Babette Maiss, CMT,CLT,CMF Brief Medical History

(to be completed by patient on intake)

Date: _____

Name: _____ **DOB:** _____

Completed by: ☐ **Patient (listed above)** ☐ **Other:**

_____

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

right arm left arm both arms breast right leg left leg both legs genital head & neck

Other, please explain: _____

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

If yes, by whom: _____

How long have you had swelling/lymphedema? _____

Was there a triggering event which caused the swelling/lymphedema? _____

_____

Please describe briefly how and why your swelling/lymphedema developed: _____

_____

_____

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 here: _____

_____

_____

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, please explain: _____

_____

Do you have any loss of function or mobility? **Yes** **No**

If yes, please explain: _____

_____

Do you have any difficulties with any of the following?

Walking	Reaching feet and toes	Preparing meals
Dressing	Bathing/showering	Other

If other, please explain: _____

_____

What is your current living situation?

Private home/apartment (alone)	Nursing home	Hospice
Home with spouse or companion	Assisted living	Other

If other, please explain: _____

Do you currently suffer from (or have you had) any of the following?

Asthma	Hyperthyroidism	Crohn's Disease
Bronchitis	Kidney failure	Diverticulitis
Difficulties breathing	Diabetes	Recent abdominal surgery
Irregular heart beat	Infections (cellulitis)	Unexplained pain
Heart edema	Sleep apnea	Deep venous thrombosis (blood clot)
Hypertension	Malignancy (cancer)	Latex allergy

Do you have any other medical problems not listed above? **Yes** **No**

If yes, please explain: _____

Are you allergic to: Latex Surgical Tape Foam Products Other

If other, please explain: _____

Are you taking any medication? **Yes** **No**

If yes, list medications and amounts here: _____

_____

At the time you are completing this, are you pregnant or is there a chance you could be pregnant?

Yes **No**

PREVIOUS TREATMENTS

Have you had previous treatment for swelling/lymphedema? **Yes** **No**

If yes, check ALL that apply:

Manual Lymph Drainage (MLD)	Compression pump	Compression garments
Compression bandaging	Flexitouch	
Lymphedema exercise	Low level laser	

If yes, please explain your experience, success, or lack of success:

_____

_____

_____

_____

Do you currently wear a compression sleeve or stocking? **Yes** **No**

If yes, how often do you wear it and how old is it?:_____

_____

Do you currently use compression at night? **Yes** **No**

If yes, please explain: _____

Do you exercise regularly? **Yes** **No**

If yes, please describe: _____

_____

Are you familiar with the National Lymphedema Network? **Yes** **No**

Are you familiar with the precautions (risk-reduction practices) for Lymphedema? Yes No

Are you a member of a breast cancer or lymphedema support group? **Yes** **No**

If yes, please describe: _____

What is the reason that you are seeking help? _____

_____

What are your treatment goals? _____

_____

_____

Is there anything else you would like to tell us at this time? _____

_____

_____