

Comprehensive Rehabilitation Services...to help meet life's challenges

Patient Name

Please check all that apply:

1. Referring Physician: _____ Phone: _____

2. Medical Doctor (Primary) _____ Phone: _____

3. Type's of surgery done, please down including the date's (if you have breast surgery, kindly fill up the details in No. 4) _____

4. Breast surgery: Right Side Left Side Both Lumpectomy
 Simple/Total Mastectomy Modified/Radical Axillary node dissection

5. How many lymph node's were taken? _____ of w/c how many were positive? _____

6. Have you had: Chemotherapy # of treatments? _____ Dates: _____
 Radiation # of treatments? _____ Dates: _____
 Chemotherapy Antibiotics? _____

7. Have you been hospitalized due to lymphedema/infection? No Yes

8. Do you have any pain or discomfort (please circle which) associated with your lymphedema? No Yes

Location: _____ Duration of pain or discomfort: Constant Intermittent

What kind of pain or discomfort do you feel? _____

Severity of pain or discomfort (circle one) No pain/discomfort 1 2 3 4 5 6 7 8 9 10 Severe pain/discomfort

9. Have you had previous intervention for your lymphedema? No Yes

Decongestive Therapy Therapist: _____ Duration: _____

Pump, what kind? _____ Garments, what type? _____

Diuretics _____ Other: _____

10. Have you ever had open sores on your affected limb? No Yes

11. Have you ever leaked lymph fluid? No Yes

12. Have you traveled outside the United States? No Yes

13. Have you been diagnosed or treated for HIV/AIDS? No Yes

