Lymphedema Patient Health History

Name:____ Date:______________________

Height: ________________ (inches or cm) Weight:________________________ (lbs. or kg)

Medical Doctor:__________________ Address:_________________________ Phone:____________

What type of lymphedema has your doctor diagnosed?____

How long have you had: the diagnosis________________ the lymphedema __________________

Did it appear suddenly or gradually?__________________

Do you know the cause of the lymphedema?____

Have you been treated for cancer or malignant disease?_____________________ when?___________

If yes, what type of treatment did you receive (indicate dates)? __________________________________

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What type of treatment have you received for your lymphedema and when?

Medication:____

Combined Decongestive Therapy:____

Compression Garments:____

Pneumatic Pump:____

Surgery:____

Other:____

On a scale of 1 (non-existent) to 10 (most severe)

Pain: Mobility: Bursting: Increased Temperature: Numbness: Loss of Sensation:

Have you ever has an infection in the limb (dates)?____

Was it treated with antibiotics?______________ Which type?_______________________________

Have you recently noted any changes in: the skin_________________ the nails___________________

Are any areas of the limb noticeably harder than usual?____

At home: do you have someone to help you with day today functions?_________ Name:_____________

Are you prepared to make a commitment to the treatment programme explained to you by the therapist? Please circle and initial Yes / No ______________

If you have an arm lymphedema, the therapist will need to work on the chest/breast area in order to provide effective care. Are you willing to consent to the treatment of your chest/breast area? Please circle and initial Yes / No ___________

If you have a leg lymphedema, the therapist will need to work on the upper inner thigh and buttock area. Are you willing to consent to treatment of these areas? Please circle and initial Yes / No _____

I have read this Case History Form and answered all the questions to the best of my ability. The therapist may contact my referring medical doctor and I hereby give permission to do so.

Signed____ Date:_________________________