We're so *swell* - you don't have to be
Compression *wear* it counts.
Specialists in Venous & Lymphatic Insufficiencies
LUNA MEDICAL, INC. · 1057 W GRAND AVENUE, SUITE 1, CHICAGO, IL 60642
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ACCREDITED BY THE JOINT COMMISSION · OFFICIAL LANA SPONSOR

PATIENT INTAKE - CLINICAL HISTORY

Patient Name: _____
Have you attended an Outpatient, Rehabilitation Lymphedema Treatment Program: ☐Yes ☐ No
Name of Hospital or Facility: _____
Name of therapist: _____ **Address:** _____ State: _____
Zip Code: _____ **Telephone:** _____

Diagnosis: ☐ I87.2 Venous insufficiency (chronic) (peripheral) ☐I89.0 Lymphedema, not elsewhere classified
☐ I97.2Postmastectomy lymphedema syndrome ☐ Q82.0 Hereditary lymphedema
☐ I97.89 Other postprocedural complications and disorders of the circulatory system, not elsewhere classified
☐ Other_____

Affected Extremity: _____
Affected Body Part (List multiple if more than one): _____

History includes Cellulitis/Lymphangitis infections: ☐Yes ☐ No

History of any Cancer: ☐Yes ☐ No (If yes, please check the boxes below. If no, please skip this step)

☐Breast ☐Melanoma ☐ Cervical ☐Ovarian ☐ Uterine ☐ Vulvar ☐ Prostate ☐Head/Neck ☐Other _____
Did you have any Surgery: ☐ Yes ☐ No
If yes, what type of surgery: _____
If Breast Cancer did you have a mastectomy or lumpectomy? Please check one of the boxes:
☐ Mastectomy ☐ Lumpectomy
Did you have any lymph nodes removed or Dissected? ☐ Yes ☐ No
If yes, please check off one the boxes: ☐Axillary Node Dissection ☐Axillary Node Removal ☐Groin Node Dissection
☐Groin Node Removal ☐Other: _____
Please provide the Month/Year of Surgery: _____/_____
Did you receive any Radiation or Chemotherapy treatment? If Yes please check the boxes:
☐Radiation Therapy ☐ Chemotherapy

History of Venous insufficiency ☐Yes ☐ No
Did you have any Surgery ☐Yes ☐ No
If yes, what type of surgery: _____

Completed By: _____ Date: _____