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Lymphedema Evaluation

Integumentary Physiotherapy Clinic

Please use black or blue ink only. If requested fields are unknown, please leave blank and request assitant

Patient Name	

Todays Date	

SECTION 1

For how long have you had lymphedema?	years	months
Have you ever had any lymphedema infections?	☐ yes	☐ no
Do you ever leak fluid?	☐ yes	☐ no
Do you take prophylactic antibiotics?	☐ yes	☐ no
Do you take diuretics for lymphedema?	☐ yes	☐ no
Do you take benzopyrones for lymphedema?	☐ yes	☐ no
Do you take any other drugs for lymphedema?	☐ yes	☐ no
Does anyone in your family have lymphedema?	☐ yes	☐ no

SECTION 2

Which extremety has lymphedema?	☐ left arm	☐ right arm
(check all that apply)	☐ left leg	☐ right leg
Have you had prior treatment for lymphedema?	☐ yes	☐ no
(if yes, what for? - check all that apply)	☐ surgery	
	☐ antibiotics	
	☐ compression garment	
	☐ manual lymph drainage	
	☐ pneumatic pump	

SECTION 3

Do you have bronchial asthma?	☐ self	☐ family
Do you have hypertension?	☐ self	☐ family
Do you have diabetes?	☐ self	☐ family
Do you have cardiac problems?	☐ self	☐ family
Do you have any circulatory problems?	☐ self	☐ family
Do you have kidney problems?	☐ self	☐ family
Have you ever received chemotherapy?	☐ yes	☐ no
Does patient use any tobaco products?	☐ yes	☐ no

SECTION 4

List medications currently taking	
List operations that you've had	
List any allergies	

IMPORTANT NOTICE

If you are treated at this office you will then be asked to follow a maintenance program at home consisting of:

1. Elastic sleeve or stocking worn during the day.
2. Bandaging of limb overnight.
3. Meticulous skin care to avoid infections.
4. Remedial exercises to accelerate lymph flow.

Are you prepared for such program?

Your Signature	

REFERRING PHYSICIAN

Primary Care Physician		
Physician's Phone		
Physician's Address		
Can we discuss your lymphedema case with this physician?	☐ yes	☐ no