Patient History- Lymphedema

Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____

Referring Physician: _____ **Primary Physician:** _____

Medical History: *Please circle all that apply. Please include surgeries on the lines below. You may attach an additional sheet if necessary.*

Diabetes	Vascular Problems	High Blood Pressure	Heart Disease
Cancer	Broken Bones	Pacemaker	Pregnant
Allergies	Thyroid Problems	Pulmonary Problems	Kidney Problems
Obesity	Autoimmune Problems	Skin Infections	Wounds
Scarring	Other: _____		

_____

_____

_____

_____

Medications: *Name, dose and frequency. You may attach a list.*

_____

_____

_____

_____

_____

Allergies: *Medications, materials, etc. and response (for example: poison ivy- rash)*

_____

_____

What body part(s) are affected by lymphedema or are swelling?

_____

Do you know how your lymphedema developed? If so, describe how and why:

_____

_____

_____

How long have you had lymphedema? _____

Does your swelling come and go (episodic), fluctuate throughout the day or stay the same? Describe.

_____

_____

Do you have any pain associated with your swelling? **Yes** **No**

Is your pain constant or intermittent? _____

What kind of discomfort or pain do you feel related to your swelling? *Circle all that apply*

Ache Tenderness Heaviness Throbbing Shooting

Burning Tingling Numbness Other: _____

What relieves your pain? _____

What aggravates your pain? _____

Do you have any skin changes associated with your swelling? **Yes** **No**

If so, what type of skin changes have you noticed? *Circle all that apply*

Dry Scaly Red/pink discoloration Brawny discoloration

Thickened Orange peel texture Hardened areas Fragile Weeping

Other: _____

Have you ever had a wound or open sore in the area of your swelling? **Yes** **No**

Did you ever seek care from your physician or a wound care specialist? If so, when and what treatment was performed?

_____

_____

Have you ever had lymphedema treatment before? **Yes** **No**

If so, were you recommended any of the following interventions?

Massage: Yes No Type: _____

Compression bandaging: Yes No Type: _____

Compression garments: Yes No Type: _____

Diuretics/medication: Yes No Type: _____

Compression pump: Yes No Type: _____

Exercise: Yes No Type: _____

Do you currently use any type of compression garment? If so, what is it?

_____

Do you perform any interventions to manage your swelling at home? Yes No

If so, please describe. _____

_____

What activities are difficult or are you unable to perform because of your swelling? *For example, activities of daily living, hobbies or interests*

_____

_____

_____

_____

Do you feel tired much of the time? Yes No

Have you experienced weight gain? Yes No

If so, how much weight have you gained? In what period of time?

_____

Has your lymphedema affected any of your relationships? Yes No

What are your expectations from your treatment?

_____

_____

_____

Do you have any other questions, concerns or comments?

_____

_____

_____

Patient Signature: _____