



13. Have you ever had radiation therapy? \_\_\_\_\_

14. Have you ever received chemotherapy? \_\_\_\_\_

15. What operation(s) have you had? \_\_\_\_\_

16. What are your goals for treatment? \_\_\_\_\_

17. In the past have you had any serious injuries?  Yes  No If yes, please list and give dates  
\_\_\_\_\_  
\_\_\_\_\_

18. Please describe below any vehicle accidents or personal injuries in which you have been involved.

AGE (OR APPROXIMATE YEAR)

0-10 \_\_\_\_\_

11-20 \_\_\_\_\_

21-30 \_\_\_\_\_

31-40 \_\_\_\_\_

41-50 \_\_\_\_\_

51-60 \_\_\_\_\_

61 & over \_\_\_\_\_

19. Have you taken cortisone (steroids) by pill within the last 5 years?  Yes  No

20. Do you smoke? Yes No If yes, how much? \_\_\_\_\_

21. If you are female, is there any possibility you are pregnant?  Yes  No

22. Which physician referred you to our facility?

Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Yes No

23. Can we write or discuss your lymphedema problem with this physician? \_\_\_\_\_

24. If you are treated at this office, you will then be asked to follow a maintenance program at home. This consists of:

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

Are you prepared to follow such a program? \_\_\_\_\_

## Lymphedema ~ Health Questionnaire

Please mark all areas that are involved in your medical history. These will be discussed with your therapist and are very important in determining the safety or modification of your lymphedema treatment.

- Infection
- Cardiac Edema
- Congestive Heart Failure
- Bronchitis
- Deep Vein Thrombosis (Clot)
- Active Cancer
- Asthma
  
- Cardiac Arrhythmia (Irregular rhythm)
- Carotid-Sinus-Syndrome
- Hyperthyroidism
- Stroke/TIA's

- Pregnancy
- Painful Periods
- Abdominal/Intestinal Problems
- Abdominal Aortic Aneurysm
- Recent Abdominal Surgery (past 1 year)
- Radiation Treatment
- Unexplained Abdominal Pain

- Arterial Diseases
- Reflex Sympathetic Dystrophy (RSD)
- Spasticity
- Uncontrolled High Blood Pressure
- Coronary Artery Sclerosis
- Paralysis

### Other Medical History

---

---

---

---

### Medications

---

---

---

---

## Lymphedema~ Health Questionnaire

Please mark all areas that are involved in your medical history. These will be discussed with your therapist and are very important in determining the safety or modification of your lymphedema treatment.

- Infection
- Cardiac Edema
- Congestive Heart Failure
- Bronchitis
- Deep Vein Thrombosis (Clot)
- Active Cancer
- Asthma
  
- Cardiac Arrhythmia (Irregular Rhythm)
- Cardiac- Sinus-Syndrome
- Hyperthyroidism
- Stroke/TIA's
  
- Pregnancy
- Painful Periods
- Abdominal/Intestinal Problems
- Abdominal Aortic Aneurysm
- Recent Abdominal Surgery (Past 1 year)
- Radiation Treatment
- Unexplained Abdominal Pain
  
- Arterial Diseases
- Reflex Sympathetic Dystrophy (RSD)
- Spasticity
- Uncontrolled High Blood Pressure
- Coronary Artery Sclerosis
- Paralysis