# Breast Cancer / Lymphedema Intake Form

Print and fill out or fill out electronically and share with me.
If you don't have a printer, we can review this at your initial visit.

| Name: | Birth date: |
|---|---|
| Type of cancer: | Date of Diagnosis: |
| Past medical history: | |
| | |

| | DATE | PHYSICIAN |
|---|---|---|
| Initial Surgery | | |
| Reconstruction | | |
| Radiotherapy | | |
| Chemotherapy | | |
| Hormone Therapy | | |

**Circle type of surgery for tumor removal and node biopsy below:**

| | |
|---|---|
| Lumpectomy | Mastectomy |
| Sentinel lymph node biopsy | Axillary lymph node dissection |

**Circle reconstruction procedure if applicable:**

| | |
|---|---|
| Immediate reconstruction with implant | Expander then implant |
| Latissimus dorsi flap (LDF) | Rectus abdominus flap (TRAM) |

Any complications (infection, cellulitis, wound dehiscence, capsular contracture):

_____

_____

Signature of prescribing provider & date: _____

**Circle radiation details if applicable:**

| Radiation to breast | Breast/chest + axilla (armpit) |
|---|---|

**Circle Hormone Therapy if applicable:**

**SERMs:**

- Tamoxifen **(Novladex)**
- Raloxifene **(Evista)**
- Toremifene **(Fareston)**

**SERD:** Fulvestrant **(Faslodex®)**

**Aromatase Inhibitors:**

- Letrozole **(Femara)**
- Anastrozole **(Arimidex)**
- Exemestane **(Aromasin)**

| **Have you experienced the following during or after treatment for breast cancer? Please feel free to describe impairments or write N/A if not applicable.** |
|---|
| Memory loss: |
| Weight gain: |
| Fatigue: |
| Depression and/or anxiety: |
| Swelling (chest, arm, whole body): |
| Restricted motion (arm, trunk): |
| Decreased strength (hand, arm, trunk, legs): |
| Skin changes (tight cords, scar tissue, skin thickening and tightness): |

Signature of prescribing provider & date: _____

| |
|---|
| Change in sensation (describe changes in feeling of breast, chest wall, hands, feet or elsewhere): |
| Pain (please describe and rate below on a scale of 0-10):<br><br>breast or chest / generalized joint pain / shoulder / low back / abdomen / hands / feet |
| Bone fractures: |
| Decreased balance (falls and near falls): |
| Decreased endurance (shortness of breath with activity, irregular heart rhythm): |
| Impaired sexual function (vaginal dryness, pain with intercourse, decreased interest or arousal): |

Activity level prior to treatment: _____

Activity level during/after treatment: _____

Goal for physical therapy:

_____

Compression garmets?_____

Obtained from?_____

**Have you been diagnosed with any of the following:**

❑ CAD: coronary artery disease ❑ CHF: congestive heart failure

❑ MI: myocardial infarction ❑ cardiomyopathy (enlarged heart or thickening of the heart)

❑ HTN: hypertension ❑ valve dysfunction

❑ arrythmias (irregular heartbeat) ❑ anemia (low iron levels)

❑ DVT (deep vein thrombosis) ❑ PE (pulmonary embolism)

❑ lung condition *(please describe):* _____

**Are you currently taking chemotherapy?** ❑ yes ❑ no

**Do you take any of the following medications?**

Signature of prescribing provider & date: _____

❑ Diuretics (ex: furosemide or Lasix)
❑ Beta blockers (drug name usually ends in 'lol')
❑ ACE inhibitors (drug name usually ends in 'pril')

**Have you had any surgeries to the heart or lungs?** _____

**Please check if you experience any of the following with activity:**

❑ dizziness
❑ fatigue
❑ chest pain
❑ significant shortness of breath
❑ arrhythmias (altered heart rhythm)
❑ leg swelling
❑ drop in blood pressure with activity
❑ extremely high blood pressure

Is there anything else you would like me to know?

_____

_____

_____

_____

_____

_____

Thank you!

Signature of prescribing provider & date: _____