Lymphedema Evaluation

Name: _____ Date:_____

1. For how long have you had lymphedema? _____
2. Have you ever had any lymphedema infection? _____
3. Do you ever leak fluid? _____
4. Do you take prophylactic antibiotics? _____
5. Do you take diuretics for lymphedema? _____
6. Do you take benzopyrones for lymphedema? _____
7. Do you take any other drugs for lymphedema? _____
8. Does anyone in your family have lymphedema? _____
9. Which extremity has lymphedema?
   (check all that apply)
   Left Arm _____ Right Arm _____
   Left Leg _____ Right Leg _____
10. Have you had prior treatment for lymphedema?
    (check all that apply)
    Surgery ____ Compression Garment ____
    Antibiotics____ Pneumatic Pump _____
    Manual Lymph Drainage _____
11. What medications are you currently taking? _____

    _____
12. Do you currently have or have you previously had any of the diseases listed below?

Yes	No		If yes, when diagnosed
☐	☐	Bronchial Asthma	_____
☐	☐	High Blood Pressure	_____
☐	☐	Diabetes	_____
☐	☐	Cardiac Problems	_____
☐	☐	Kidney Problems	_____
☐	☐	Circulatory Problems	_____
☐	☐	Lung Disease	_____
☐	☐	Stomach Disorders (Ulcer, hernia, etc.)	_____
☐	☐	Liver Disorder (Hepatitis, etc.)	_____
☐	☐	HIV Positive	_____
☐	☐	Glands (Thyroid, etc.)	_____
☐	☐	Skin Disease	_____
☐	☐	Cancer	_____
☐	☐	Fainting Spells	_____
☐	☐	Vision Problems (not glasses)	_____
☐	☐	Hearing Problems	_____
☐	☐	Other	_____

13. Have you ever had radiation therapy? _____

14. Have you ever received chemotherapy? _____

15. What operation(s) have you had? _____

16. What are your goals for treatment? _____

17. In the past have you had any serious injuries? □ Yes □ No If yes, please list and give dates
_____

_____

18. Please describe below any vehicle accidents or personal injuries in which you have been involved.
AGE (OR APPROXIMATE YEAR)
0-10 _____

11-20 _____

21-30 _____

31-40 _____

41-50 _____

51-60 _____

61 & over _____

19. Have you taken cortisone (steroids) by pill within the last 5 years? □ Yes □ No

20. Do you smoke? Yes No If yes, how much? _____

21. If you are female, is there any possibility you are pregnant? □ Yes □ No

22. Which physician referred you to our facility?

Name _____

Address _____

_____

Phone (_____) _____-_____

	Yes	No
23. Can we write or discuss your lymphedema problem with this physician?	___	___

24. If you are treated at this office, you will then be asked to follow a maintenance program at home. This consists of:
a) Elastic sleeves or stocking worn during the day.
b) Bandaging of limb overnight.
c) Meticulous skin care to avoid infections
d) Remedial exercises to accelerate lymph flow.

Are you prepared to follow such a program? _____

Lymphedema~ Health Questionaire

Please mark all areas that are involved in your medical history. These will be discussed with your therapist and are very important in determining the safety or modification of your lymphedema treatment.

___ Infection
___ Cardiac Edema
___ Congestive Heart Failure
___ Bronchitis
___ Deep Vein Thrombosis (Clot)
___Active Cancer
___Asthma

___ Cardiac Arrhythmia (Irregular Rhythm)
___ Cartoid- Sinus-Syndrome
___ Hyperthyroidism
___ Stroke/TIA's

___ Pregnancy
___ Painful Periods
___ Abdominal/Intestinal Problems
___ Abdominal Aortic Aneurysm
___ Recent Abdominal Surgery (Past 1 year)
___ Radiation Treatment
___ Unexplained Abdominal Pain

___ Arterial Diseases
___ Reflex Sympathetic Dystrophy (RSD)
___ Spasticity
___ Uncontrolled High Blood Pressure
___ Coronary Artery Sclerosis
___ Paralysis

Other Medical History

_____

_____

_____

_____

Medications

_____

_____

_____

_____