MICHIGAN STATE
UNIVERSITY

Office Use Only

MRN:

PATIENT HISTORY - LYMPHEDEMA

Patient's Name (First, Middle, Last)	Today's Date (mm/dd/yyyy)

Who referred you for lymphedema evaluation/treatment? ***Please state referring physician name and contact information.***

Have you had any physical therapy for the same condition for which you are here today? ☐ **YES,** ☐ **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? ☐ **Yes** ☐ **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)*** ☐ **YES,** ☐ **NO**

CURRENT CONDITION(S)/CHIEF COMPLAINTS:

Is your Lymphedema:

☐ **Primary (born with lymphedema OR onset during childhood/puberty/adult without an apparent reason)**

☐ **Secondary (due to cancer surgery or radiation treatment OR resulting from injury, infection, other surgeries, accident, wt. gain)**

☐ **Unknown**

At what age did swelling first occur	At birth: ☐ Yes ☐ No	If not at birth what year did the swelling begin?

Did the swelling begin: ☐ **Gradually** ☐ **Suddenly**

Which area(s) is/are affected? Check all that apply.	☐ **Left arm** ☐ **Left leg** ☐ **Neck/face** ☐ **Breast** ☐ **Right arm** ☐ **Right leg** ☐ **Genitalia** ☐ **Trunk**
If you had breast cancer surgery please check/fill all that apply: ☐ **Right** ☐ **Left** ☐ **Bilateral**	☐ **Lumpectomy** ☐ **Mastectomy** ☐ **Surgery date:_____** ☐ **# lymph nodes removed: _____** ☐ **# positive: _____**
If you had surgery/treatment for other types of cancer please check/fill all that apply: Area:_____	☐ **Surgery date:_____** ☐ **# lymph nodes removed: _____** ☐ **# positive: _____**

How long after surgery (breast or other) did your swelling begin? _____

Have you undergone any of the following treatments? If 'yes' when, how much and what area? ☐ **None**

Treatment type?	When?	How much?	What area?
☐ Radiation			
☐ Chemotherapy			
☐ Hormonal			
☐ Other			

If you did NOT have cancer surgery, what do you think caused the onset of your swelling?

☐ **Infection** ☐ **Trauma (injury)** ☐ **Venous insufficiency** ☐ **Post-surgery** ☐ **Weight gain** ☐ **Immobility**
☐ **Liposuction** ☐ **Primary/congenital** ☐ **Post-childbirth** ☐ **Lipedema** ☐ **DVT/clot** ☐ **Congestive Heart Failure**
☐ **Other:**

Have you had any tests for this problem: ☐ **X-ray** ☐ **MRI** ☐ **Lymphoscintigraphy** ☐ **Doppler** ☐ **Ultrasound (abdominal/venous)**

Since the first onset of your swelling have you had any infections in the affected limb(s)? ☐ **Yes** ☐ **No** **If yes # times: _____**	**Ever been hospitalized to treat your infection?** ☐ **Yes** ☐ **No** **If yes, # times hospitalized to treat the infection? _____** **Are you currently taking preventative antibiotics?** ☐ **Yes** ☐ **No**
Do you have any of the following issues in relation to your swelling?	☐ **Pain** ☐ **Numbness** ☐ **Limited motion** ☐ **Skin issues** ☐ **Stiffness** ☐ **Heaviness** ☐ **Itching** ☐ **Weeping**
As a result of your edema are you having difficulties:	☐ **Dressing** ☐ **Bathing** ☐ **Sleeping** ☐ **Walking** ☐ **Driving** ☐ **Standing** ☐ **Reaching** ☐ **Reaching** ☐ **Sitting** ☐ **Reaching** ☐ **Chores** ☐ **Meal prep**
What increases your swelling?	
What decreases your swelling?	
Does your swelling every go away? ☐ **Yes** ☐ **No**	**If 'yes' what makes it go away? -**

TREATMENT

Have you been treated previously for your swelling? If 'yes' when and how? ☐ **Yes** ☐ **No**	
How are you currently managing your swelling?	☐ **Self-manual lymph drainage** ☐ **Bandaging** ☐ **Exercise** ☐ **Compression garments** ☐ **Skin care** ☐ **Nothing**

(OVER)

FAMILY HISTORY:

Do you have a family history of limb swelling? ☐ **YES,** ☐ **NO**

Please list any major health problems of your blood relatives

Relationship to you	Problem/Disease	Relationship to you	Problem/Disease

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, etc.)

