Dental and Medical History

Are you currently wearing dentures? ☐ **no** ☐ **yes** *Year of fabrication* ___________

If yes, please check all that apply:

UPPER arch ☐ Partial OR ☐ Full ☐ Implant(s)

LOWER arch ☐ Partial OR ☐ Full ☐ Implant(s)

- **Year** you became a partial/ full denture wearer ________________
- Who provided you with your current dentures? ____________________________________
- Do your gums get sores underneath your dentures? ☐ **yes** ☐ **no**
  - If yes, how often do the sores appear? _____________________________________
- Are you happy with the appearance of your teeth? ☐ **yes** ☐ **no**
- Do you use denture adhesives? ☐ **yes** ☐ **no**
- **Are you familiar with the benefits of implant-supported dentures? ☐ yes ☐ no**

Check (✓) if you have had problems with any of the following

___ Sensitive teeth
___ Mouth, jaw or neck injury
___ Difficulty chewing
___ Clicking/Popping Jaw
___ Pain when Biting
___ Tender/Sore Gums
___ Bad breath
___ Grinding Teeth
___ Bleeding Gums
___ Jaw Pain
___ Clenching Teeth
___ Food collection under plates
___ Growths in your mouth
___ Other: ____________________

Dentist (if applicable): ____

Family Doctor: ____

- Are you currently under a physician's care? ☐ **yes** ☐ **no**
- If **yes,** please specify the reason: ____
- Have you recently lost or gained a significant amount of weight? ☐ **yes** ☐ **no**
- Do you have any allergies (e.g. foods, metals, latex) ☐ **yes** ☐ **no**
  - **If yes**, please specify: ____

List **all medications** you are currently taking (including over the counter & herbal remedies):

______________________________ ______________________________

______________________________ ______________________________

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Attach an additional listing if necessary (e.g. pharmacy print out)

Patient Signature: **Date:**