

## Denture / Partial History

**Patient Name:** (Please Print) \_\_\_\_\_ **Date:** \_\_\_\_\_

### Denture / Partial History

If you are wearing a partial or complete artificial denture, please complete the following questions by marking yes or no.

**YES**    **NO**

    Do you have a denture or partial?  
Please indicate what you have on the upper \_\_\_\_\_ (denture or partial)

Please indicate what you have on the lower \_\_\_\_\_ (denture or partial)

    Has your present denture/partial been relined? When? \_\_\_\_\_

    Is your present denture a problem? Please describe \_\_\_\_\_

    Are you satisfied with the appearance?

    Are you satisfied with the comfort?

    Are you satisfied with the chewing ability?

When did you receive your first partial or complete denture? \_\_\_\_\_

How long have you worn your present partial or denture? \_\_\_\_\_