Lymphedema Evaluation

Name:_____ Date:_____

1. For how long have you had lymphedema? _____
2. Have you ever had any lymphedema infections? _____
3. Do you ever leak fluid ? _____
4. Do you take prophylactic antibiotics? _____
5. Do you take diuretics for lymphedema? _____
6. Do you take benzopyrones for lymphedema? _____
7. Do you take any other drugs for lymphedema? _____
8. Does anyone in your family have lymphedema? _____
9. Which extremity has lymphedema?
   (check all that apply) Left Arm _____ Right Arm _____
   Left Leg _____ Right Leg _____
10. Have you had prior treatment for lymphedema?
    (check all that apply) Surgery _____ Compression Garment _____
    Antibiotics _____ Pneumatic Pump _____
    Manual Lymph Drainage _____
11. Do you have bronchial asthma? _____
12. Do you have hypertension? _____
13. Do you have diabetes? _____
14. Do you have allergies? _____
15. Do you have any cardiac problems? _____
16. Do you have any kidney problems? _____
17. Do you have any circulatory problems? _____
18. What medication(s) are you currently taking? _____
    _____
    _____

(OVER)

Lymphedema Evaluation
(continued)

19. Have you ever had radiation therapy? _____

20. Have you ever received chemotherapy? _____

21. What operation(s) have you had? _____

22. Which physician referred you to our facility?

Name _____

Address _____

_____

Phone (___) _____-_____

23. Can we write to or discuss your lymphedema problem with this physician? yes _____ no _____

24. If you are treated at this office, you will then be asked to follow a maintenance program at home. This consists of:

a) Elastic sleeve or stocking worn during the day.
b) Bandaging of limb overnight.
c) Meticulous skin care to avoid infections.
d) Remedial exercises to accelerate lymph flow.

Are you prepared to follow such a program? _____

Physical Examination

Patient's Name _____ Date _____

D.O.B. _____

General appearance: _____

Skin: _____

HEENT: head— _____
ears - _____
eyes - _____
nose - _____
throat - _____

Neck: _____

Chest/Lungs: _____

Cardiac: _____

Abdomen/Back: _____

Genitalia: _____

Musculo/Skeletal: _____

Neurological: _____

Other: _____