



*** MEDICAL HISTORY – LYMPHEDEMA ***

History of Present Injury / Illness

How did your swelling develop? Please specify:

- Activities of daily living: _____
- Motor vehicle accident: _____
- Following an illness: _____
- Following a surgery: _____
- Sports: _____
- Work: _____
- Other: _____

Have you had treatment for Lymphedema in the past? YES NO
If yes, when and where? _____

Are you currently receiving Home Care Services? YES NO

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

Have you used a Compression Pump? YES NO
If yes, for how long and what type? _____

Do you wear a Compression Sleeve or Stocking? YES NO

Have you had a physical examination by your doctor in the past year? YES NO

*Comments: _____

Please list ANY major surgeries / hospitalizations:

Date: _____

Date: _____

Date: _____

Within the past year have you had any of the following? YES NO

- | | | | |
|---------------------------------------|------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> CT Scan | <input type="checkbox"/> MRI | <input type="checkbox"/> Stress Test |
| <input type="checkbox"/> Radiation | <input type="checkbox"/> Biopsy | <input type="checkbox"/> Doppler / US | <input type="checkbox"/> X-ray |
| <input type="checkbox"/> Bone Scan | <input type="checkbox"/> EMG / NCV | <input type="checkbox"/> Spinal Tap | <input type="checkbox"/> Other |