Stony Brook Medicine

Outpatient Physical Therapy
Lymphedema History Form

Place Label here

Date: _____

Social History:

Age: _____ Male / Female Employed: Yes / No Occupation:_____

Lives: Alone _____ Caregiver _____ Other _____ Activity level: □Low □ Mod □High

Tobacco use: packs/day _____; past / present Alcohol consumption: drinks/day _____

Lymphedema History:

Where is your swelling? _____

When did it begin? _____

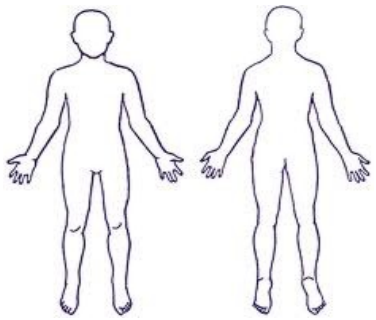
Did it start □ Suddenly or □ Gradually?

Is it getting □ Better □ Worse □ Same ?

Is there a family history of Lymphedema? Yes / No

Have you undergone any tests for this problem? (please list with dates)

[X-Ray, MRI, CT Scan, Ultrasound, etc.]



_____

Infections in affected part? Yes / No; most recent_____, Antibiotics used_____

Do you have pain? Yes / No Where:_____

Please give a numeric value to your pain:	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
		Less pain									*Most pain*

Describe your pain: □ ache □ dull □ sore □ sharp □ shooting □ throbbing
□ numb □ full □ burn □ tight □ tingling □ heavy

Treatment history: □None □ Complete/ Modified Decongestive Therapy □ Garments □ Pump □ Other

Response to treatment: _____

Dates of last Lymphedema treatment: _____

Medical History: Please check all that apply

__ High Blood Pressure	__ Abdominal pain	__ Diabetes
__ Heart Arrhythmia	__ Abdominal surgery	__ Vein problems
__ Congestive heart failure	__ Abdominal Aortic Aneurysm	__ Arterial disease
__ Heart Condition	__ Greenfield Filter	__ HIV
__ Deep Vein Thrombosis	__ Stomach Disorders	__ Seizure Disorder
__ Kidney Dysfunction	__ Intestinal Disorders	__ Arthritis
__ Acute infection/Cellulitis	__ Liver Disease	__ Pacemaker
__ Hypo/Hyperthyroidism	__ Pregnancy	__ Headaches/Migraines
__ Cancer Active: Yes / No	__ Lung Disease	__ PORT: Y N; Right/Left

Please continue on next page.

Place label here

Breast:	Gynecological:	Head and Neck:
Mastectomy/Lumpectomy Axillary Nodes #____ (# positive___) Sentinel Nodes #____ (# positive___) Reconstruction: Yes No Type: _____	Type: _____ Hysterectomy: Yes No Inguinal Nodes #____ (# positive __) Pelvic Nodes #____ (# positive __)	Type: _____ Nodes removed:_____

Surgical History: Date of Surgery_____

Cancer Treatment: *Chemotherapy:* Yes No # of treatments_____; Date completed _____
Radiation: Yes No # of treatments_____; Date completed _____

Have you had any other surgeries? Please list:

_____

List any allergies: _____ Latex: Yes No

Please list any medications you are taking: _____

Are you having any difficulty with activities at home or work? Please explain: _____

_____

What do you hope to achieve with therapy? _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Surgeon: _____ Phone: _____ Fax: _____

Oncologist: _____ Phone: _____ Fax: _____

Plastic Surgeon: _____ Phone: _____ Fax: _____

All of the above information is accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

For Therapist Use Only:

_____

_____

_____

The above has been reviewed with the patient for accuracy.

Therapist Signature/ID: _____ Date: _____ Time: _____