Callan-Harris Physical Therapy

Patient History Lymphedema

Patient Name: ______________________ Date: ____/____/____ DOB: ___/___/___

Referring Physician: ______________________ Oncologist: ______________________

Primary Care Physician: ______________________ Rad. Oncol: ______________________

Plastic Surgeon: ______________________ Surgeon: ______________________

Lymphedema of:	☐ Right Arm ☐ Right Leg	☐ Left Arm ☐ Left Leg	☐ Head/Neck ☐ Trunk/Chest ☐ Genital Region	☐ Breast ☐ Other
Hardening, Tightness, Fibrosis:	Date noticed:	Where:		
Breast Surgery:	☐ Right Side (date)_____ ☐ Left Side (date) ______ ☐ Both Sides (date) _____	☐Lumpectomy	☐ Simple/total Mastectomy ☐ Modified Mastectomy ☐ Radical Mastectomy	Node Dissection: ☐ Sentinel Node Biopsy ☐ Axillary #: _________ ☐ Head/Neck #: ______
Reconstruction: ☐ Not Applicable	☐ TRAM (date) _________ ☐ Gracilis (date) ________	☐ Latissimus Dorsi Flap (date) _______ ☐ Gluteal Free Flap (date) __________	☐ Expander __________ ☐ Silicone _______ ☐ Saline _____	
Abdominal Surgery:	☐ Pelvic Resection (date)__________________ ☐ Hysterectomy (date) __________________ ☐ Other Surgeries; please list:		☐ Oophorectomy: R / L / B (date) __________________ ☐ Inguinal or iliac node dissection (date) _____________	
Prostate Surgery:	When:			
Have you had:	☐ Chemotherapy ☐ Radiation ☐ Infection	# treatments ______________ # treatments ______________ Antibiotics: __________________	When: _______________ When: _______________ Hospitalized: ______________________________	

When did your swelling/hardness/lymphedema begin? ______________________________

Do you know how your lymphedema developed? ☐ Yes ☐ No If so, how? ______________________

Do you perform any repetitive activities on a regular basis? (e.g. cleaning, carrying heavy objects, knit for several hours, saw, computer work, lift children) ______________________________

Do you stand for long periods of time? ☐ Yes ☐ No If so, how long? ______________________

Did a pet scratch you or an insect bite you? ☐ Yes ☐ No If so, which? ______________________

Do you go sunbathing? ☐ Yes ☐ No Did you get an injection in the edematous limb? ☐ Yes ☐ No

Have you ever had open sores on the affected limb(s)? ☐ Yes ☐ No If so, where? ______________________

Have you ever leaked lymph fluid? Any blisters? ☐ Yes ☐ No

Have you had previous treatment for your lymphedema? ☐ Yes ☐ No

- ☐ Manual Lymph Drainage ☐ Pump………. What kind? ______________________
- ☐ Massage ☐ Garments….. What kind? ______________________
- ☐ Bandaging ☐ Diuretics…... List: ______________________
- ☐ Surgery ☐ Antibiotics… List: ______________________
- ☐ Other………. ______________________

Do you have any pain associated with the lymphedema or scar tissue? ☐ Yes ☐ No

Duration of pain: ☐ Constant ☐ Intermittent

Severity of pain: (circle one) No pain 1 2 3 4 5 6 7 8 9 Emergency Room

What kind of pain do you experience? ______________________________

What relieves the pain? ______________________________

What makes the pain worse? ______________________________

Do you currently wear a compression sleeve/garment? ☐ Yes ☐ No

What tests/studies have been done for your lymphedema? ______________________________

Have you traveled outside of the United States? ☐ Yes ☐ No If so, where? ______________________

Please See Other Side

Patient Name: ______________________________ DOB: ___/___/___

Do you exercise regularly? ☐ Yes ☐ No If so, what activities do you do? ______________________________

Do you smoke? ☐ Yes ☐ No Do you drink? ☐ Yes ☐ No

Do you have any allergies, (are you latex sensitive)? ______________________________

What is your occupation? ______________________________

What is your normal daily lifting activity? ☐ Light ☐ Moderate ☐ Heavy

What can't you do because of your lymphedema? ______________________________

Please list your hobbies & interests if they have been affected by your lymphedema: ______________________________

How frequently do you feel tired/fatigued? ☐ Never ☐ Sometimes ☐ Often

Has the lymphedema or scar tissue affected any of your relationships? ☐ Yes ☐ No

What are your expectations from treatment?

☐ no expectations ☐ skin not as hard ☐ able to wear regular clothing ☐ close to normal size

☐ decreased infections ☐ increased movement ☐ limb will become "normal" ☐ decreased size

☐ Other: ______________________________

Does the way your limb looks embarrass you? ☐ Yes ☐ No

If so, please rate on as scale of 1-10 where 1 is minor embarrassment: 1 2 3 4 5 6 7 8 9 10

HOW DOES THE AREA OF CONCERN FEEL?

On a scale of 0-10 where 0 means no discomfort, 5 indicates moderate discomfort, 10 indicates unbearable.

Hot	0	1	2	3	4	5	6	7	8	9	10
Full	0	1	2	3	4	5	6	7	8	9	10
Numb	0	1	2	3	4	5	6	7	8	9	10
Heavy	0	1	2	3	4	5	6	7	8	9	10
Tired	0	1	2	3	4	5	6	7	8	9	10
Stiff	0	1	2	3	4	5	6	7	8	9	10
Achy	0	1	2	3	4	5	6	7	8	9	10
Painful	0	1	2	3	4	5	6	7	8	9	10
Tingling	0	1	2	3	4	5	6	7	8	9	10
Needles and pins	0	1	2	3	4	5	6	7	8	9	10
Decreased function	0	1	2	3	4	5	6	7	8	9	10
Bursting Sensation	0	1	2	3	4	5	6	7	8	9	10

Describe any additional information below:

Patient Signature: ______________________________ Date: ____________________