VEIN CENTRE

Name:_____Date_____

Using ink COMPLETELY FILL IN BUBBLE

General/Constitutional		
Chills	O Yes	O No
Fatigue	O Yes	O No
Fever	O Yes	O No
Weight gain	O Yes	O No
Weight loss	O Yes	O No
Insomnia	O Yes	O No
Skin		
Rash/Itching	O Yes	O No
Dry skin	O Yes	O No
Discoloration	O Yes	O No
Change in hair or nails	O Yes	O No
Nodule(s)	O Yes	O No
Respiratory		
Cough	O Yes	O No
Coughing up blood	O Yes	O No
Shortness of breath at rest	O Yes	O No
Shortness of breath with exertion	O Yes	O No
Sputum production	O Yes	O No
Peripheral Vascular		
Pain/cramping in legs after exertion	O Yes	O No
Cardiovascular	O Yes	O No
Chest pain at rest	O Yes	O No
Chest pain with exertion	O Yes	O No
Shortness of breath	O Yes	O No
Palpitations	O Yes	O No
Swelling Hands / Feet	O Yes	O No
Orthopnea	O Yes	O No

VC | VEIN CENTRE

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Gastrointestinal

Difficulty swallowing	O Yes	O No
Heartburn	O Yes	O No
Decreased appetite	O Yes	O No
Nausea/vomiting	O Yes	O No
Bowel problems	O Yes	O No
Rectal bleeding	O Yes	O No
Constipation	O Yes	O No
Diarrhea	O Yes	O No

Musculoskeletal

Trauma to hip(s)	O Yes	O No
Trauma to knee(s)	O Yes	O No
Trauma to ankle(s)	O Yes	O No
Stiffness/Swelling Joints	O Yes	O No
Muscle pain/Cramps	O Yes	O No
Joint Pain	O Yes	O No

Neurologic

Dizziness	O Yes	O No
Fainting	O Yes	O No
Seizures	O Yes	O No
Loss of strength	O Yes	O No
Tingling/Numbness	O Yes	O No
Paralysis or Tremor	O Yes	O No

Hematology

Easy bruising	O Yes	O No
Prolonged bleeding	O Yes	O No

Endocrine

Cold intolerance	O Yes	O No
Excessive thirst	O Yes	O No
Easily Bruised	O Yes	O No
Excessive sweating	O Yes	O No