Medical History

Name:_____ Date:_____

Name you like to be called:_____ Phone #(s):_____

Address:_____ City & Zip:_____

Age:_____ Birthdate:_____ Height:_____Weight:_____Gender:_____

Email:_____

Permission to receive text messages, emails, and/or voice messages from our office*? Y / N

*We do not share your personal information with anyone. Standard messaging and data rates may apply. Message frequency may vary but will not exceed more than a few messages per month. You may opt out at any time.

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:_____ Phone:_____
5. Pharmacy:_____ Phone:_____
6. How is your general health?_____ HIV positive? Y / N HepC positive? Y / N
7. Do you smoke? Y / N Packs per day_____ Do you drink? Y / N Drinks per day_____
8. List all medications you are now taking (include over-the-counter meds, birth control, vitamins, herbal supplements, etc.):_____

_____

9. List all previous surgeries or major illnesses you have had, with dates:_____

_____

Were there any complications? (Describe any):_____

10. 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? _____
11. Do you wear glasses? Y / N Do you wear contacts? Y / N
12. Have you ever been under the care of a psychiatrist? Y / N For what reason:_____
13. 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

14. Women only: When was your last menstrual period?_____ Are your periods regular? Y / N
    Are you pregnant? Y / N Are you breastfeeding? Y / N
15. 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:_____