Denture Patient Questionnaire

Patient Name Printed Date

1. **What is your age? 18-24 25-34 35-44 45-54 55-64 65-74 75 or older**

2. **Approximately how long have you worn your current denture?**
    a. Less than one year
    b. 1-4 years
    c. 5-7 years
    d. 8-10 years
    e. 11-15 years
    f. Over 15 years

3. **In general, how do you feel about your denture?**
    a. I am quite pleased with my denture.
    b. I am somewhat pleased with my denture.
    c. I don't really care for my denture, but I tolerate it.
    d. I don't care for my denture at all and rarely wear it, if ever.

4. **What do you like about your denture? (select as many answers that apply):**
    a. My denture helps me to chew my food better.
    b. My denture improves my smile.
    c. My denture feels very natural.
    d. There is nothing I really like about my denture.
    e. Other (please specify) _____

5. **Which, if any, problems are you experiencing with your denture (select as many answers that apply):**
    a. My denture moves when I chew my food.
    b. I am embarrassed to remove my denture at night, or at other times.
    c. I don't particularly care for the way my denture looks.
    d. Food gets trapped beneath my denture.
    e. I am not experiencing problems associated with my denture.
    f. Other (please specify) _____

6. **Do you generally wear your denture to bed at night?** Yes No

1. **How much longer do you expect your denture to look, fit and function well?**
    a. Less than 5 years
    b. 5 to 10 years
    c. 11 to 15 years
    d. 16 to 20 years or more
    e. I am not sure
    f. I am no longer pleased with my denture(s)

8. **Do you use some form of denture adhesive with your denture?** (Poligrip, Fixadent, etc.)?

    a. No
    b. Yes

If yes, which brand or product do you use?

_____

9. **How familiar are you with dental implants?**
    a. Very familiar
    b. Somewhat familiar
    c. Not familiar at all