CharlotteRadiology™

Vein Centers

Patient Name: _____ Date of birth: _____

All patients who are new to the Vein Centers or returning patients with new symptoms are requested to fill out the below to the best of their knowledge for your records to be the most up-to-date.

In each area, if you are experiencing any of the symptoms listed, PLEASE CHECK THE ONES THAT APPLY. If you have any questions, please ask one of the technicians or your physician.

GENERAL

- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Weight gain
- ☐ Weight loss
- ☐ Not applicable

GENITOURINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Erectile dysfunction
- ☐ Heavy / painful periods
- ☐ Not applicable

NEUROLOGICAL

- ☐ Burning of toes, feet, hands
- ☐ Clumsiness
- ☐ Difficulty speaking
- ☐ Headaches
- ☐ Numbness / tingling
- ☐ Seizures
- ☐ Arm / leg weakness
- ☐ Sensation loss
- ☐ Not applicable

MUSCULOSKELETAL

- ☐ Back pain
- ☐ Muscle cramps / pain
- ☐ Not applicable

GASTROINTESTINAL

- ☐ Abdominal pain after meal
- ☐ Blood in stool
- ☐ Not applicable

ENDOCRINE

- ☐ Appetite changes
- ☐ Not applicable

HEMATOLOGICAL / LYMPHATIC

- ☐ Blood clotting problems
- ☐ Enlarged lymph nodes
- ☐ Genetic factors
- ☐ Prolonged bleeding
- ☐ Not applicable

VASCULAR

- ☐ Pain in feet at rest
- ☐ Pain in legs with walking
- ☐ Slow healing wounds
- ☐ Varicose veins
- ☐ Not applicable

RESPIRATORY

- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ Not applicable

SKIN / INTEGUMENTARY

- ☐ Rash
- ☐ Sores
- ☐ Discoloration
- ☐ Not applicable

PSYCHIATRIC

- ☐ Depression
- ☐ Insomnia
- ☐ Nervousness
- ☐ Not applicable

ENT

- ☐ Visual loss
- ☐ Hearing loss
- ☐ Not applicable

CARDIAC

- ☐ Chest pain
- ☐ Palpitations
- ☐ Not applicable

Patient Signature: _____ Date: _____