VinCon Diagnostic Center
5732 Canton Cove Winter Springs, FL 32708

Today's date: ______/______/_______

Patient Name: ______________________________DOB: _____/_____/_____

Please fill out following information pertaining to your test today:

Body part / area being tested:

Axilla (underarm)	☐ Right	☐ Left	☐ Bilateral
Forearm(s)	☐ Right	☐ Left	☐ Bilateral
Groin	☐ Right	☐ Left	☐ Bilateral
Thigh(s)	☐ Right	☐ Left	☐ Bilateral
Buttock	☐ Right	☐ Left	☐ Bilateral
Chest	☐ Right	☐ Left	☐ Bilateral
Back	☐ Right	☐ Left	☐ Bilateral

Why is this exam being performed? ___________________________
____

Do you have any symptoms? ☐ No ☐ Yes
If yes, When did they begin? _________________________________

Have you had this problem before? ☐ No ☐ Yes

Have you been treated for this problem before? ☐ No ☐ Yes
If yes, When? ____

What type of treatment did you receive? ________________________
____

Have you had any prior imaging to this body part / area? ☐ No ☐ Yes

Please check all that apply:

☐Pain ☐Fever ☐Swelling ☐Palpable lump

☐Injury? , Please explain: _____________________________________
____
____

____
Technologist Signature