Lymphedema Patient Case History Patient Name:_____

When you noticed the lymphedema?_____
Did your swelling appear (Please Circle) suddenly gradually
What type of lymphedema has our doctor diagnosed? (Please circle) Primary Secondary
Date of the diagnosis?_____

Please answer the following questions if you have, or have had, a diagnosis of cancer if not, proceed to the next section:

Doctors	Name	Address
Surgeon		
Medical Oncologist		
Radiation Oncologist		

Type of Cancer: _____Affected side: (please circle) Right Left
Did you have surgery for your Cancer?(please circle) Yes No
If yes, date of surgery: _____Type of surgery: _____
Did you have lymph nodes removed?(please circle) Yes No
If yes, # of nodes removed:_____ # positive: _____
Did you, or will you receive radiation treatments?(Please circle) Yes No
If yes, # of treatments: _____ Start Date:_____
Did you or will you receive chemotherapy treatment?(please circle) Yes No
If yes, # of cycles:_____ Start date:_____

Have you received any of the following treatments for your lymphedema? (Insert last date)
Medication?_____
CDT (Bandaging or Manual Lymph drainage)?_____
Compressive garments -type,mmHg?_____
Pneumatic pump(hours a day/ days a week)_____
Surgery? (type/date)_____
Other:_____
On a scale of 0(non-existent) to 10(most severe)
Pain:_____ Mobility:_____ Increased temperature:_____ Numbness: _____ Heaviness:_____
Have you ever had an infection in the limb (date)?_____
Was it treated with antibiotics?(please circle) YES NO Which type? (Oral/ Intravenous)_____
Have you recently noticed any changes in the skin?_____ The nails?_____
Are any areas on the limb noticeably harder than usual?_____
At home: do you have someone to help you with day to day function? (Please circle) Yes No