MSU Health Care

PATIENT HISTORY – UPPER EXTREMITY LYMPHEDEMA

Office Use Only

MRN:

Patient's Name (First, Middle, Last)	Today's Date

Who referred you for lymphedema evaluation/treatment? *Please state referring physician name and contact information.*

Have you had any physical therapy for the same condition for which you are here today? ☐ YES, ☐ NO. If yes, please indicate where and when:

While you are treated at this facility, you will be asked to follow a program at home. This consists of wearing bandages 23 hours/day, meticulous skin care to avoid infections, and exercises and self-massage to facilitate lymph flow. Are you prepared to follow such a program? ☐ Yes ☐ No

Do you have someone who can assist you with your home lymphedema treatment if you are unable to do it yourself? *(this will include bandaging the affected area(s), skin care and self-massage)* ☐ YES, ☐ NO

If your lymphedema is related to treatment for breast cancer, would you need financial assistance to purchase garment and/or bandages (*each with approximate cost of $75*)? ☐ YES, ☐ NO

Are you currently receiving any HOME HEALTH CARE SERVICES? ☐ YES, ☐ NO

CURRENT CONDITION(S)/CHIEF COMPLAINTS

Is your Lymphedema;

☐ Primary (born with lymphedema OR onset during childhood/puberty/adult without an apparent reason)

☐ Secondary (cancer surgery or radiation treatment OR resulting from injury, infection, other surgeries, accident, wt. gain)

☐ Unknown

At what age did swelling first occur?	Which area(s) is/are affected? Check all that apply: ☐ Left arm ☐ Trunk ☐ Breast ☐ Right arm ☐ Other:
Did the swelling begin: ☐ Gradually ☐ Suddenly	
If you had breast cancer surgery please check/fill all that apply: ☐ Right ☐ Left ☐ Bilateral	☐ Lumpectomy ☐ Mastectomy ☐ Surgery date:_____ ☐ # lymph nodes removed: _____ ☐ # positive: _____
If you had surgery/treatment for other types of cancer please check/fill all that apply: Area:_____	☐ Surgery date:_____ ☐ # lymph nodes removed: _____ ☐ # positive: _____

How long after surgery (breast or other) did your swelling begin? _____

Have you undergone any of the following treatments? If 'yes' when, how much and what area? ☐ None

Treatment type?	When?	How much?	What area?
☐ Radiation			
☐ Chemotherapy			

If you did NOT have cancer surgery, what do you think caused the onset of your swelling?

☐ Infection ☐ Trauma (injury) ☐ Venous insufficiency ☐ Post-surgery ☐ Weight gain ☐ Immobility
☐ Liposuction ☐ Post-childbirth ☐ Primary/congenital ☐ Lipedema ☐ DVT/clot ☐ Congestive Heart Failure
☐ Other:

Have you had any tests for this problem: ☐ X-ray ☐ MRI ☐ Lymphoscintigraphy ☐ Doppler ☐ Ultrasound

Since the first onset of your swelling have you had any infections in the affected limb(s)? ☐ Yes ☐ No If yes # times: _____	Ever been hospitalized to treat your infection? ☐ Yes ☐ No If yes, # times hospitalized to treat the infection?_____ Are you currently taking preventative antibiotics? ☐ Yes ☐ No
Do you have any of the following issues in relation to your swelling?	☐ Pain ☐ Numbness ☐ Limited motion ☐ Skin issues ☐ Itching ☐ Heaviness ☐ Stiffness ☐ Weeping
What increases your swelling?	
What decreases your swelling?	
Does your swelling every go away? ☐ Yes ☐ No	If 'yes' what makes it go away? -

TREATMENT

Have you been treated previously for your swelling? If 'yes' when and how?	
How are you currently managing your swelling?	☐ Self-manual lymph drainage ☐ Bandaging ☐ Exercise ☐ Compression garments ☐ Skin care ☐ Nothing

- OVER -

FAMILY HISTORY

Do you have a family history of limb swelling? ☐ YES, ☐ NO

MEDICAL HISTORY

Current medications (prescription and over the counter) – PLEASE ATTACH A SEPARATE LIST OF YOUR CURRENT MEDICATIONS

Allergies and type of reaction (medication, foods, etc.)

PLEASE CHECK ALL THAT APPLY:			
	☐ Active Cancer	☐ Aortic aneurysm	☐ Diabetes
	☐ Acute Infection	☐ Hyperthyroidism	☐ Bronchial asthma
	☐ Blood clot/DVT	☐ Hypothyroidism	☐ Hypertension
	☐ Major Heart Problems	☐ Kidney Problems	☐ Hypotension
	☐ Acute Renal Failure	☐ Congestive Heart Failure	
PLEASE LIST ANY OTHER MAJOR MEDICAL ISSUES:			

SOCIAL HISTORY

Occupation:		Sports/Hobbies:		
Living Status	Alone: ☐ YES	Live with Family: ☐ YES *(please specify)*	Roommate(s): ☐ YES	Pet(s): *(please specify)*

Do you have reliable transportation to appointments? ☐ YES, ☐ NO

Do you use any of the following assistive devices?

☐ Cane ☐ Walker ☐ Crutches ☐ Manual/☐ Power wheelchair ☐ Splints/braces

FUNCTIONAL QUESTIONNAIRES

Lymphedema Quality of Life Tool – ARM (adapted)

How much does your swollen arm affect the following activities?	Not at all	A little	Quite a bit	A lot
a) Occupation				
a) Housework				
b) Combing Hair				
c) Dressing				
d) Writing/Computer				
e) Eating				
f) Washing				
g) Cleaning Teeth				
How much does it affect your leisure activities/social life?				
How much do you have to depend on other people?				
How much do you feel the swelling affects your appearance?				
How much difficulty do you have finding clothes to wear?				
Does the swelling affect how you feel about yourself?				
Does it affect your relationships with other people?				
Does your lymphedema cause you pain?				

PATIENT SPECIFIC FUNCTIONAL SCALE – rate each of the following on a 0 to 10 scale *(0= no problem, 10= can't do)*

Please rate relative to your lymphedema condition

Sleep all night 0 1 2 3 4 5 6 7 8 9 10	Stand 0 1 2 3 4 5 6 7 8 9 10	Lift 0 1 2 3 4 5 6 7 8 9 10
Self-care 0 1 2 3 4 5 6 7 8 9 10	Walk 0 1 2 3 4 5 6 7 8 9 10	Reach 0 1 2 3 4 5 6 7 8 9 10
Sit 0 1 2 3 4 5 6 7 8 9 10	Up/Down stairs 0 1 2 3 4 5 6 7 8 9 10	Work tasks 0 1 2 3 4 5 6 7 8 9 10
Other:_____ 0 1 2 3 4 5 6 7 8 9 10	Other:_____ 0 1 2 3 4 5 6 7 8 9 10	Other:_____ 0 1 2 3 4 5 6 7 8 9 10

Patient signature: Date -

This form has been reviewed by: Date -