

## Medical History

Date \_\_\_\_\_

Name \_\_\_\_\_

D.O.B. \_\_\_\_\_

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

Right arm      Left arm      both arms      breast

Right leg      Left leg      both legs      head & neck      genital

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

**How long have you had swelling / lymphedema?** \_\_\_\_\_

**Was there a triggering event which caused the swelling / lymphedema?** \_\_\_\_\_

**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: \_\_\_\_\_

**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, where is your pain level at?



