

## \* MEDICAL HISTORY – LYMPHEDEMA \*

### History of Present Injury / Illness

**How did your swelling develop? Please specify:**

- Activities of daily living: \_\_\_\_\_
- Motor vehicle accident: \_\_\_\_\_
- Following an illness: \_\_\_\_\_
- Following a surgery: \_\_\_\_\_
- Sports: \_\_\_\_\_
- Work: \_\_\_\_\_
- Other: \_\_\_\_\_

**Have you had treatment for Lymphedema in the past?** YES NO  
If yes, when and where? \_\_\_\_\_

**Are you currently receiving Home Care Services?** YES NO

**Do you have a family history of limb swelling?** YES NO

**Have you used a Compression Pump?** YES NO  
If yes, for how long and what type? \_\_\_\_\_

**Do you wear a Compression Sleeve or Stocking?** YES NO

**Have you had a physical examination by your doctor in the past year?** YES NO

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

**Please list ANY major surgeries / hospitalizations:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

**Within the past year have you had any of the following?** YES NO

- |                                       |                                    |                                       |                                      |
|---------------------------------------|------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> CT Scan   | <input type="checkbox"/> MRI          | <input type="checkbox"/> Stress Test |
| <input type="checkbox"/> Radiation    | <input type="checkbox"/> Biopsy    | <input type="checkbox"/> Doppler / US | <input type="checkbox"/> X-ray       |
| <input type="checkbox"/> Bone Scan    | <input type="checkbox"/> EMG / NCV | <input type="checkbox"/> Spinal Tap   | <input type="checkbox"/> Other       |