

Patient Clinical History Form

Last Name: _____

Name of Lymphedema Treatment Center:

_____ Lymphedema Treatment Program
(Name of hospital or facility)

Clinical History:

Affected Extremity(ies):	_____	Right arm
	_____	Left arm
	_____	Both arms
	_____	Right leg
	_____	Left leg
	_____	Both legs

Please check the appropriate box on the left (below) pertaining to this patient's clinical diagnosis and check/circle/answer the corresponding questions.

Please complete the section with the checked box at the bottom of the form.

Secondary Lymphedema:

_____	Breast Cancer
_____	Melanoma Cancer
_____	Cervical Cancer
_____	Vulvar Cancer
_____	Other

• DATE OF CANCER SURGERY? _____/_____/_____ (MONTH/YEAR)

IF THE DIAGNOSIS WAS BREAST CANCER DID PATIENT HAVE A:
LUMPECTOMY / MASTECTOMY (circle one)

• DID PATIENT HAVE RADIATION THERAPY? YES / NO (circle one)

Secondary Lymphedema (other):

_____ Venous Insufficiency

⇒ HISTORY OF VENOUS STASIS ULCERS?	YES / NO	(circle one)
Does patient currently have any venous ulcers?	YES / NO	(circle one)
⇒ HISTORY OF POST PHLEBITIC SYNDROME?	YES / NO	(circle one)
⇒ HISTORY OF DEEP VEIN THROMBOSIS (DVT)	YES / NO	(circle one)

Primary Lymphedema:

_____	Milroy's Disease/Congenital (at birth)
_____	Lymphedema Praecox (begins in adolescence)
_____	Lymphedema Tarda (begins after 35 years old)

FOR PRIMARY AND SECONDARY LYMPHEDEMA, PLEASE ANSWER QUESTIONS BELOW

• HISTORY OF CELLULITIS/LYMPHANGITIS INFECTIONS? YES / NO (circle one)

Completed By: _____

Date: _____