CORAL
Center for Oncological Rehabilitation and Lymphedema

Brief Medical History

_____
DATE

_____
NAME D.O.B.

COMPLETED BY ☐ PATIENT (LISTED ABOVE) ☐ OTHER: _____

Do you currently experience swelling/lymphedema? (Please circle all that apply)

right arm | left arm | both arms | breast | right leg | left leg | both legs | head & neck | genital

Other, please explain: _____

Have you been diagnosed with Lymphedema? ☐ Yes ☐ No

If yes, by whom: _____

How long have you had swelling/Lymphedema? _____

Was there a triggering event which caused the swelling/Lymphedema?

_____

Please describe briefly how and why your swelling/lymphedema developed.

_____

_____

Have you had any surgery? ☐ Yes ☐ No

If yes, list surgeries and dates: _____

_____

Have you had any lymph nodes removed? ☐ Yes ☐ No

If yes, how many: _____

Have you ever received radiation therapy for cancer? ☐ Yes ☐ No

If yes, list area of radiation and dates here: _____

Have you had Chemotherapy? ☐ Yes ☐ No

If yes, how long ago? _____

Have you had any infections (Cellulitis)? ☐ Yes ☐ No

If yes, how long ago was the last one? _____

Is there a family history of Lymphedema? ☐ Yes ☐ No

If yes, please explain: _____

Do you have pain? ☐ Yes ☐ No

If yes, please explain: _____

On a scale from 0-10 where 0=NO PAIN and 10=UNBEARABLE PAIN, what is your pain level today?

(circle one) 0 1 2 3 4 5 6 7 8 9 10

Any loss of function or mobility? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Do you have any difficulties with any of the following?

☐ Walking ☐ Reaching Feet & Toes ☐ Preparing Meals ☐ Dressing ☐ Bathing/Showering ☐ Other

If other, please explain: _____

_____

_____

What is your current living situation?

☐ Private Home/Apartment (alone) ☐ Nursing Home ☐ Hospice ☐ Assisted Living

☐ Home with Spouse or Companion ☐ Other

If other, please explain: _____

Do you currently suffer from (or have you had) any of the following?

☐ Asthma ☐ Hyperthyroidism ☐ Crohn's Disease ☐ Bronchitis ☐ Kidney failure ☐ Diverticulitis

☐ Difficulties Breathing ☐ Diabetes ☐ Recent Abdominal Surgery ☐ Irregular Heart Beat

☐ Infections (Cellulitis) ☐ Unexplained Pain ☐ Heart Edema ☐ Sleep Apnea ☐ Hypertension

☐ Deep Venous Thrombosis (blood clot) ☐ Malignancy (Cancer) ☐ Latex Allergy

Do you have any other medical problems not listed above? ☐ Yes ☐ No

If yes, please explain: _____

Are you allergic to: ☐ Latex ☐ Surgical Tape ☐ Foam Products ☐ Other

If other, please explain: _____

Are you taking any medication? ☐ Yes ☐ No

If yes, list medications and amounts here: _____

_____

At the time you are completing this, are you, or is the a chance you could be pregnant? ☐ Yes ☐ **No**

Previous Treatments

Have you had previous treatment for swelling/lymphedema? ☐ Yes ☐ No

If yes, check all that apply: ☐ Manual Lymph Drainage (MLD) ☐ Compression Pump ☐ Compression Garments ☐ Compression Bandaging ☐ Flexitouch ☐ Lymphedema Exercise ☐ Low Level Laser

If yes, please explain your experience, success or lack of success:

_____

_____

Do you currently wear a compression sleeve or stocking? ☐ Yes ☐ No

If yes, how often do you wear it and how old is it? _____

_____

Do you currently use compression at night? ☐ Yes ☐ No

If yes, please explain: _____

_____

Do you exercise regularly? ☐ Yes ☐ No

If yes, please explain: _____

_____

Are you familiar with the National Lymphedema Network? ☐ Yes ☐ No

Are you familiar with the precautions (risk reduction practices) for Lymphedema? ☐ Yes ☐ No

Are you a member of a breast cancer or lymphedema support group? ☐ Yes ☐ No

If yes, please explain: _____

Would you like to receive newsletters and/or product updates from our office? ☐ Yes ☐ No

Is there anything else you would like to tell us at this time? _____

_____

_____