730 Davis Drive - Unit 1, Newmarket, Ont. L3Y 2R4 - Tel: 905.715.7201

**Date:** _______________

**Name:** ____________________________________________ **DOB:** _________________________

**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 genital head & neck

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**

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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: ______________________________________________________________

_____________________________________________________________________________

**Do you have any loss of function or mobility?** ☐ **Yes** ☐ **No**

If yes, please explain: ______________________________________________________________

_____________________________________________________________________________

**Right or left handed:** **R** **L**

**Do you have any difficulties with any of the following?**

| | | |
|---|---|---|
| ☐ Walking | ☐ Reaching feet and toes | ☐ Preparing meals |
| ☐ Dressing | ☐ Bathing/showering | ☐ Other |

If other, please explain: ____________________________________________________________

_____________________________________________________________________________

**What is your current living situation?**

| | | |
|---|---|---|
| ☐ Private home/apartment (alone) | ☐ Nursing home | ☐ Hospice |
| ☐ Home with spouse or companion | ☐ Assisted living | ☐ Other |

Age of Children: _____________________________________________________________

**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 | ☐ Deep venous thrombosis (blood clot) |
| ☐ Hypertension | ☐ Malignancy (cancer) | ☐ Latex allergy |
| ☐ Other heart issues | ☐ Circulation issues | ☐ Dizziness/blackouts |
| ☐ Epilepsy | ☐ Osteoporosis / Arthritis | ☐ Sudden weight loss |

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

If yes, please explain: ______________________________________________________________

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

If other, please explain: ____________________________________________________________

**At the time you are completing this, are you pregnant or is there a chance you could be pregnant?**

☐ **Yes** ☐ **No**

**List all medications you are taking:**

____________________________________

____________________________________

____________________________________

____________________________________

____________________________________

____________________________________

____________________________________

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## 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 describe: ______________________________________________________________

______________________________________________________________________________

**Household Tasks:** ___________________________________________________________________

**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 describe: ______________________________________________________________

**What is the reason that you are seeking help?** ___________________________________________

______________________________________________________________________________

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**What are your treatment goals?** ____________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

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

__________________________________________________________________________________________

__________________________________________________________________________________________