



Please describe any type of discomfort or awareness of pain associated with your denture or partial

- What is your experience sleeping with dentures in your mouth?
- Do you notice a burning sensation in your mouth?
- Do you currently have sore spots with your denture?

Esthetics

- Have you noticed changes in the appearance of your face?
- Are you happy with the appearance of your teeth?
- Are you confident with your smile?
- Are you concerned with signs of aging (appearance of face)?
- Has there been accelerated signs of aging with your smile?
- Do you have sores at the corners of your mouth?

Function - Chewing and Speaking

- Can you eat and speak comfortably without pain or looseness of the denture?
- Do you use denture adhesives? Occasional or routine? What is your attitude toward adhesives?
- Can you easily eat dry food (for example, a granola bar)?
- Do you ever notice dryness of your mouth, including your lips?
- Do you ever feel like your lips stick together?

Dental History

- When was your last reline or adjustment to a denture? Upper/Lower?
- How long have you been using dentures/this denture?
- Did you use a removable partial denture before full denture?
- What was the reason for tooth loss? (perio/destructive function/cavities & decay)
- What food limitations have you experienced because of chewing challenges? Any special requirement for food preparation?
- Can you eat what you would like to eat? Why or why not?