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

Arms and/or legs:

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

Leg swelling? ____No ____Yes, which one? ___Left ___Right ___Both
Calf pain with exercise? ____No ____Yes
Calf pain without exercise? ____No ____Yes
Pain in arms? ____No ____Yes
Numbness in arms? ____No ____Yes
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:

_____

Feet and/or Toes:

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

Swelling in feet? _____No _____Yes
Pain in feet or toes? _____No ____Yes, please explain: _____

_____

Discoloration of feet or toes? _____No _____Yes, please explain: _____

_____

Is this problem related to injury or trauma? ____No ____Yes, please explain: _____

_____

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:

_____

_____

Hand and/or Fingers:

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

Swelling of Hands and/or fingers? ____No _____Yes, Which one(s)? _____
Which finger or hand are you having a problem with? _____
What is the cause of this problem? _____
Have you had this problem in the past? _____No _____Yes, How long ago? _____
Is this problem related to injury or trauma? _____No ____Yes, please describe: _____

_____

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: _____