

Aviva Lymphatics LLC

Brief Medical History

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

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: _____

Do you have any difficulties with any of the following?

<input type="checkbox"/> Walking	<input type="checkbox"/> Reaching feet and toes	<input type="checkbox"/> Preparing meals
<input type="checkbox"/> Dressing	<input type="checkbox"/> Bathing/showering	<input type="checkbox"/> Other

If other, please explain: _____

What is your current living situation?

<input type="checkbox"/> Private home/apartment (alone)	<input type="checkbox"/> Nursing home	<input type="checkbox"/> Hospice
<input type="checkbox"/> Home with spouse or companion	<input type="checkbox"/> Assisted living	<input type="checkbox"/> Other

If other, please explain: _____

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

<input type="checkbox"/> Asthma	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Crohn's Disease
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Kidney failure	<input type="checkbox"/> Diverticulitis
<input type="checkbox"/> Difficulties breathing	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Recent abdominal surgery
<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Infections (cellulitis)	<input type="checkbox"/> Unexplained pain
<input type="checkbox"/> Heart edema	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Deep venous thrombosis (blood clot)
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Malignancy (cancer)	<input type="checkbox"/> Latex allergy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 pregnant 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:

<input type="checkbox"/> Manual Lymph Drainage (MLD)	<input type="checkbox"/> Compression pump	<input type="checkbox"/> Compression garments
<input type="checkbox"/> Compression bandaging	<input type="checkbox"/> Flexitouch	<input type="checkbox"/>
<input type="checkbox"/> Lymphedema exercise	<input type="checkbox"/> Low level laser	<input type="checkbox"/>

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: _____

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? _____

What are your treatment goals? _____

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