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

Head or Sinus:

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

Headaches ____ No ____Yes, how often? _____ How long does the pain last? _____

Dizziness ____No____Yes, how often? _____ How long does the dizziness last? _____

Lightheadedness ____No____Yes, how often? _____ How long does this last? _____

Migraine headaches ____No ____Yes, how often? _____ How long have you had migraines? _____

Tenderness ____No ____Yes, how often? _____ Where does your head feel tender? _____

History of tumors? ____No ____Yes, where have tumor(s) been seen? _____

Blurred vision? ____No ____Yes, when did this begin? _____ How often do you have it?_____

Fainting? ____No ____Yes, when did this begin? _____ How often does/did it occur?_____

Numbness? ____No ____Yes, where are you numb at? _____ When did this begin? _____

Difficulty walking? ____No ____Yes, when did this begin? _____ How long has this been happening?

Weakness? ____No ____Yes, what part of your body feels weak? _____

Sinus pressure? ____No ____Yes, how often? _____ Do you suffer from allergies? _____

History of cancer? ____No ____Yes, where was the cancer located? _____ What type?_____

How long ago were you treated? _____

Surgery on head/brain? ___No ____Yes

Head Trauma? ____No ____Yes, where? _____ **Date of injury/trauma: ____/_____/_____**

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

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

Comments:_____

_____

TECHNOLOGIST ONLY:

_____

Neck:

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

Pain? ____No ____Yes, where is the pain located? _____ How long has it been present? _____

Swelling? ____No ____Yes, where is the swelling located?_____

Where did it originate? _____Has it moved around?_____

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

Trouble breathing? ____No ____Yes

Trouble eating? ____No ____Yes, which one? ____Solid food ____Liquids

Any lumps? ____No ____Yes, where at? _____ Does it move? _____

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

How long ago were you treated? _____ What type?_____

History of surgery on neck? ____No ____Yes, where? _____

Do you smoke? ____No ____Yes, how many years? _____

Related to injury/trauma? ____No ____Yes **Date of injury/trauma: ____/_____/_____**

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

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

Comments:

_____

_____

TECHNOLOGIST ONLY: _____

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