Jennifer M. Zavoral, D.M.D., M.P.H.
Patient Questionnaire

Name_____ Date_____
Address_____
Home Telephone_____ Work Telephone_____
Date of Birth_____ Occupation_____

1. Are you missing any teeth in your upper jaw? ☐ Yes ☐ No Lower jaw? ☐ Yes ☐ No
   If you have any remaining teeth, how do you feel about the condition of your teeth?_____

2. How do you feel about your smile?_____

3. When were your teeth removed?_____

4. For what reason(s) were your teeth removed?_____

5. Has your loss of teeth led to or affected any of the following?
   ☐ Changes in appearance ☐ Decrease in self-confidence ☐ Physical discomfort
   ☐ Your professional life ☐ Your personal life ☐ Health problems
   ☐ Diet changes ☐ Discomfort in social situations (smiling, etc.)

6. Are you concerned about any of the following?
   ☐ Health of the remaining teeth ☐ Facial appearance and premature aging
   ☐ Shrinkage of the jawbone due to missing teeth ☐ Physical discomfort
   ☐ Appearance of your smile ☐ Other_____

7. If you have a partial / denture, what type do you have? ☐ Full ☐ Partial

8. Do you wear your partial / denture all day? ☐ Yes ☐ No

9. If there are times that you do not wear your partial / denture, please describe the reason(s):_____

10. Do you ever experience difficulty wearing the partial / denture for any of the following reasons?
    ☐ Its appearance ☐ Difficulty eating ☐ Difficulty speaking
    ☐ It does not fit well ☐ It is uncomfortable ☐ It is painful

11. How often have adjustments been made to the partial / denture and when was it last adjusted?_____

12. Have you ever had your partial / denture replaced? ☐ Yes ☐ No

13. Do you feel that your partial / denture fits better when you first began wearing it, than it does now?
    Upper Jaw ☐ Yes ☐ No Lower Jaw ☐ Yes ☐ No

14. Which gives you the most trouble? ☐ Upper ☐ Lower

15. What is the main concern or problem that you would like to resolve with replacement teeth?_____

16. What benefits do you expect from replacement teeth?_____