VinCon Diagnostic Center 5732 Canton Cove, Winter Springs, FL 32708

Patient Name: _____ DOB: ____/____/_____ Today's date:_____

Please fill out the section that pertains to your test today

ABDOMEN: **Weight: _____lbs**

Do you have or have you had any of the following problems?

Weight loss? ____No ____Yes, how much? _____ Are you trying to lose weight? _____

Nausea? ____No ____Yes, how often? _____

Vomiting? ____No ____Yes, how often? _____

Diarrhea? ____No ____Yes, how often? _____

Constipation? ____No ____Yes, how often? _____

Heartburn? ____No ____Yes, how often? _____

Epigastric pain? (Mid chest area) ___No ___Yes, how often? _____ How long does it last?_____

Bloating? ____No ____Yes

History of cancer? ___No ____Yes, where was it located? _____ What type?_____

How long ago were you treated? _____

Abdominal surgery? ___No ____Yes, what type of surgery? _____

Blood in stool? ___No ____Yes

Fever? ____No ____Yes, Temp _____degrees. How many days have you had fever? _____

Related to injury/trauma? ____No ___Yes **If Yes, What is the Date of injury/trauma: ____/_____/_____**

What date did your symptom(s) begin? ____/____/_____ _____

Females: Are you pregnant? (Please circle one) **Yes No Unsure**

Comments: _____

TECHNOLOGIST ONLY: _____

Pelvis: Weight _____lbs

Do you have or have you had any of the following problems?

____*Right* or ___*Left* lower quadrant pain, How long has the pain been present? _____ and how often do you have it? _____.

Tenderness ____No ____Yes, Where? _____

Any bowel habit changes? ____No ____Yes, How have they changed?_____

Frequency or burning with urination? ____No ____Yes, How long has this been happening?_____

Any fever present with your symptoms? ____No ____Yes, How long have you had a fever?_____

Painful urination? ____No ____Yes

Bloody urination? ____No ____Yes

Vaginal or Penile discharge? ____No ____Yes

Bloating? ____No ____Yes

Blood in stool? ____No ____Yes

History of cancer? ____No ____Yes, where was it located?_____

How long ago were you treated? _____

What date did your symptom(s) begin? ____/____/_____ _____

Surgery of pelvis? ____No ____Yes

Fever? ____No ____Yes, Temp _____degrees. How many days have you had fever? _____

Related to injury/trauma? ____No ___Yes **If Yes, What is the Date of injury/trauma: ____/_____/_____**

Females: Are you pregnant? (Please circle one) **Yes No Unsure**

Are you on hormone replacement therapy? ____Yes ____No

Are you on birth control? ____Yes ___No

First date of last menstrual period? _____/_____/_____

Comments: _____

TECHNOLOGIST ONLY: _____