Medical History Form

Date: _____

Name: _____ **DOB**: _____

Completed by: ☐ Patient (listed above) ☐Other: _____

PCP: _____ **Date of last visit:** _____

Do you currently experience swelling/lymphedema? (Please circle all that apply)

☐ Right Arm ☐ Left Arm ☐ Both Arms ☐ Breast ☐ Right Leg

☐ Left Leg ☐ Both Legs ☐ Head & Neck ☐ Genital

Other, please explain: _____

Have you been diagnosed with Lymphedema? ☐ Yes ☐ No

If yes, by whom: _____

Chief Complaint: _____

How long have you had swelling/Lymphedema? _____

Was there a triggering event which caused the swelling/Lymphedema?_____

_____

Please describe briefly how and why your swelling/lymphedema developed:

_____

Have you had any surgery? ☐ Yes ☐ No

If yes, list surgeries and dates: _____

_____

Have you had any reconstruction surgery? ☐ Yes ☐ No

If yes, please explain: _____

_____

Have you had any lymph nodes removed? ☐ Yes ☐ No

If yes, how many and location: _____

Axillary Node Dissection**?** ☐ Yes ☐ No Sentinel Node Dissection**?** ☐ Yes ☐ No

Inguinal Node Dissection**?** ☐ Yes ☐ No Pelvic Node Dissection**?** ☐ Yes ☐ No

Have you ever received radiation for cancer? ☐ Yes ☐ No

If yes, list areas of radiation and dates here: _____

_____

Have you had Chemotherapy? ☐ Yes ☐ No

If yes, how long ago? _____

Have you had any infections (Cellulitis)? ☐ Yes ☐ No

If yes, how long ago was the last one? _____

Is there a family history of Lymphedema? ☐ Yes ☐ No

If yes please explain: _____

Do you have pain? ☐ Yes ☐ No

On a scale of 0 – 10: _____ Is the pain constant or intermittent? _____

Describe pain (ache, stabbing, throbbing): _____

Any loss of function or mobility? ☐ Yes ☐ No

Prior level of function (0-100%):_____

Current level of function (0-100%): _____

Do you have any difficulties with any of the following?

☐ Walking ☐ Reaching Feet and Toes ☐ Preparing Meals ☐ Dressing ☐ Bathing/Showering ☐ Other

If other, please explain: _____

Occupation: _____ **Work Status:** _____

Hobbies/Leisure Activities: _____

What is your current living situation?

☐ Private Home/Apartment (alone) ☐ home with spouse/other ☐ Other:_____

Do you currently suffer from (or have you had) any of the following? (circle all that apply)

☐ Asthma	☐ Hyperthyroidism	☐ Chron's Disease
☐ Bronchitis	☐ Kidney Disease/Failure	☐ Diverticulitis
☐ Difficultly Breathing	☐ Diabetes	☐ Recent Abdominal Surgery
☐ Irregular Heart Beat	☐ Infections (Cellulitis)	☐ Unexplained Pain
☐ Heart Edema	☐ Sleep Apnea	☐ Deep Venous Thrombosis (blood clot)
☐ Hypertension	☐ Malignancy (Cancer)	☐ Latex Allergy
☐ Neurological Condition	☐ Arterial Disease	☐ Radiation Fibrosis

Do you have any other medical problems not listed above? ☐ Yes ☐ No

If yes, please explain: _____

Are you allergic to: ☐ Latex ☐ Surgical Tape ☐ Foam Products ☐ Other

If other, please explain: _____

Are you taking any medication? ☐ Yes ☐ No

If yes, list medications and amounts here: _____

_____

At this time you are completing this, are you, or is there a chance you are pregnant? ☐ Yes ☐ No

Previous Treatments:

Have you had previous treatment for swelling/lymphedema? ☐ Yes ☐ No

If yes check all that apply: ☐ Manual Lymphatic Drainage (MLD) ☐ Compression Pump ☐ lexitouch

☐ Compression Garment ☐ Compression Bandaging ☐ Lymphedema Exercise ☐ Low Level Laser

Please explain your experience, success or lack of success: _____

_____

_____

Do you currently wear a compression sleeve or stocking? ☐ Yes ☐ No

If yes, how often do you wear it and how old is it? _____

_____

Do you currently use compression at night? ☐ Yes ☐ No

If yes, please explain: _____

_____

Do you exercise regularly? ☐ Yes ☐ No

If yes, please explain: _____

_____

What would you like us to do for you: _____

_____

Are you familiar with the precautions (risk reduction practices) for Lymphedema? ☐ Yes ☐ No

Are you a member of a breast cancer or lymphedema support group? ☐ Yes ☐ No

If yes, please explain: _____

Is there anything else you would like to tell us? _____

_____

_____