Denture/Dental History

Name: _____

Patient # _____

	Circle	
Do you chew well with your dentures?	Yes	No
Do you wear your dentures at night?	Yes	No
If yes, ____Upper or _____ Lower		
Are your dentures loose?	Yes	No
If yes, _____Upper or ____Lower		
Age of present dentures? ____0-4 years?		
____5-9 years?		
____10+ years		
How long have you been wearing dentures? ___		
How many dentures have you had? ____		

	Circle	
Does food get under your dentures?	Yes	No
If yes, ____Upper or _____ Lower		
Do you grind or clench your teeth?	Yes	No
Are your dentures comfortable?	Yes	No
If no, do you mean ____Upper or _____Lower		
Do you gag easily?	Yes	No
Do you chew mints/gum?	Yes	No
Were your present dentures made by a		
____ denturist or ____ dentist?		

If you have any natural teeth remaining, when was your last visit with a dentist? _____

Please list the concerns you have with your present dentures: