MICHIGAN STATE UNIVERSITY

PATIENT HISTORY – LOWER 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**

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 (due to 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:**
Did the swelling begin: ☐ **Gradually** ☐ **Suddenly**	☐ **Left leg** ☐ **Right leg** ☐ **Genitalia** ☐ **Trunk** **Other:**
If you had surgery/treatment for cancer that is related to your swelling, please identify the area(s):	☐ **Surgery date:_____** ☐ **# lymph nodes removed: _____** ☐ **# positive: _____**

How long after surgery did your swelling begin? _____

Have you undergone any of the following cancer treatments ☐ **None** ☐ **Radiation** ☐ **Chemotherapy**

If you did NOT have surgery for cancer, 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/CT** ☐ **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**

FAMILY HISTORY

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

- OVER -

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, tape etc.)

PLEASE CHECK ALL THAT APPLY:	☐ Active Cancer ☐ Acute Infection ☐ Blood clot/DVT ☐ Major Heart Problems ☐ Acute Renal Failure	☐ Aortic aneurysm ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Kidney Problems ☐ Congestive Heart Failure	☐ Diabetes ☐ Bronchial asthma ☐ Hypertension ☐ Hypotension
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/orthotics?

☐ **Cane** ☐ **Walker** ☐ **Ankle foot orthosis/brace** ☐ **Crutches** ☐ **Manual/** ☐ **Power wheelchair** ☐ **Foot orthotics/Custom shoes**

If your household layout is part of your concern please list the following:

FUNCTIONAL QUESTIONNAIRES

Lymphedema Quality of Life Tool LEG (adapted)

How much does your swollen leg affect the following activities?	Not at all	A little	Quite a bit	A lot
a) Walking				
a) Bending, e.g. to tie shoes or cut toenails				
b) Stand				
c) Get up from a chair				
d) Occupation				
e) Housework				
f) Go up/down stairs				
g) Driving				
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 -**