Allergic To	Type of Reaction	Allergic To	Type of reaction

CONSTITUTIONAL	☐ Fever/chills ☐ Poor sleep ☐ Changes in appetite ☐ Night sweats	☐ Fatigue ☐ HIV/AIDS ☐ Tuberculosis ☐ Wt loss/gain	☐ **Cancer** ☐ **Hypothyroidism** ☐ **Hyperthyroidism** ☐ **Diabetes**
EARS/THROAT/NOSE	☐ Hard of hearing ☐ Difficulty swallowing	☐ Headaches ☐ Difficulty chewing	☐ Sore throat ☐ Difficulty talking
EYES	☐ Double vision	☐ Blurry vision	☐ Eye pain
CARDIOVASCULAR	☐ Lightheadedness ☐ Pacemaker ☐ Poor circulation ☐ Chest pain/angina ☐ Palpitations	☐ Hypotension ☐ Fainting ☐ **Hypertension** ☐ **Swelling in hands/feet** ☐ **Peripheral vasc. dis.**	☐ **Cardiac edema** ☐ **Arrhythmia** ☐ **Blood clot/DVT** ☐ **Aortic aneurysm**
PULMONARY	☐ Shortness of breath ☐ Cough	☐ Wheezing ☐ Asthma	☐ **Congestive heart failure** ☐ **Acute bronchitis**
GASTROINTESTINAL	☐ Heartburn ☐ Diarrhea ☐ Nausea/vomiting	☐ Constipation ☐ Black tarry stools ☐ Loss of bowel control	☐ **Ileus** ☐ **Diverticulosis** ☐ **Bowel inflam. conditions**
GENITO/URINARY	☐ **Kidney problems** ☐ Catheter program	☐ Loss of bladder control ☐ Urinary frequency/urgency	☐ Burning with urination ☐ Sexual difficulty
MUSCULO/SKELETAL	☐ Joint pain/swelling ☐ Muscle spasms ☐ Osteoporosis ☐ Muscle pain	☐ Back pain ☐ Gout ☐ Muscle weakness ☐ Arthritis	☐ Infections ☐ **Regional pain syndrome** ☐ **Spasticity** ☐ **Paralysis**
NEURO	☐ Numbness ☐ Tingling ☐ Weakness/paralysis	☐ Head injury ☐ Dizziness ☐ Tremors	☐ Seizures ☐ MS / ☐ MD ☐ **Stoke/TIA**
PSYCHIATRIC	☐ Anxiety ☐ Memory problems	☐ Depression ☐ Thinking problems	☐ Hallucinations ☐ Fluctuating emotions

SOCIAL HISTORY:

Employment/Work (job/school/play)	☐ **Work f/t outside of home**	☐ **Working p/t outside of home**	☐ **Working f/t from home**	☐ **Working p/t from home**	☐ **Retired**	☐ **Student**	☐ **Unemployed**

Occupation: **Sports/Hobbies:**

Living Status	**Alone:** ☐ **YES**	**Live with Family:** ☐ **YES** *(please specify)*	**Roommate(s):** ☐ **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 (**☐ **single point,** ☐ **quad)** ☐ **Walker (type:_____)** ☐ **Ankle foot orthosis/brace**

☐ **Crutches** ☐ **Manual/** ☐ **Power wheelchair or cart** ☐ **Foot orthotics/Custom shoes**

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

# of Entry steps:	**FRONT** _____ **(handrail** ☐ **YES,** ☐ **NO)** **BACK** _____ **(handrail** ☐ **YES,** ☐ **NO)** **GARAGE** _____ **(handrail** ☐ **YES,** ☐ **NO)**	**Basement:**	☐ **YES,** ☐ **NO (handrail** ☐ **YES,** ☐ **NO)**
		Second Floor:	☐ **YES,** ☐ **NO (handrail** ☐ **YES,** ☐ **NO)**

Other Issues:

Patient signature: **Date -**

This form has been reviewed by (Physician/PT): **Date -**