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

Patient Name: ___________________________ DOB: ____/____/____ Today's date:________

Your Weight ___________lbs

Chest:

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

Cough? ____No ____Yes, How often? ________________ For how long? ______________

Any sputum production? ____No ____Yes, what color is it? ______________

Have you coughed up any blood? ____No ____Yes, When? _______________

Do you smoke? ____No ____Yes, for how long? _______, I quit ___________ ago.

How many cigarettes/cigars do you smoke a day? ______ Cigarettes/packs per day.

Do you live with someone who smokes? ____No ____Yes, Do they smoke in the house? ____No ____Yes

Fever? ____No ____Yes, how long have you had fever? _________

Asthma? ____No ____Yes, how long have you had it? ____________

Wheezing? ____No ____Yes, how long have you been wheezing? _______________

Pain when you breathe? ____No ____Yes, for how long? ___________________

Shortness of breath? ____No ____Yes, for how long? ___________________

Chest pain? ____No ____Yes, where is the pain located? ______________________

History of cancer? ____No ____Yes, where was it located? ___________What type?_______

How long ago were you treated? __________________________

History of lung/chest surgery?____No ____Yes, where? __________________ Due to what? ________

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:

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TECHNOLOGIST ONLY:

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