OLY FLOAT

Manual Lymph Drainage & Lymphedema

Brief Medical History

Date: _____

Name: _____ **DOB:** _____

Completed by: ☐ **Client (listed above)** ☐ **Other:** _____

Do you currently experience swelling/lymphedema? (Please circle all that apply)

right arm left arm both arms breast right leg left leg both legs genital head & neck

Other, please explain: _____

Have you been diagnosed with lymphedema? ☐ **Yes** ☐ **No**

If yes, by whom: _____

How long have you had swelling/lymphedema? _____

Was there a triggering event which caused the swelling/lymphedema? _____

_____

Please describe briefly how and why your swelling/lymphedema developed: _____

_____

_____

Have you had any surgery? ☐ **Yes** ☐ **No**

If yes, list surgeries and dates: _____

_____

_____

Have you had any lymph nodes removed? ☐ **Yes** ☐ **No**

If yes, how many: _____

Have you ever received radiation therapy for cancer? ☐ **Yes** ☐ **No**

If yes, list area of radiation and dates here: _____

_____

_____

Have you had chemotherapy? ☐ **Yes** ☐ **No**

If yes, how long ago?_____

Have you had any infections (cellulitis)? ☐ **Yes** ☐ **No**

If yes, how long ago was the last one? _____

Is there a family history of lymphedema? ☐ **Yes** ☐ **No**

If yes, please explain: _____

Do you have pain? ☐ **Yes** ☐ **No**

If yes, please explain: _____

_____

Do you have any loss of function or mobility? ☐ **Yes** ☐ **No**

If yes, please explain: _____

Do you have any difficulties with any of the following?

☐ Walking	☐ Reaching feet and toes	☐ Preparing meals
☐ Dressing	☐ Bathing/showering	☐ Other

If other, please explain: _____

_____

What is your current living situation?

☐ Private home/apartment (alone)	☐ Nursing home	☐ Hospice
☐ Home with spouse or companion	☐ Assisted living	☐ Other

If other, please explain: _____

Do you currently suffer from (or have you had) any of the following?

☐ Asthma	☐ Hyperthyroidism	☐ Crohn's Disease
☐ Bronchitis	☐ Kidney failure	☐ Diverticulitis
☐ Difficulties breathing	☐ Diabetes	☐ Recent abdominal surgery
☐ Irregular heart beat	☐ Infections (cellulitis)	☐ Unexplained pain
☐ Heart edema	☐ Sleep apnea	☐ Deep venous thrombosis (blood clot)
☐ Hypertension	☐ Malignancy (cancer)	☐ Latex allergy
☐	☐	☐

Do you have any other medical problems not listed above? ☐ **Yes** ☐ **No**

If yes, please explain: _____

Are you allergic to: ☐ Latex ☐ Surgical Tape ☐ Foam Products ☐ Other

If other, please explain: _____

Are you taking any medication? ☐ **Yes** ☐ **No**

If yes, list medications and amounts here: _____

_____

At the time you are completing this, are you pregnant or is there a chance you could be pregnant?

☐ **Yes** ☐ **No**

PREVIOUS TREATMENTS

Have you had previous treatment for swelling/lymphedema? ☐ Yes ☐ No

If yes, check ALL that apply:

☐ Manual Lymph Drainage (MLD)	☐ Compression pump	☐ Compression garments
☐ Compression bandaging	☐ Flexitouch	☐
☐ Lymphedema exercise	☐ Low level laser	☐

If yes, please explain your experience, success, or lack of success:

_____

_____

_____

_____

Do you currently wear a compression sleeve or stocking? ☐ Yes ☐ No

If yes, how often do you wear it and how old is it?:_____

_____

Do you currently use compression at night? ☐ Yes ☐ No

If yes, please explain: _____

Do you exercise regularly? ☐ Yes ☐ No

If yes, please describe: _____

_____

Are you familiar with the National Lymphedema Network? ☐ Yes ☐ No

Are you familiar with the precautions (risk-reduction practices) for Lymphedema? ☐ Yes ☐ No

