**PATIENT NAME:**

**DATE:**

# LYMPHEDEMA EVALUATION

1. How long have you had lymphedema? ____________________
2. Have you ever had any lymphedema infections? (YES / NO)
3. Do you ever leak lymph fluid? (YES / NO)
4. Do you take prophylactic antibiotics? (YES / NO)
5. Do you take diuretics for lymphedema? (YES / NO)
6. Do you take benzo pyrones for lymphedema? (YES / NO)
7. Do you take any other drugs for lymphedema? (YES / NO)
8. Does anyone in your family have lymphedema? (YES / NO)
9. Which extremity has lymphedema?
   (Check all that apply)
   *Left Upper_____
   *Left Lower _____
   *Right Upper_____
   *Right Lower_____
10. Have you had previous treatment for lymphedema? (YES / NO)
    (Check all that apply)
    *Surgery_____
    *Compression Garment_____
    *Antibiotics_____
    *Pneumatic Pump_____
    *Manual Lymph Drainage_____
11. Do you have Bronchial Asthma? (YES / NO)
12. Do you have Hypertension? (YES / NO)
13. Do you have diabetes? (YES / NO)
14. Do you have allergies? (If YES please list them) (YES / NO)

______________________________________________________________

______________________________________________________________

15. Do you have any cardiac problems? ( If YES please list) ( YES / NO )

______________________________________________

16. Do you have kidney problems? (YES / NO)

17. Do you have any circulatory problems? ( If YES please list them) (YES / NO)

______________________________________________

18. Are you currently taking medication(s)? (YES / NO ) (If YES please list them)______________________________________________

______________________________________________

19. Have you ever had radiation therapy? (YES / NO)

20. Have you ever received chemotherapy? (YES / NO)

21. Have you had any operations? (If YES please list them) (YES / NO)

______________________________________________

______________________________________________

22. What physician referred you to our facility?

Name: ______________________________________________

Address:______________________________________________

Phone: (________)______________________________________________

23. Can we write to or discuss your lymphedema problem with this physician?

Y___N_____

24. If you are treated at this office, you will then be asked to follow a maintenance program at home. This consists of:

a) Elastic sleeve or stocking worn during the day.
b) Bandaging of limb overnight.
c) Meticulous skin to avoid infections
d) Remedial Exercises to accelerate lymph flow.

Are you prepared to follow such a program? Y______N_______

Patient Initials: ______________ DATE: ____________________