Lymphedema History Questionnaire

CANCER HISTORY
Type(s) of Cancer: ____ Date Diagnosed: ___________________
Surgeries performed: ____
Number of lyjmph nodes removed: ____

RADIATION
Are you still receiving radiation or are you scheduled to begin radiation? □ YES □ NO
Number of treatments performed: _______________ Number of treatments left to complete? _______________

CHEMOTHERAPY
Are you still receiving chemo? □ YES □ NO
Number of treatments performed: _______________ Number of treatments left to complete? _______________

RADIOLOGY
Have you undergone any of the following procedures?

X-Rays	□ **YES**	□ **NO**	Date:________	results?______________________________________
CT Scan	□ **YES**	□ **NO**	Date:________	results?______________________________________
MRI	□ **YES**	□ **NO**	Date:________	results?______________________________________
Bone Scan	□ **YES**	□ **NO**	Date:________	results?______________________________________
Ultrasound	□ **YES**	□ **NO**	Date:________	results?______________________________________

LYMPHEDEMA HISTORY
When did you first notice the swelling? ____
Where did you notice the most swelling? ____
Do you know what triggered the swelling? ____
Does the swelling go down at night? □ YES □ NO
Have you been treated for Lymphedema before? □ YES □ NO

Check any treatments you have had before.

□ Massage MDL	□ Compression Garment	□ Exercise
□ Bandaging	□ Compression Pump	□ Other: _________________________

Are you currently seeing anyone else for this problem? Who? ____
Have you had or been treated for an infection? Where/When? ____
Have you been treated for any wounds? Where/When? ____
Any additional comments: ____
____

WORK / HOBBIES: Please list any work, hobby or sport activities in which you are currently unable to perform due to injury, medical condition OR lymphedema. ____
____

Patient Name (Please Print): ____

Patient or Representative Signature: __________________________________ Date: __________ Time: _____