

Patient's Name (First, Middle, Last)		Today's Date	
Who referred you for lymphedema evaluation/treatment? <i>Please state referring physician name and contact information.</i>			
Have you had any physical therapy for the same condition for which you are here today? <input type="checkbox"/> YES, <input type="checkbox"/> NO. If yes, please indicate where and when:			
While you are treated at this facility, you will be asked to follow a program at home. This consists of wearing bandages 23 hours/day, meticulous skin care to avoid infections, and exercises and self-massage to facilitate lymph flow. Are you prepared to follow such a program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have someone who can assist you with your home lymphedema treatment if you are unable to do it yourself? (this will include bandaging the affected area(s), skin care and self-massage) <input type="checkbox"/> YES, <input type="checkbox"/> NO			
Are you currently receiving any HOME HEALTH CARE SERVICES? <input type="checkbox"/> YES, <input type="checkbox"/> NO			
CURRENT CONDITION(S)/CHIEF COMPLAINTS			
Is your Lymphedema;			
<input type="checkbox"/> Primary (born with lymphedema OR onset during childhood/puberty/adult without an apparent reason)			
<input type="checkbox"/> Secondary (due to cancer surgery or radiation treatment OR resulting from injury, infection, other surgeries, accident, wt. gain)			
<input type="checkbox"/> Unknown			
At what age did swelling first occur?		Which area(s) is/are affected? Check all that apply:	
Did the swelling begin: <input type="checkbox"/> Gradually <input type="checkbox"/> Suddenly		<input type="checkbox"/> Left leg <input type="checkbox"/> Right leg <input type="checkbox"/> Genitalia <input type="checkbox"/> Trunk	
If you had surgery/treatment for cancer that is related to your swelling, please identify the area(s):		Other:	
		<input type="checkbox"/> Surgery date: _____	
		<input type="checkbox"/> # lymph nodes removed: _____ <input type="checkbox"/> # positive: _____	
How long after surgery did your swelling begin? _____			
Have you undergone any of the following cancer treatments <input type="checkbox"/> None <input type="checkbox"/> Radiation <input type="checkbox"/> Chemotherapy			
If you did NOT have surgery for cancer, what do you think caused the onset of your swelling?			
<input type="checkbox"/> Infection <input type="checkbox"/> Trauma (injury) <input type="checkbox"/> Venous insufficiency <input type="checkbox"/> Post-surgery <input type="checkbox"/> Weight gain <input type="checkbox"/> Immobility			
<input type="checkbox"/> Liposuction <input type="checkbox"/> Post-childbirth <input type="checkbox"/> Primary/congenital <input type="checkbox"/> Lipedema <input type="checkbox"/> DVT/clot <input type="checkbox"/> Congestive Heart Failure			
<input type="checkbox"/> Other:			
Have you had any tests for this problem: <input type="checkbox"/> X-ray <input type="checkbox"/> MRI/CT <input type="checkbox"/> Lymphoscintigraphy <input type="checkbox"/> Doppler <input type="checkbox"/> Ultrasound			
Since the first onset of your swelling have you had any infections in the affected limb(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Ever been hospitalized to treat your infection? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes # times: _____		If yes, # times hospitalized to treat the infection? _____	
		Are you currently taking preventative antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any of the following issues in relation to your swelling?		<input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Limited motion <input type="checkbox"/> Skin issues	
		<input type="checkbox"/> Itching <input type="checkbox"/> Heaviness <input type="checkbox"/> Stiffness <input type="checkbox"/> Weeping	
What increases your swelling?			
What decreases your swelling?			
Does your swelling every go away? <input type="checkbox"/> Yes <input type="checkbox"/> No		If 'yes' what makes it go away?	
TREATMENT			
Have you been treated previously for your swelling? If 'yes' when and how?			
How are you currently managing your swelling?		<input type="checkbox"/> Self-manual lymph drainage <input type="checkbox"/> Bandaging <input type="checkbox"/> Exercise	
		<input type="checkbox"/> Compression garments <input type="checkbox"/> Skin care <input type="checkbox"/> Nothing	
FAMILY HISTORY			
Do you have a family history of limb swelling? <input type="checkbox"/> YES, <input type="checkbox"/> NO			

MEDICAL HISTORY

Current medications (prescription and over the counter) – PLEASE ATTACH A SEPARATE LIST OF YOUR CURRENT MEDICATIONS

Allergies and type of reaction (medication, foods, tape etc.)

PLEASE CHECK ALL THAT APPLY:	<input type="checkbox"/> Active Cancer	<input type="checkbox"/> Aortic aneurysm	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> Acute Infection	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Bronchial asthma
	<input type="checkbox"/> Blood clot/DVT	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Hypertension
	<input type="checkbox"/> Major Heart Problems	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Hypotension
	<input type="checkbox"/> Acute Renal Failure	<input type="checkbox"/> Congestive Heart Failure	

PLEASE LIST ANY OTHER MAJOR MEDICAL ISSUES:

SOCIAL HISTORY

Occupation:		Sports/Hobbies:		
Living Status	Alone: <input type="checkbox"/> YES	Live with Family: <input type="checkbox"/> YES (please specify)	Roommate(s): <input type="checkbox"/> YES	Pet(s): (please specify)

Do you have reliable transportation to appointments? YES, NO

Do you use any of the following assistive devices/orthotics?
 Cane Walker Ankle foot orthosis/brace Crutches Manual/ Power wheelchair Foot orthotics/Custom shoes

If your household layout is part of your concern please list the following:

FUNCTIONAL QUESTIONNAIRES

Lymphedema Quality of Life Tool LEG (adapted)

How much does your swollen leg affect the following activities?	Not at all	A little	Quite a bit	A lot
a) Walking				
a) Bending, e.g. to tie shoes or cut toenails				
b) Stand				
c) Get up from a chair				
d) Occupation				
e) Housework				
f) Go up/down stairs				
g) Driving				
How much does it affect your leisure activities/social life?				
How much do you have to depend on other people?				
How much do you feel the swelling affects your appearance?				
How much difficulty do you have finding clothes to wear?				
Does the swelling affect how you feel about yourself?				
Does it affect your relationships with other people?				
Does your lymphedema cause you pain?				

PATIENT SPECIFIC FUNCTIONAL SCALE – rate each of the following on a 0 to 10 scale (0= no problem, 10= can't do)
*****Please rate relative to your lymphedema condition*****

Sleep all night 0 1 2 3 4 5 6 7 8 9 10	Stand 0 1 2 3 4 5 6 7 8 9 10	Lift 0 1 2 3 4 5 6 7 8 9 10
Self-care 0 1 2 3 4 5 6 7 8 9 10	Walk 0 1 2 3 4 5 6 7 8 9 10	Reach 0 1 2 3 4 5 6 7 8 9 10
Sit 0 1 2 3 4 5 6 7 8 9 10	Up/Down stairs 0 1 2 3 4 5 6 7 8 9 10	Work tasks 0 1 2 3 4 5 6 7 8 9 10
Other: _____ 0 1 2 3 4 5 6 7 8 9 10	Other: _____ 0 1 2 3 4 5 6 7 8 9 10	Other: _____ 0 1 2 3 4 5 6 7 8 9 10

Patient signature: _____ **Date -** _____

This form has been reviewed by: _____ **Date -** _____