

Centreville Physical Therapy, P.C.

Lymphedema Questionnaire

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)
 - a. Left Arm _____
 - b. Right Arm _____
 - c. Left Leg _____
 - d. Right Leg _____
10. Have you had prior treatment for lymphedema? _____
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? _____

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? _____
23. Can we 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? _____



Centreville Physical Therapy, P.C.

14631 Lee Highway, Suite 310

Centreville, VA 20120

Ph: (703) 222-5903 Fax: (703) 222-3765

Patient Name _____

MEDICAL HISTORY

Date of Birth: ____/____/____ Gender: M Right-handed
 F Left-handed

Please check if you have ever had:

- | | |
|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Arthritis (Osteoarthritis or Rheumatoid Arthritis) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Breathing / Lung Problems | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Diabetes / High Blood Sugar | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Other: _____ |

Please check if you have experienced the following symptoms in the past year:

- | | |
|---|--|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Loss of balance or falls | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Fever / Chills / Sweats |
| <input type="checkbox"/> Difficulty dressing | <input type="checkbox"/> Pain at night |
| <input type="checkbox"/> Difficulty lifting | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Nausea / Vomiting |
| <input type="checkbox"/> Joint pain or swelling | <input type="checkbox"/> Coordination problems |
| <input type="checkbox"/> Weakness in arms or legs | |

Have you ever had surgery? Yes No If yes, please describe and provide date:

Date: ____/____/____

Date: ____/____/____

Date: ____/____/____

Do you take any prescription or non-prescription medications? Yes No If yes, please list below:

Do you: Smoke ____ppd Drink alcohol ____drinks/week
 Exercise ____times/week for ____minutes

Are you currently pregnant? Yes No