

Alexander Spring Rehab, Inc.
Lymphedema History Form

Name: _____ Date of Birth: _____

1. Problem: _____

Prior treatment for this problem? Yes: ___ No: ___ Describe: _____

2. Please list any related surgeries, with dates: _____

Please list any other surgeries, with dates: _____

Have you had any lymph nodes removed? Yes: ___ No: ___. If so, where? _____

How many? _____. Were they positive for cancer? Yes: ___ No: ___

Have you undergone chemotherapy? Yes: ___ No: ___ How many times? _____

Have you undergone radiation therapy? Yes: ___ No: ___ How many times? _____

Have you had any current studies done that include X-ray, PET scan, MRI, CAT scan, MUGA scan? Yes: ___ No: ___

If yes, describe results, as you understand them: _____

Functional Status/Activity Level (check all that apply)

3. Employment: _____ Describe major job tasks: _____

Do you do any repetitive motion? Yes: ___ No: ___. Describe: _____

At home, do you (Please check those that apply): Cook: ___ Clean: ___ Do laundry: ___ Buy groceries: ___

Garden: ___ Mow lawn: ___ Dress yourself: ___ Bathe yourself: ___ Eat independently: ___

Get regular exercise: Yes: ___ No: ___. If yes, describe: _____

Play sports: Yes: ___ No: ___. If yes, describe: _____

What do you do in your leisure time? _____

Do you have trouble sleeping? Yes: ___ No: ___. If yes, describe: _____

How far can you walk without stopping? Distance: _____ Time: _____

Can you go up and down stairs? Yes: ___ No: ___ If yes, how many? _____ Can you crawl? Yes: ___ No: ___

Squat? Yes: ___ No: ___ Reach overhead? Yes: ___ No: ___ Can you drive the car? Yes: ___ No: ___

Can you take care of family members/pets? Yes: ___ No: ___

Pain/Symptoms:

4. Please indicate location of your scars by line drawings on body diagram:

Please indicate location of any pain by drawing an "x" or series of "xxx"'s on the body diagram wherever your pain is located:

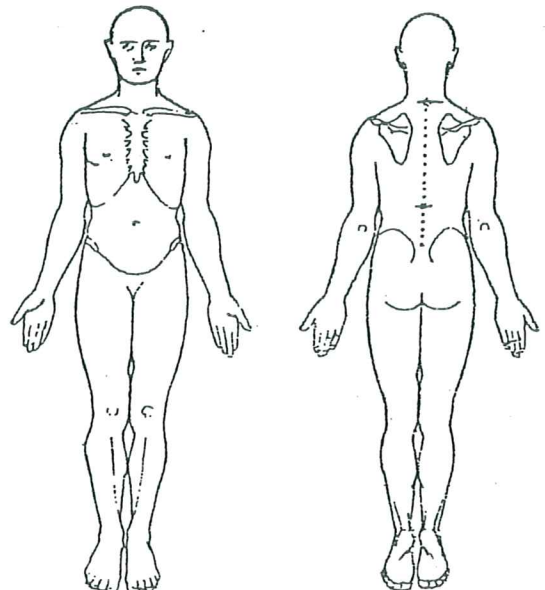
Please rate your pain on a scale of 0-10, with 0 being no pain, and 10 being the worst pain imaginable (such that you would go to the emergency room):

At rest: ___/10; with activity: ___/10

Pain is worse at what time of day:

Early a.m.: ___ Late a.m.: ___

Early p.m.: ___ Late p.m.: ___ Nighttime: ___



4. Please check all of the following that apply to:

	You	Parent	Sibling	Grandparent
Asthma/emphysema/COPD	___	___	___	___
Heart attack/heart problems	___	___	___	___
Stroke	___	___	___	___
High blood pressure	___	___	___	___
Diabetes (blood sugar problem)	___	___	___	___
Arthritis	___	___	___	___
Seizure disorder	___	___	___	___
Cancer	___	___	___	___
Circulatory problems	___	___	___	___
Osteoporosis	___	___	___	___
Cholesterol problem	___	___	___	___
Problems with your eyesight (other than corrective lenses)	___	___	___	___
Dizziness, fainting spells	___	___	___	___
Hearing aid	___	___	___	___
Metal implants	___	___	___	___
Radioactive implants	___	___	___	___
Pacemaker or implanted defibrillator	___	___	___	___
Thyroid problem	___	___	___	___
Fractures	___	___	___	___
Other: _____	___	___	___	___

5. Living Environment:

Do you: Live alone ___; with spouse ___; with family ___

Do you live in a:

- ___ One-story home
- ___ Two-story home
- ___ Apartment with stairs
- ___ Apartment without stairs

Do You Use:

- ___ Cane
- ___ Walker or rollator
- ___ Manual wheelchair
- ___ Motorized wheelchair
- ___ Glasses; hearing aids: Left ___; Right ___
- ___ TENS unit
- ___ Diabetic pump
- ___ Pacemaker
- ___ Mediport

6. Are you allergic to anything? Yes ___; No ___. If so, please list here: _____

7. Medications (please list below)	Condition for which you take this medication (list below)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

8. If female, is there a possibility that you may be pregnant? Yes: _____ No: _____

9. Do you smoke? Yes: ___ No: ___ If yes, how often? _____
 Previous smoking amount/length & quit date (if you smoked more than 20 years before quitting): _____

10. Do you drink alcohol? Yes: ___ No: ___ If yes, how often? _____

Height: _____ Weight: _____ Hand Dominance: R ___ L ___

Please review your answers now. If there is any other medical condition or concern that you have, please indicate it in this space. Remember, this is part of your medical record and is confidential information. Having as much information as possible will help us to help you. Thank you.

Signature: _____ Date: _____
 (patient or person completing form)