Lymphedema Patient History Form

Please complete the following as best as you can.

Name: _____ Date: _____

Occupation: _____

Chief Complaint(s): _____

_____

Please briefly describe how and why your lymphedema developed: _____

_____

How long have you had lymphedema? _____

Where is your lymphedema located? _____

If 0 is no pain, and 10 was the worst pain, what number would you rate it today? _____

Where is your pain located? _____

What makes your pain worse? _____

What makes your pain better? _____

Do you have any loss of function or mobility? _____ If yes, please briefly describe? _____

_____

Do you currently wear a compression sleeve or stocking? _____ Please list type/brand: _____

Have you ever, or do you currently, use a compression pump? _____ For how long? _____

Have you had any previous treatment for lymphedema? _____ If yes, please briefly describe: __

_____

Have you received chemotherapy? _____ When? _____

Have you received radiation therapy? _____ When? _____

Have you had any infections? _____ If yes, please describe what kind, where, and when: ____

_____

Is your lymphedema smaller in the morning? _____ Larger at the end of the day? _____

Do you exercises regularly? (what activities?) _____

Are you currently having trouble with any of the following? _____Dressing _____Toileting ____Bathing

_____Sleeping _____Eating _____Cooking _____Reaching _____Walking

Please list any other medical problems: _____

_____

_____

Please list any surgeries you have had: _____

_____

_____

Please list any medications you are currently taking: _____

_____

Please list any allergies that you know of: _____

PLEASE CHECK ANY OF THE FOLLOWING CONDITION IF CURRENT:

- Malignancies (active cancer)
- Renal Failure
- Hyperthyroidism
- Cardiac Arrhythmia
- Menstruation
- Diverticulitis, Diverticulosis
- Crohn's Disease
- Recent Abdominal Surgery
- Unexplained Pain
- Asthma
- Radiation over Abdomen
- Congestive Heart Failure (CHF)
- Acute Deep Vein Thrombosis (DVT)
- Hypersensitive Carotid Sinus
- Pregnancy
- Abdominal Aortic Aneurism (AAA)
- Severe Arteriosclerosis
- Ulcerative Colitis
- Pelvic Deep Vein Thrombus
- Acute Bronchitis
- Latex Allergy

Patient Signature: _____

All information above has been verified by the physical therapist with the patient at the time of evaluation.

Therapist's Signature: _____