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Comprehensive Family Dentistry

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HEALTH QUESTIONNAIRE
 (All Information is Confidential)

Patients Name _____ Birth Date _____
 Today's Date _____

Do you or have you ever had (circle "Yes" or "No")

- High or Low Blood Pressure.....Y.....N
- Heart Disease of Heart Attack.....Y.....N
- Heart Murmur.....Y.....N
- Angina or Chest Pain.....Y.....N
- Stroke.....Y.....N
- Circulatory Problems.....Y.....N
- Bleeding Problems.....Y.....N
- Cancer.....Y.....N
- Benign Tumors.....Y.....N
- Diabetes.....Y.....N
- Ulcers, Intestinal Disorders.....Y.....N
- Eating Disorders.....Y.....N
- Hepatitis, Jaundice, Liver Disease.....Y.....N
- Seizures.....Y.....N
- Arthritis, Joint Disease.....Y.....N
- Artificial Joints, Implants.....Y.....N
- Chronic Neck or Back Pain.....Y.....N
- Tuberculosis.....Y.....N
- Asthma.....Y.....N
- Blood Transfusions.....Y.....N
- Are You In a High Risk Group for AIDS.....Y.....N
- AIDS or HIV +.....Y.....N
- Sexually Transmitted Diseases.....Y.....N
- Alcohol/Substance Abuse.....Y.....N
- Women – Are you Pregnant?.....Y.....N

How Many Months _____

Any Other Medical Concerns We Should Be Aware Of _____

- Headaches, Migraines, Cluster Headaches.....Y.....N
- Cold Sores, Fever Blisters.....Y.....N
- Slow Healing Sores on Mouth or Lips.....Y.....N
- Jaws That Click, Lock, or Pop.....Y.....N
- Face, Neck, or Ear Pain.....Y.....N
- Restless, Interrupted Sleep.....Y.....N

