



Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_

Email address: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Phone #: \_\_\_\_\_

Spouse: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Referred by: (Please be specific as to who or which)**

Doctor: \_\_\_\_\_ Spa: \_\_\_\_\_ Magazine: \_\_\_\_\_

Friend: \_\_\_\_\_ Internet: \_\_\_\_\_ Television: \_\_\_\_\_

Relative: \_\_\_\_\_ VociCenter.com \_\_\_\_\_ Yellow Pages: \_\_\_\_\_

Patient: \_\_\_\_\_ Seminar: \_\_\_\_\_ Other: \_\_\_\_\_

Nurse: \_\_\_\_\_ Newspaper: \_\_\_\_\_

Would you like to be on our mailing list?    Yes    No

How may we contact you privately: email    cellphone    home address    home phone    business phone  
(Please circle those that apply)

Updated: Date & Initial: \_\_\_\_\_ Date & Initial: \_\_\_\_\_ Date & Initial: \_\_\_\_\_

Date & Initial: \_\_\_\_\_ Date & Initial: \_\_\_\_\_ Date & Initial: \_\_\_\_\_

**WE DO NOT ACCEPT INSURANCE**

# YOUR MEDICAL INFORMATION for VOCICENTER

## GENERAL MEDICAL EVALUATION:

Family or Primary Physician: \_\_\_\_\_

How is your general Health? \_\_\_\_\_

Are you presently being treated for any medical conditions?    Yes    No

If so, please explain: \_\_\_\_\_

When was your last physical exam? \_\_\_\_\_

By whom? \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

## FEMALES

Last menstrual period: \_\_\_\_\_

Are you pregnant?    Yes    No

Have you had a mammogram?    Yes    No

If so, when? \_\_\_\_\_

Have you had children?    Yes    No

If so, what are the ages? \_\_\_\_\_

Do you use Birth Control pills?    Yes    No

## HEALTH:

Coronary occlusion or heart attack	Yes	No
Angina or chest pain	Yes	No
Congenital heart disease (at birth)	Yes	No
Heart murmur	Yes	No
Rheumatic fever	Yes	No
Palpitations or irregular heart beat	Yes	No
Prolapsing valve	Yes	No
Hypertension (high blood pressure)	Yes	No
Stroke	Yes	No
Shortness of breath	Yes	No
Chronic lung disease	Yes	No
Cough	Yes	No
Asthma	Yes	No
Vision problems	Yes	No
Glaucoma	Yes	No

Dry eyes requiring drops	Yes	No
Hearing problems	Yes	No
Sinus problems or infections	Yes	No
Frequent infections	Yes	No
Previous blood clots	Yes	No
Thrombophlebitis	Yes	No
Bleeding disorders in self or family	Yes	No
Blood transfusion	Yes	No
Diabetes	Yes	No
Auto-immune diseases (lupus, RA, etc.)	Yes	No
Unusual healing problems	Yes	No
Keloids or thick scars	Yes	No
Cold sores	Yes	No

If you answered yes to any of these questions, please explain: \_\_\_\_\_

## MEDICATIONS:    Are you taking?

Aspirin, ibuprofen, or meds containing aspirin	Yes	No
Anticoagulants	Yes	No
Steroids/Cortisone	Yes	No
Vitamin E	Yes	No
Herbals/Supplements	Yes	No
Fat Burners	Yes	No
Accutane	Yes	No

Date of last Tetanus Shot: \_\_\_\_\_

List all medications you are currently taking or have taken in the last month and the dosage:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## PSYCHIATRIC

Psychiatric Treatment	Yes	No
Is so, were you hospitalized?	Yes	No
Any recent crisis in your life?	Yes	No

If so, please explain: \_\_\_\_\_

\_\_\_\_\_

Name of Person treating you: \_\_\_\_\_

**ALLERGIES:**

Drug allergies (including anesthetics, Antibiotics & Codeine)	Yes	No
Aspirin or Ibuprofen allergy	Yes	No
Tape allergy	Yes	No
Latex allergy	Yes	No
Egg allergy	Yes	No
Beef allergy	Yes	No
Soybean oil	Yes	No

Any food allergies? Yes No

Please list which ones; \_\_\_\_\_

\_\_\_\_\_

Any problems with anesthesia? Yes No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**SOCIAL:**

Do you smoke? Yes No

If so, how much a day? \_\_\_\_\_

Do you use other tobacco products? Yes No

If so, what type? \_\_\_\_\_

How often? \_\_\_\_\_

Do you consume alcohol? Yes No

If yes, how much per day? \_\_\_\_\_

**FAMILY HISTORY:**

Any medical problems or illness? Yes No

Is so, explain: \_\_\_\_\_

\_\_\_\_\_

Does anyone in your family have problems with anesthesia? Yes No

If so, explain: \_\_\_\_\_

\_\_\_\_\_

**List below questions you would like to have answered during your consultation:**

\_\_\_\_\_

\_\_\_\_\_

**Previous Operations and Hospitalizations:**

Type/Reason:	Hospital:	Surgeon:	Date:	Complications:
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**AUTHORIZATION FOR DISCLOSURE OF INFORMATION:**

I authorize Voci Center to disclose information concerning medical findings and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who are required to receive such information for medical treatment, medical quality assurance and peer review. All other requests for information about me will be allowed ONLY with further express written permission by me or my legal guardian.

PATIENTS OR GUARDIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_