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	Grinding Teeth
Mouth, jaw or neck injury	Bleeding Gums
Difficulty chewing	Jaw Pain
Clicking/Popping Jaw	Clenching Teeth
Pain when Biting	Food collection under plates
Tender/Sore Gums	Growths in your mouth
Bad breath	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 (foods, metals, latex)? [ ] Yes [ ] No Specify (if yes)_____

List all medications you are currently taking (including weight loss medication & herbal remedies):

_____ _____ _____

_____ _____ _____

Attach an additional list if necessary (e.g. pharmacy printout)

Patient Signature: _____ Date: _____