Are you a member of a breast cancer or lymphedema support group? ☐ Yes ☐ No

If yes, please describe: _____

What is the reason that you are seeking help? _____

_____

What are your treatment goals? _____

_____

_____

Is there anything else you would like to tell us at this time? _____

_____

_____

This page of the questionnaire to be completed by your therapist

KEY

Lymphedema: ///

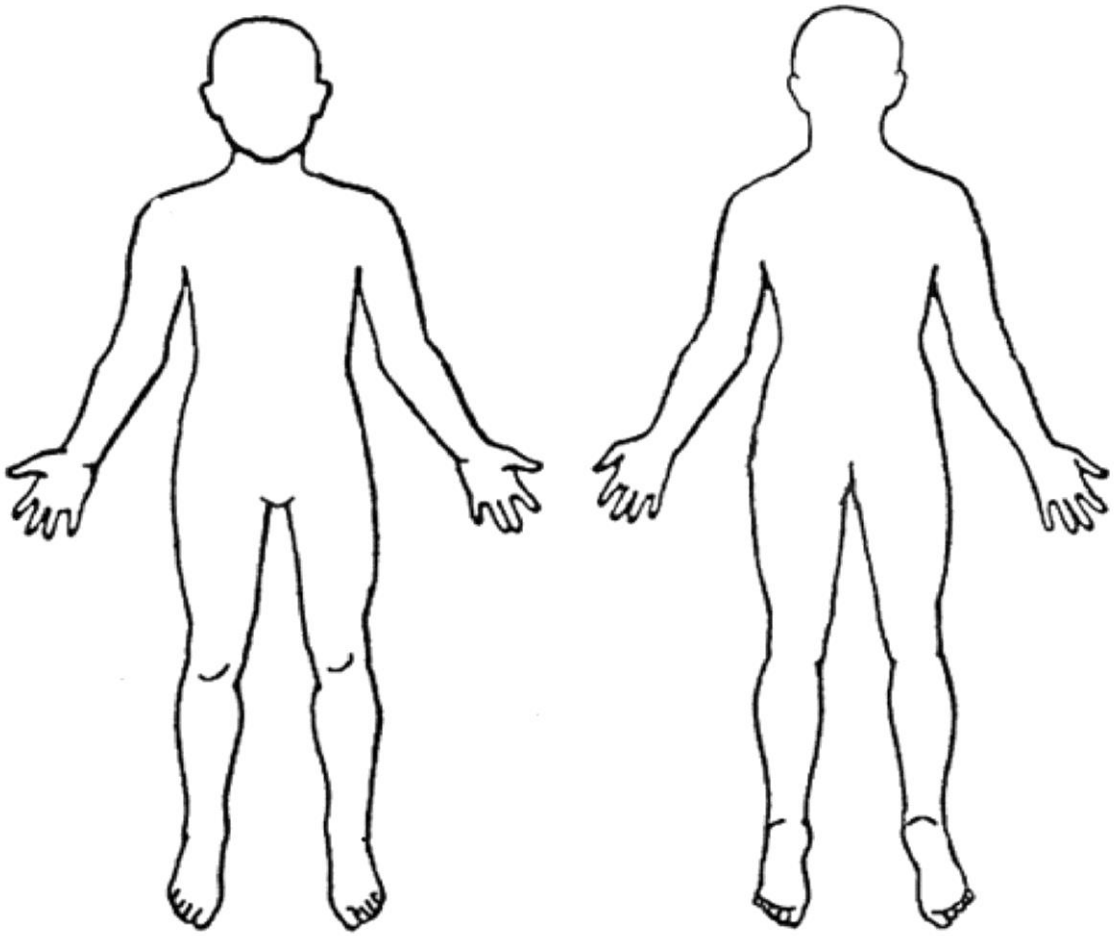
Scar(s):

Node removal: ♦

Radiation field: ☐

Radiation fibrosis: # #

Pain/Sensory deficits: ✶



Therapist Notes: _____

_____

_____

_____

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