

13. Have you had prior treatment for lymphedema? (Check all that apply):

- Combined Decongestive Therapy _____
- Manual Lymph Drainage _____
- Myofascial Therapy _____
- Trigger Point Therapy _____
- Swedish Massage _____
- Other type of Massage _____

14. Have you ever worn a Compression garment? Yes _____ No _____ (if "yes" check all that apply):

- a) How often? _____
- b) Brand? _____
- c) Ready made _____ or Custom Fit _____
- d) Compression Class (mmHg) _____
- e) Style _____
- f) Bandaging of the affected limb(s) overnight _____

15. Have you ever had any of the following:

- a) Remedial movement exercises: _____ How often? _____
- b) Respiration Therapy (breathing exercises): _____ How often? _____
- c) Pneumatic Pump: _____ Manufacturer: _____
Frequency/hours of use: _____ Pressure Settings: _____

16. Do you have bronchial asthma or any upper respiratory problems? (please describe)

17. Do you have hypertension (High Blood Pressure)? (Please Describe) _____

18. Do you have low blood pressure? (Please describe) _____

19. Do you have any cardiac problems such as congestive heart failure? (Please describe) _____

20. Do you have any kidney problems? (Please describe) _____

21. Do you have circulatory problems? (Please describe) _____

22. Do you have allergies? (Please describe) _____

23. Have you ever had tuberculosis? (Please describe) _____

24. Have you ever been diagnosed as being "Hyperthyroid"? (Please describe) _____

25. Have you ever had radiation therapy? _____ (Please include: a) when b) #of treatments c) where:
a) _____ b) _____
c) _____

26. Have you ever received Chemotherapy? (Please describe and indicate *approximate* date of last treatment)

27. Are you presently taking anti-cancer drugs? (Please describe and indicate *specific* drugs) _____

28. Do you have active cancer? (Please describe) _____

29. Do you have any pre-cancerous moles? (Please describe *all moles* if you are not sure and use diagram on last page to indicate location) _____

30. Are you pregnant? _____ If "yes" what trimester? _____

31. Do you have diabetes? _____ If "yes" please describe: a) Type b) When Diagnosed:
a) _____ b) _____

32. Are you experiencing pain? _____ If "yes" please describe _____

***** PLEASE LIST SPECIFIC MEDICATIONS ON THE FOLLOWING QUESTIONS *****

33. Do you take any medication for your pain? _____ If "yes" please describe specific medications: _____

34. Please list all Surgeries you have undergone: _____

35. Please list all ANTIBIOTICS you have taken in the past year: _____

36. Please list all SUPPLEMENTS you take on a regular basis: _____

37. Who referred you to our clinic?
Name: _____
Address: _____
City: _____ State: _____
Zip Code: _____ Phone: _____

38. Can we write to or discuss your lymphedema condition with your physician? _____

Name: _____

Address: _____

City: _____ State: _____

Zip Code: _____ Phone: _____

39. During treatment and following treatment you will be asked to follow specific guidelines which are integral to the success of this treatment namely:

- a) Compression garment(s) worn daily during the day
- b) Bandaging (self and assisted) of the affected limb(s) overnight
- c) Remedial movement exercises to accelerate lymph flow
- d) Meticulous skin and nail care
- e) Addressing Perpetuating Factors which can affect your condition (i.e., Nutrition, Posture, Mechanical & Functional PF's)

Are you prepared to follow such a program? YES _____ NO _____

Signature _____ Date _____