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Hilton Head Occupational Therapy
Myofascial Rehabilitation & Lymphedema Services

Suite 502
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Tel. (843) 757-9292 Fax (843) 757-9294

PATIENT LYMPHEDEMA HISTORY

Name: _____ Today's Date: _____

1. When did your lymphedema first occur? (Please describe) _____

_____

2. How many times have you had a lymphedema infection? (Please describe) _____

_____

3. Have you ever been hospitalized due to a lymphedema infection? (If "yes" Please describe) _____

_____

4. Did you take antibiotics for the infection? (Please describe) _____

_____

5. Do you take prophylactic antibiotics? (Please describe) _____

_____

6. If you have had a lymphedema infection, when was the last outbreak? _____

7. Do you ever leak lymph fluid? (Please describe) _____

_____

8. Does anyone in your family have lymphedema? (Please describe) _____

_____

9. Do you take any of the following medications:

	YES	NO
a) Benzopyrones	☐	☐
b) Diuretics (Lasix, etc)	☐	☐

10. Which limb has the lymphedema (Check all that apply):

- Right Arm ☐
- Left Arm ☐
- Right Leg ☐
- Left Leg ☐

11. Do you have restricted range of motion in your limb(s)? (Yes) ☐ (No) ☐ If "yes" please describe:

_____

_____

_____

12. Do you have any *loss of sensation* in your limb(s)? Yes ☐ No ☐ If "yes" please describe:

_____

_____

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PATIENT LYMPHEDEMA HISTORY (page 2)

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) _____

_____

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PATIENT LYMPHEDEMA HISTORY (page 3)

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: _____

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PATIENT LYMPHEDEMA HISTORY (page 4)

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 _____