HARRIS
REGIONAL HOSPITAL

Lymphedema Intake Form

Personal Information (Please print clearly)

Name____

Date of Birth: _____________ Sex: M/F

Medical Information

Reason for being seen: ____

Primary Physician: __________________ Phone (_____)____________________

Surgeon: __________________________ Phone (_____)____________________

Oncologist: ________________________ Phone (_____)____________________

Where do you currently experience swelling/Lymphedema? (Circle all that apply)

Arm Left/Right BreastLeg Left/Right Head Neck Genital Trunk

How long have you had Swelling/Lymphedema?__________________________

Does there seem to be a triggering event which caused your swelling/
Lymphedema: ____

____

Describe how and why your swelling/Lymphedema developed:

____

Does there seem to be a trigger that caused your swelling?

____

Have you had any lymph nodes removed? Y / N How many and where?

____

Have you had Chemotherapy? Y / N If yes, how long ago? ___________

Radiation Therapy for Cancer? Y / N If yes, list area(s) of radiation and dates:

____

Is there a family history of Lymphedema? Y / N If yes, please explain:

____

Do you have pain? Y / N

Do you have a loss of function or mobility related to your swelling/Lymphedema?

____

Do you have difficulties with any of the following?

Walking Reaching feet/toes Preparing Meals Combing/Brushing Hair

Dressing Bathing/Showering Toileting Self Other

Please explain____

Do you currently suffer from any of the following: Circle all that apply

Asthma:
Bronchitis:
Diabetes
Difficulty Breathing
Irregular heartbeat
Heart Edema
Hypertension
Hyperthyroidism
Hypothyroidism
Infections/Cellulitis
Decreased Sensation
Kidney Failure
Malignancy
Crohn's Disease
Diverticulitis
Recent Abdominal Surgery
Sleep apnea
Deep Vein Thrombosis
Latex Allergy
Arterial Disease
Stroke
Arrhythmia

Do you have any other medical conditions/allergies not listed above?

PREVIOUS TREATMENTS

Have you had previous treatments for swelling/Lymphedema?

Do you wear any compression garments?

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

____

____

Are you: ( ) Left-handed ( ) Right-handed

Occupation: ___________________________________ (please list occupation)

( ) Full Time ( ) Unemployed/ disabled ( ) Homemaker

( ) Part Time ( ) Retired ( ) Student: ________________

Living Environment:

Your home: ( ) Single-level home ( ) Multi-level home

( ) Apartment/ Condo ( ) Assisted Living ( ) Ramp

How many steps to enter your home? ________________

Does your stairs have hand rails? ( ) Yes ( ) No

How many steps are inside your home? ______________

Whom do you live with:

( ) Alone ( ) Spouse only ( ) Spouse and children

( ) Parents/ family ( ) Other: _________________________

Lifestyle Questionnaire:

How do you rate your Health? ( ) Good ( ) Fair ( ) Poor

Eating Habits? ( ) Good ( ) Fair ( ) Poor

Sleeping Patterns? ( ) Good ( ) Fair ( ) Poor

Energy Level? ( ) Good ( ) Fair ( ) Poor

What is your knowledge of exercise and fitness? ( ) Good ( ) Fair ( ) Poor

How often do you exercise per week? ( ) greater than 3 ( ) 3 ( ) less than 3

Do you have any cultural or religious considerations which may impact your treatment? ( ) No ( ) Yes, ______________________________________

Are you being threatened or hurt by anyone? ( ) Yes ( ) No

Have you recently had thoughts of harming yourself or others? ( ) Yes ( ) No

Fall Risk Screening:

Have you fallen in the last 12 months? ( ) Yes ( ) No

How many times? _____________

Do you feel unsteady when standing or walking? ( ) Yes ( ) No

Please return completed form to Physical & Occupational Therapy.

If you are treated at this facility you will be asked to follow a maintenance program at home that consists of: Compression garment, Bandaging of limb overnight, Meticulous skin care to avoid infection, Remedial exercises to accelerate lymph flow.