Brief Medical History

(completed by patient on intake)

Date: ______________

Name: ____ D.O.B.: __________________

Completed by: ☐ Patient (listed above) ☐ Other : ___________________________

Do you currently experience swelling/lymphedema? (Please circle all that apply)

right arm left arm both arms breast right leg left leg both legs head & neck genital

Other, please explain: ____

Have you been diagnosed with Lymphedema? ☐ Yes ☐ No

If yes, by whom: ____

How long have you had swelling/Lymphedema? __________________________

Was there a triggering event which caused the swelling/Lymphedema? ______________

____

Please describe briefly how and why your swelling/lymphedema developed: __________

____

____

Have you had any surgery? ☐ Yes ☐ No

If yes, list surgeries and dates: ____

____

____

Have you had any lymph nodes removed? ☐ Yes ☐ No

If yes, how many: ____

Have you ever received radiation therapy for cancer? ☐ Yes ☐ No

If yes, list area of radiation and dates here: ______________________________

____

____

Have you had Chemotherapy? ☐ Yes ☐ No

If yes, how long ago?____

Have you had any infections (Cellulitis)? ☐ Yes ☐ No

If yes, how long ago was the last one? ____________________________________

© Klose Training & Consulting, LLC, 2010

Previous Treatments

Have you had previous treatment for swelling/lymphedema? ☐ **Yes** ☐ **No**

If yes, check all that apply:

☐ Manual Lymph Drainage (MLD)	☐ Compression Pump	☐ Compression Garments
☐ Compression Bandaging	☐ Flexitouch	☐
☐ Lymphedema Exercise	☐ Low Level Laser	☐

If yes, please explain your experience, success or lack of success:

____

____

____

Do you currently wear a compression sleeve or stocking? ☐ **Yes** ☐ **No**

If yes, how often do you wear it and how old is it?:____________________________

____

Do you currently use compression at night? ☐ **Yes** ☐ **No**

If yes, please explain: ____

____

Do you exercise regularly? ☐ **Yes** ☐ **No**

If yes, please explain: ____

____

Are you familiar with the National Lymphedema Network? ☐ **Yes** ☐ **No**

Are you familiar with the precautions (risk reduction practices) for Lymphedema? ☐ **Yes** ☐ **No**

Are you a member of a breast cancer or lymphedema support group? ☐ **Yes** ☐ **No**

If yes, please explain: ____

Would you like to receive a newsletter and/or product updates from our office in the future?
☐ **Yes** ☐ **No**

Is there anything else you would like to tell us at this time? ____________________

____

____

© *Klose Training & Consulting, LLC, 2010*

Is there a family history of Lymphedema? ☐ **Yes** ☐ **No**

If yes, please explain: ______________________________

Do you have pain? ☐ **Yes** ☐ **No**

If yes, please explain: ______________________________

____

Any loss of function or mobility? ☐ **Yes** ☐ **No**

If yes, please explain: ______________________________

____

Do you have any difficulties with any of the following?

☐ walking	☐ reaching feet and toes	☐ preparing meals
☐ dressing	☐ bathing/showering	☐ other

If other, please explain: ______________________________

____

What is your current living situation?

☐ private home/apartment (alone)	☐ nursing home	☐ hospice
☐ home with spouse or companion	☐ assisted living	☐ other

If other, please explain: ______________________________

Do you currently suffer from (or have you had) any of the following?

☐ Asthma	☐ Hyperthyroidism	☐ Crohn's Disease
☐ Bronchitis	☐ Kidney failure	☐ Diverticulitis
☐ Difficulties Breathing	☐ Diabetes	☐ Recent Abdominal Surgery
☐ Irregular Heart Beat	☐ Infections (Cellulitis)	☐ Unexplained Pain
☐ Heart Edema	☐ Sleep Apnea	☐ Deep Venous Thrombosis (blood clot)
☐ Hypertension	☐ Malignancy (Cancer)	☐ Latex Allergy
☐	☐	☐

Do you have any other medical problems not listed above? ☐ **Yes** ☐ **No**

If yes, please explain: ______________________________

Are you allergic to: ☐ Latex ☐ Surgical Tape ☐ Foam Products ☐ Other

If other, please explain: ______________________________

Are you taking any medication? ☐ **Yes** ☐ **No**

If yes, list medications and amounts here: ______________________________

____

At the time you are completing this, are you, or is the a chance you could be pregnant?
☐ **Yes** ☐ **No**

© *Klose Training & Consulting, LLC, 2010*

Authorization for the use of Photographs and Medical Information

I, ____________________________ herby authorize _______________________ to take and use any photographs or medical information for treatment and educational purposes. I give my permission for _________________________ to disclose my health information to necessary staff for treatment plan purposes. This authorization extends to copies of said information.

I authorize _________________________ to share/release my medical information <u>to my physician or insurance company</u> for appropriate purposes.

I also allow release of my medical records to: __________________________________

____

Date: _____________________

Patient signature: ____

Patient printed name: ____

Witness Signature: ____

Witness printed name: ____

© *Klose Training & Consulting, LLC, 2010*