

**Outpatient Physical Therapy
Lymphedema History Form**

Place Label here

Date: _____

Social History:

Age: _____ Male / Female Employed: Yes / No Occupation: _____
 Lives: Alone _____ Caregiver _____ Other _____ Activity level: Low Mod High
 Tobacco use: packs/day _____; past / present Alcohol consumption: drinks/day _____

Lymphedema History:

Where is your swelling? _____

When did it begin? _____

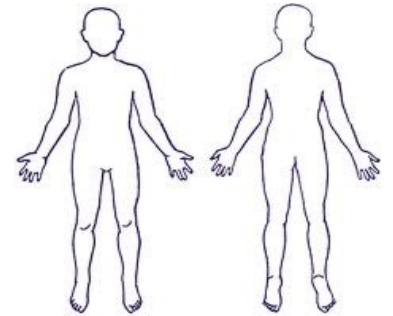
Did it start Suddenly or Gradually?

Is it getting Better Worse Same ?

Is there a family history of Lymphedema? Yes / No

Have you undergone any tests for this problem? (please list with dates)

[X-Ray, MRI, CT Scan, Ultrasound, etc.]



Infections in affected part? Yes / No; most recent _____, Antibiotics used _____

Do you have pain? Yes / No Where: _____

Please give a numeric value to your pain:	0	1	2	3	4	5	6	7	8	9	10
	<i>Less pain</i>										<i>Most pain</i>

Describe your pain: ache dull sore sharp shooting throbbing
 numb full burn tight tingling heavy

Treatment history: None Complete/ Modified Decongestive Therapy Garments Pump Other

Response to treatment: _____

Dates of last Lymphedema treatment: _____

Medical History: Please check all that apply

- | | | |
|---|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Arrhythmia | <input type="checkbox"/> Abdominal surgery | <input type="checkbox"/> Vein problems |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Abdominal Aortic Aneurysm | <input type="checkbox"/> Arterial disease |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Greenfield Filter | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Stomach Disorders | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Kidney Dysfunction | <input type="checkbox"/> Intestinal Disorders | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Acute infection/Cellulitis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Hypo/Hyperthyroidism | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Cancer Active: Yes / No | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> PORT: Y N; Right/Left |

Please continue on next page.

Place label here

Breast: Mastectomy/Lumpectomy Axillary Nodes # ____ (# positive ____) Sentinel Nodes # ____ (# positive ____) Reconstruction: Yes No Type: _____	Gynecological: Type: _____ Hysterectomy: Yes No Inguinal Nodes # ____ (# positive __) Pelvic Nodes # ____ (# positive __)	Head and Neck: Type: _____ Nodes removed: _____
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Surgical History: Date of Surgery _____

Cancer Treatment: *Chemotherapy:* Yes No # of treatments _____; Date completed _____
Radiation: Yes No # of treatments _____; Date completed _____

Have you had any other surgeries? Please list:

List any allergies: _____ Latex: Yes No

Please list any medications you are taking: _____

Are you having any difficulty with activities at home or work? Please explain: _____

What do you hope to achieve with therapy? _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Surgeon: _____ Phone: _____ Fax: _____

Oncologist: _____ Phone: _____ Fax: _____

Plastic Surgeon: _____ Phone: _____ Fax: _____

All of the above information is accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

For Therapist Use Only:

The above has been reviewed with the patient for accuracy.

Therapist Signature/ID: _____ Date: _____ Time: _____