[Patient Identifier]

PATIENT INFORMATION HISTORY -- LYMPHEDEMA

Name: _____ Date: _____

Address: _____

Telephone # (home) _____ (cell) _____ (work) _____
Which is the best one to use to contact you during the day? _____

Next Doctor's appointment: _____ Occupation: _____

How long have you had Lymphedema? _____

Affected Area(s):

A) Arm(s) Right_____ Left_____ Both_____ None_____
B) Leg(s) Right_____ Left_____ Both_____ None_____
C) Other Face_____ Neck_____ Breast(s)_____ Trunk_____ Abdomen_____ Genitalia_____

Have you had cancer related surgery? Yes / No

If yes, please specify:

Breast: Lumpectomy_____ Modified Radical Mastectomy_____ Radical Mastectomy_____ Reconstruction_____

Gynecological: Ovarian_____ Uterine_____ Cervical_____ Vulva_____

Head / Neck _____ Prostate_____ Melanoma_____ Other_____

Did your surgery include lymph node removal? Yes / No / Unsure If yes, how many? _____

Did you have Sentinel Node Biopsy? Yes / No / Unsure

How long after your surgery did your Lymphedema first occur? _____

What therapy did you receive, if any, pre- or post- surgery? Radiation_____ Chemotherapy_____ Hormonal_____
Physical_____ Occupational_____ None_____

After your surgery, were you informed about the risk of developing Lymphedema and risk reduction methods? Yes / No

If you did NOT have cancer surgery, what do you think caused the onset of your Lymphedema?

Primary/Congenital_____ Infection_____ Trauma/Injury _____ Post-Surgery (not cancer) _____ Lipedema_____
Venous Insufficiency_____ Filariasis_____ Post-Childbirth_____ Liposuction_____ Immobility_____ Don't Know_____

Since the first onset of your Lymphedema, have you had an infection in the affected limb(s)? Yes / No / Unsure

If yes, how many times? 1-3 _____ 4-9 _____ 10 or more _____ Dates: _____
Have you taken antibiotics for your infection? Yes / No
Have you been hospitalized to treat your infection? Yes / No
If yes, how many times? 1, 2, 3, 4, 5, more _____ Dates: _____
Are you currently taking prophylactic (preventive) antibiotics? Yes / No

Patient Signature: _____ **Date:** _____ **Time:** _____

[Patient Identifier]

PATIENT INFORMATION HISTORY – LYMPHEDEMA

Please answer the following questions with respect to your area affected by Lymphedema:

Do you currently have, or in the last 30 days, experienced swelling in these area(s)? Yes / No
If yes, how much? Minimal / Moderate / Extreme

Do you currently have, or in the last 30 days, experienced pain in these areas? Yes / No
If yes, how distressing is the pain? Minimal / Moderate / Extreme

Do you experience a limited range of motion? Yes / No If yes, how limited? Minimal / Moderate / Extreme

Do you experience a feeling of heaviness in your limb? Yes / No

Do you experience a feeling of tightness or stiffness? Yes / No

Have you ever leaked fluid from your affected area(s)? Yes / No

How does your Lymphedema affect your activities of daily living? Give examples: _____
_____

Previous Lymphedema Treatment

What previous treatment have you had for Lymphedema?
Manual Lymph Drainage (MLD) _____ Compression Bandaging _____ Compression Garments_____
Pump_____ Skin Care _____ Exercise_____ Surgery_____

Are you currently following a daily self-care program to help manage your Lymphedema? Yes / No
If yes, please explain what you do?
_____

Which physician referred you to our facility?

Physician's Name: _____
Physician's Office Address: _____
_____
Physician's Phone #: _____

May we contact this physician to discuss your Lymphedema? Yes / No

If you are treated at our facility you will be asked to follow a maintenance program at home requiring:

a) Elastic sleeve or stocking worn during the day.
b) Bandaging of affected area overnight.
c) Meticulous skin care to avoid infections.
d) Remedial exercises to accelerate lymph flow.

Are you ready to follow such a program? Yes / No

How do you learn best? Visual / Demonstration / Other _____

Patient Signature_____**Date**_____**Time**_____

Origin: 2/11 Revised: 10/12