable
   - [ ] Symptoms did not change
   - [ ] I don’t know/I did not ask

4. Thinking of your patient’s CURRENT sensitive tooth/teeth episode, how long have these symptoms been present?
   - [ ] Less than 1 month
   - [ ] 1 month to 1 year
   - [ ] More than 1 year
   - [ ] I don’t know/I did not ask

5. Is your patient currently using any OTC products for treatment of the current sensitive tooth/teeth?
   - [ ] Yes------> Go to the next question
   - [ ] No------> Go to question 9
   - [ ] I don’t know/I did not ask -------> Go to question 9
6. How long has your patient been using OTC products for treatment of the current sensitive tooth/teeth?
   - ☐ Less than 1 month
   - ☐ 1 month to 1 year
   - ☐ More than 1 year
   - ☐ I don’t know/I did not ask ----> Go to question 9

7. How frequently has your patient been using OTC products for treatment of the current sensitive tooth/teeth?
   - ☐ More than once a day
   - ☐ Once a day
   - ☐ A few times per week
   - ☐ Weekly
   - ☐ Less than weekly
   - ☐ I don’t know/I did not ask ----> Go to question 9

8. When your patient uses OTC products what effect do they have on his/her currently sensitive tooth/teeth?
   - ☐ Symptoms go away temporarily
   - ☐ Symptoms decrease and are comfortable
   - ☐ Symptoms decrease but are uncomfortable
   - ☐ Symptoms do not change
   - ☐ I don’t know/I did not ask

9. Has your patient had recent tooth-whitening done either by a dental professional or using OTC whitening products (within the last month)?
   - ☐ Yes----> Go to the next question
   - ☐ No----> Go to question 12
   - ☐ I don’t know/I did not ask----> Go to question 12

10. What type of products has your patient used for tooth-whitening?
    - ☐ In-office bleaching
    - ☐ Products purchased from a dental office
    - ☐ OTC whitening products
    - ☐ Home remedies
    - ☐ I don’t know/I did not ask ----> Go to question 12

11. How frequently has your patient been using tooth-whitening products?
    - ☐ Daily
    - ☐ At least weekly
    - ☐ At least monthly
    - ☐ A few times per year
    - ☐ Once a year
    - ☐ I don’t know/I did not ask
12. Has your patient ever had gum/periodontal surgery or non-surgical scaling/root planing?
   ☐ Yes------> Go to the next question
   ☐ No------> The form is completed
   ☐ I don’t know/I did not ask -------> The form is completed

13. When did your patient have gum/periodontal surgery or non-surgical scaling/root planing?
   ☐ Less than 1 month ago
   ☐ 1 month to 1 year ago
   ☐ More than 1 year ago
   ☐ I don’t know/I did not ask

14. How extensive was the gum/periodontal surgery or non-surgical scaling/root planing?
   ☐ Involved less than 1 quadrant
   ☐ Involved 1-2 quadrants
   ☐ Involved 3-4 quadrants
   ☐ I don’t know/I did not ask

15. When your patient had gum/periodontal surgery or non-surgical scaling/root planing, was the gingiva of sensitive tooth/teeth involved in it?
   ☐ Yes
   ☐ No
   ☐ I don’t know/I did not ask

Thank you for completing the form!

________________________________________  ____________________________
Practitioner Signature                       Date:          | |/| |/ | 0 | 1 | | |
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PLEASE REVIEW THIS FORM FOR COMPLETION AND ACCURACY. THANK YOU.
Questions? Contact your Regional Coordinator.