

- Maplewood Phone: 651/ 232-7820 Fax: 651/ 232-7832
- Oakdale Phone: 651/ 232-5075 Fax: 651/ 232-5085
- University Park/Midway Phone: 651/ 232-5412 Fax: 651/ 232-4971
- Woodwinds/Woodbury Phone: 651/ 232-6767 Fax: 651/ 232-6766

MEDICAL HISTORY/SUBJECTIVE INFORMATION - LYMPHEDEMA

Name you Prefer: _____ Next M.D. Visit Date: _____

Allergies/Reactions: _____ None

Sensitivities: (circle if any) Elastic Latex or Tape? Or None?

How many times have you been hospitalized within the past 5 years for an infection/cellulites? _____

Number of previous episodes, but not hospitalized? _____

How do you best learn? Please circle: Listening Pictures Watching Reading

Medications Currently Taking: <input type="checkbox"/> None Purpose	Medication: Purpose

Have you ever been diagnosed with any of the following? None

- Rheumatoid Arthritis
- Diabetes
- Kidney Disease
- Osteoporosis
- Osteoarthritis
- Heart Disease/Condition
- Stroke
- Stomach problems (Gerd., PUD)
- High Blood Pressure
- Congestive Heart Failure (CHF)
- Metal Implant or Pacemaker
- Blood Clots (superficial, deep)
- Low Blood Pressure
- Respiratory Problems
- Fibromyalgia
- Broken Bones
- Infectious Disease (AID's, HIV, TB, or Hepatitis)

Surgeries or other Procedures: Date:	Date:

Have you ever had: CT scan MRI Ultrasound Testing for Blood Clots Lymphangioscintigraphy
If yes, what were the results? _____

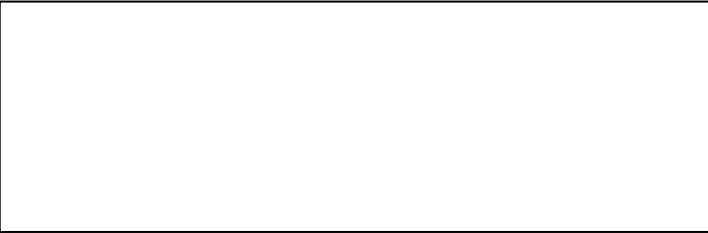
Cancer:

Were you ever diagnosed with Cancer? Yes No, then skip this section and go to the asterisk *.
When? _____ Specify type _____
Did you have any surgery? Please Explain _____
Number of Lymph Nodes removed? _____ Area? _____
Number of Radiation Treatments? _____ Date started or ended? _____
Number of Chemotherapy Treatments? _____ Date started or ended? _____
Do you have a port-a-cath? _____
Or if currently having Chemotherapy, then what is your schedule? _____

***Swelling:**

Have you ever had swelling problems before? No Yes, when? _____
Do you have any swelling now? No Yes, when did it start & where? _____
How are your clothes and/or jewelry fitting on the problem area? Tight Uncomfortable Can't wear my usual clothes/shoes
Have you had any previous treatment for Lymphedema? No Yes, when? _____
Did it include (please circle): Massage Bandaging Exercise Compression Pump Skin Care Education
Do you wear any compression garments? No Yes, when do you wear them? _____
What compression level are they? _____ Don't know What brand? Jobst Juzo Medi Sigvaris don't know
What type? Arm sleeve with or without hand portion Knee hi Thigh hi Panty hose
Do you have your own bandages? No Yes Do you bandage yourself or who helps you? _____
When and how often do you bandage? _____





***Swelling continued:**

Do you have or wear any other type of compression garment? Jovi Tribute CircAid Reid Sleeve Other? _____

Do you do Lymphedema exercises? No Yes When and how often? _____

Have you ever used a compression pump? No Yes When and how often? _____

Living Status:

Currently you live with? (please circle) Alone Spouse/significant other Children Relatives

Currently live in? (please circle) 1 or 2 story house Apartment/condo Assisted living

What kind of help do you have at home? Home health Hospice Meals on wheels Other?

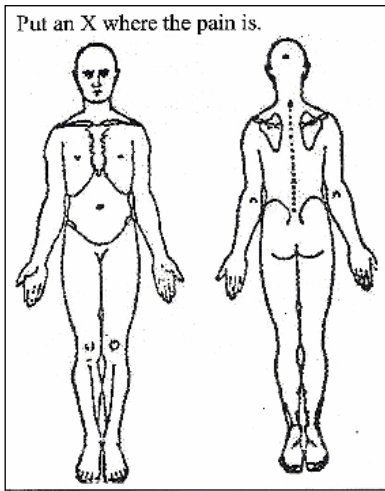
Is there anyone to help you with your therapy after we gave them instructions? No Yes

Please rate your pain level from (none) 0 – 10 (highest): Today? _____

Does pain wake you up at night? No Yes If yes, how many times? _____

Describe the pain (please circle):

Constant Intermittent Aching Heaviness Tightness Pins & Needles Burning Stabbing Throbbing



Check all the activities you have difficulty with:

- Hair Care
- Buttons, zippers, tying shoes
- Putting on shirt, jacket, bra
- Putting on pants, socks, shoes
- Bathing/Showering
- Meal Preparation
- House Cleaning
- Laundry
- Changing sheets/making bed
- Yard work, shoveling, repair
- Child Care
- Shopping
- Getting in/out of bed
- Moving/changing sleep positions
- Getting up/down from a chair
- Getting in/out from a car
- Driving
- Reaching into a cupboard
- Picking things off of floor
- Carrying groceries
- Walking on the grass
- Stepping up/down from curb
- Climbing stairs

Do you have problems with dizziness or balance Yes No **Have you fallen in the last 6 months?** Yes No

If yes, describe: _____

Which exercises, leisure activities or sports do you do outside from working? _____

How would you rate your stress level? Low Medium High

In the past year, have you been a victim of abuse (physical, emotional, financial or sexual)?

What is your chief complaint/reason for coming in today? _____

IF YOU ARE EMPLOYED, COMPLETE THE FOLLOWING SECTION NOT EMPLOYED RETIRED

1. What is your job title/occupation? _____

2. What are your job activities and work positions? _____

3. Are you currently working? No Yes If yes, number of hours per week _____ Full duty Restricted duty

PATIENT SIGNATURE: _____

Previous Medical Care: *To be completed with Therapist*

Physical/Occupational Therapy: What Rx _____ When _____ Helpful? _____ Yes No

Chiropractic Care: What Rx _____ When _____ Helpful? _____ Yes No

NOTES: _____

GOALS: What do you expect to accomplish with PT/OT? _____

CONSENT: I agree with the treatment plan of care. Yes No _____ patient initials

ABUSE: No Yes Refer to Social Services _____

Falls: Is patient at risk? Yes No; **Assessment Completed:** Tinnetti or Berg APTA _____

Therapist's Printed Signature: _____ Date: _____