TODAY'S DATE: _____

PATIENT'S NAME: _____

First Choice Physical Therapy, Inc.

Who referred you here for evaluation & treatment of your lymphedema (swelling)? _____

_____

Can we write or discuss treatment regarding your lymphedema with your physician? __YES __NO

While you are treated at our facility, you will be asked to follow a maintenance program at home. This will consist of all or some of the following:

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

→ Are you prepared to follow such a program? __YES __NO

→ If unable to do it by yourself, do you have someone who can assist you? __YES __NO

CURRENT CONDITION

1. What area of the body is your lymphedema? (Please check all that apply)

☐ Left arm	☐ Left leg	☐ Left hand	☐ Left foot
☐ Right arm	☐ Right leg	☐ Right hand	☐ Right foot
☐ Neck/Face	☐ Chest	☐ Trunk	☐ Genitalia

☐ Other _____

2. How long have you had the swelling? _____

3. What do you feel is the probable cause(s) for your swelling? (Please check all that apply)

☐ Unknown	☐ Immobility	☐ Post-surgery	☐ Weight gain and/or loss
☐ Injury/Trauma	☐ Infection	☐ DVT/clot	
☐ Insect bite	☐ Family history	☐ Lipedema	☐ Post-childbirth

☐ Congestive Heart Failure

☐ Other _____

4. What increases your swelling? _____

5. What decreases your swelling? _____

6. Does your swelling go away? __YES __NO If yes, what makes it go away? _____

7. Since the first onset of your swelling have you had any infections in the affected area? __YES __NO
   If yes, Are you currently on antibiotics for an infection? __YES __NO

8. Have you had prior treatment for lymphedema? __YES __NO
   If yes, what type(s): (Please check all that apply)
   ☐ Compression Garments ☐ Pneumatic Pump ☐ Manual Lymph Drainage
   Where and when was this treatment? _____

9. Do you have any of the following issues in relation to your swelling? (Please check all that apply)

☐ Limited motion	☐ Numbness	☐ Stiffness	☐ Skin issues
☐ Pain	☐ Heaviness	☐ Itching	☐ Weeping

   If you marked pain above, circle your level of pain below with 0 = no pain and 10 = worst pain
   Pain right now: 0 1 2 3 4 5 6 7 8 9 10
   Best the pain has been in the past 30 days: 0 1 2 3 4 5 6 7 8 9 10
   Worst the pain has been in the past 30 days: 0 1 2 3 4 5 6 7 8 9 10

10. As a result of your swelling, are you having difficulties with any of the following? (Check all that apply)
    - ☐ Dressing ☐ Sitting ☐ Standing ☐ Sleeping ☐ Chores
    - ☐ Driving ☐ Bathing ☐ Reaching ☐ Walking ☐ Meal Prep
    - ☐ Other _____

11. For leg/foot swelling: Has this caused you to wear a different size shoe than normal? __YES __NO

MEDICAL HISTORY

1. Have you had or do you currently have any of the following:
    - ☐ Bronchial asthma ☐ Blood clots ☐ Generalized weakness
    - ☐ Diabetes ☐ Shortness of breath ☐ Taking diuretics (water pills)
    - ☐ Kidney problems ☐ Hypothyroidism
    - ☐ Cardiac problems ☐ Hyperthyroidism ☐ High blood pressure (hypertension)
    - ☐ Circulatory problems ☐ Arthritis
    - ☐ Vein problems
    - ☐ Cancer, what type _____
    - ☐ Radiation therapy, if so, when? _____
    - ☐ Chemotherapy, if so, when? _____
    - ☐ Hormonal therapy, if so, when? _____
2. Current height _____
3. Current weight _____
4. Do you have any allergies? __YES __NO
   If yes, what are you allergic to? _____
5. Have you fallen in the past year? __YES __NO
   If yes, how many times? _____ Any injury? _____
6. Do you have any of the following skin problems? (Check all that apply)
    - ☐ Athlete's foot ☐ Eczema ☐ Redness ☐ Wounds
    - ☐ Psoriasis ☐ Rash ☐ Warmth ☐ Sensitivities
7. What surgeries have you had? _____

   _____

   _____

   _____
8. What medications are you taking? _____

   _____

   _____

   _____
9. Do you use any of the following assistive devices or orthotics? (Please check all that apply)
    - ☐ Cane ☐ Manual Wheelchair ☐ Foot orthotics
    - ☐ Walker ☐ Power Wheelchair ☐ Custom ortho shoes
    - ☐ Crutches ☐ Ankle brace