
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 there 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? _____

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