Medical History

Name:_____ Date:_____ SSN:_____
Name you like to be called:_____ Phone #(s):_____
Address:_____ City & Zip:_____
Age:_____ Birthdate:_____ Height:_____Weight:_____Gender:_____
Email:_____

1. From whom or how did you find out about Dr. Keni?_____
2. Procedure(s) or condition(s) to discuss with Dr. Keni:_____
_____
3. Drug related allergies (include creams, tape, makeup):_____
_____
4. Primary doctor's name:_____ Phone:_____
5. How is your general health?_____ HIV positive? Y / N HepC positive? Y / N
6. Do you smoke? Y / N Packs per day_____ Do you drink? Y / N Drinks per day_____
7. List all medications you are now taking (include over-the-counter meds, birth control, vitamins, herbal supplements, etc.):_____
_____
8. List all previous surgeries or major illnesses you have had, with dates:_____
_____
Were there any complications? (Describe any):_____
9. Have you ever had an adverse reaction to anesthetics? Y / N
   Do you have an increased bleeding tendency? Y / N
   Do you have a history of bad scarring? Y / N
   If yes, where?_____
10. Do you wear glasses? Y / N Do you wear contacts? Y / N
11. Have you ever been under the care of a psychiatrist? Y / N
12. Do you have (or have a history of):

Chest Pain	Y / N	Facial Paralysis	Y / N	Cold sores (mouth/lips)	Y / N
Hypertension	Y / N	Heart Trouble	Y / N	Gallbladder Problems	Y / N
Diabetes	Y / N	Breathing Difficulty	Y / N	Kidney/Bladder Problems	Y / N
Ulcers	Y / N	Sinus Infections	Y / N	Arthritis	Y / N
Anemia	Y / N	Nose Bleeds	Y / N	Paralysis (arm/leg)	Y / N
Asthma	Y / N	Pulmonary Trouble	Y / N	Sex-Transmitted Disease	Y / N
Hepatitis	Y / N	Nasal Allergies	Y / N	Blood in Stool or Urine	Y / N
Dizzy Spells	Y / N	Post-Nasal Drip	Y / N	Abnormal Lumps or Nodes	Y / N
Headaches	Y / N	Skin Infections	Y / N	Glaucoma	Y / N
Seizures	Y / N	Blurry Vision	Y / N	Dry Eyes	Y / N

13. Women only: When was your last menstrual period?_____ Are your periods regular? Y / N
    Are you pregnant? Y / N Are you breastfeeding? Y / N
14. List any other medical conditions or important information:_____
_____

I attest that the above information is true, correct, and complete, to the best of my knowledge:

Signature:_____