MICHIGAN STATE UNIVERSITY

# PATIENT HISTORY – UPPER EXTREMITY LYMPHEDEMA

Office Use Only

MRN:

| Patient's Name (First, Middle, Last) | Today's Date |
|---|---|
| | |

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

☐ **Unknown**

| | |
|---|---|
| **At what age did swelling first occur?**<br>**Did the swelling begin:** ☐ **Gradually** ☐ **Suddenly** | **Which area(s) is/are affected? Check all that apply:**<br>☐ **Left arm** ☐ **Trunk** ☐ **Breast** ☐ **Right arm**<br>☐ **Other:** |
| **If you had breast cancer surgery please check/fill all that apply:** ☐ **Right** ☐ **Left** ☐ **Bilateral** | ☐ **Lumpectomy** ☐ **Mastectomy** ☐ **Surgery date:_____**<br>☐ **# lymph nodes removed: _____** ☐ **# positive: _____** |
| **If you had surgery/treatment for other types of cancer please check/fill all that apply: Area:_____** | ☐ **Surgery date:_____**<br>☐ **# 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 | | | |

**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** ☐ **Post-childbirth** ☐ **Primary/congenital** ☐ **Lipedema** ☐ **DVT/clot** ☐ **Congestive Heart Failure**
☐ **Other:**

**Have you had any tests for this problem:** ☐ **X-ray** ☐ **MRI** ☐ **Lymphoscintigraphy** ☐ **Doppler** ☐ **Ultrasound**

| | |
|---|---|
| **Since the first onset of your swelling have you had any infections in the affected limb(s)?** ☐ **Yes** ☐ **No**<br>**If yes # times: _____** | **Ever been hospitalized to treat your infection?** ☐ **Yes** ☐ **No**<br>**If yes, # times hospitalized to treat the infection?_____**<br>**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**<br>☐ **Itching** ☐ **Heaviness** ☐ **Stiffness** ☐ **Weeping** |
| **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?** | |
| **How are you currently managing your swelling?** | ☐ **Self-manual lymph drainage** ☐ **Bandaging** ☐ **Exercise**<br>☐ **Compression garments** ☐ **Skin care** ☐ **Nothing** |

## FAMILY HISTORY

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

**- OVER -**

## 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.)**

| | | | |
|---|---|---|---|
| **PLEASE CHECK ALL THAT APPLY:** | ☐ Active Cancer<br>☐ Acute Infection<br>☐ Blood clot/DVT<br>☐ Major Heart Problems<br>☐ Acute Renal Failure | ☐ Aortic aneurysm<br>☐ Hyperthyroidism<br>☐ Hypothyroidism<br>☐ Kidney Problems<br>☐ Congestive Heart Failure | ☐ Diabetes<br>☐ Bronchial asthma<br>☐ Hypertension<br>☐ Hypotension |
| **PLEASE LIST ANY OTHER MAJOR MEDICAL ISSUES:** | | | |

## SOCIAL HISTORY

| | | | | |
|---|---|---|---|---|
| **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?**

☐ **Cane** ☐ **Walker** ☐ **Crutches** ☐ **Manual/** ☐ **Power wheelchair** ☐ **Splints/braces**

## FUNCTIONAL QUESTIONNAIRES

### Lymphedema Quality of Life Tool – ARM (adapted)

| How much does your swollen arm affect the following activities? | Not at all | A little | Quite a bit | A lot |
|---|---|---|---|---|
| a) Occupation | | | | |
| a) Housework | | | | |
| b) Combing Hair | | | | |
| c) Dressing | | | | |
| d) Writing/Computer | | | | |
| e) Eating | | | | |
| f) Washing | | | | |
| g) Cleaning Teeth | | | | |
| 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**<br>0 1 2 3 4 5 6 7 8 9 10 | **Stand**<br>0 1 2 3 4 5 6 7 8 9 10 | **Lift**<br>0 1 2 3 4 5 6 7 8 9 10 |
| **Self-care**<br>0 1 2 3 4 5 6 7 8 9 10 | **Walk**<br>0 1 2 3 4 5 6 7 8 9 10 | **Reach**<br>0 1 2 3 4 5 6 7 8 9 10 |
| **Sit**<br>0 1 2 3 4 5 6 7 8 9 10 | **Up/Down stairs**<br>0 1 2 3 4 5 6 7 8 9 10 | **Work tasks**<br>0 1 2 3 4 5 6 7 8 9 10 |
| **Other:**_____<br>0 1 2 3 4 5 6 7 8 9 10 | **Other:**_____<br>0 1 2 3 4 5 6 7 8 9 10 | **Other:**_____<br>0 1 2 3 4 5 6 7 8 9 10 |

**Patient signature:** **Date -**

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