

LYMPHEDEMA & WOUND CARE INSTITUTE

PATIENT HISTORY

Name: _____ DOB: _____ Age: _____ Sex: _____ Date: _____

Please fill in the blanks to the best of your knowledge:

Primary Care Physician

Referring Physician:

Any other Physician Involved

Name

Name

Name

Phone

Phone

Phone

Address:

Address:

Address:

City State Zip

City State Zip

City State Zip

Surgical History:

Type of Surgery

Hospital

Date

If more space is needed please continue on the back of this paper.

Allergies:

Present Medication: (Please list ALL medicine you are taking including over-the-counter types)

Medicine

Strength

How Often

How Long/Why

Any information that pertains to your health you would like us to know about:

Patient's Signature: _____

Date: _____

MEDICAL HISTORY

Check all the following conditions you or your family has or has had at any time:

Diseases/Conditions	Self/Age	Father	Mother	Brother	Sister	Other
Alcoholism/drug abuse	___/___	_____	_____	_____	_____	_____
Anemia	___/___	_____	_____	_____	_____	_____
Asthma/Wheezing	___/___	_____	_____	_____	_____	_____
Arthritis	___/___	_____	_____	_____	_____	_____
Angina	___/___	_____	_____	_____	_____	_____
Birth Defects	___/___	_____	_____	_____	_____	_____
Bronchitis/Chronic Cough	___/___	_____	_____	_____	_____	_____
Bleeding Tendency	___/___	_____	_____	_____	_____	_____
Breast Cancer	___/___	_____	_____	_____	_____	_____
Chest Pain	___/___	_____	_____	_____	_____	_____
Cancer/Tumor	___/___	_____	_____	_____	_____	_____
Cold Numb Feet	___/___	_____	_____	_____	_____	_____
Convulsions/Seizures	___/___	_____	_____	_____	_____	_____
Cirrhosis of Liver	___/___	_____	_____	_____	_____	_____
Congenital Heart	___/___	_____	_____	_____	_____	_____
Chronic Wounds	___/___	_____	_____	_____	_____	_____
Diabetes	___/___	_____	_____	_____	_____	_____
Emphysema	___/___	_____	_____	_____	_____	_____
Epilepsy	___/___	_____	_____	_____	_____	_____
Edema/Leg Swelling	___/___	_____	_____	_____	_____	_____
Enlarged Heart	___/___	_____	_____	_____	_____	_____
Fainting Spells	___/___	_____	_____	_____	_____	_____
Gynecological Problems	___/___	_____	_____	_____	_____	_____
Heart Attacks	___/___	_____	_____	_____	_____	_____
Heart Attacks	___/___	_____	_____	_____	_____	_____
High Blood Pressure	___/___	_____	_____	_____	_____	_____
Heart Murmur	___/___	_____	_____	_____	_____	_____
Kidney Disease	___/___	_____	_____	_____	_____	_____
Leukemia	___/___	_____	_____	_____	_____	_____
Liver Disease	___/___	_____	_____	_____	_____	_____
Leg Pain When Walking	___/___	_____	_____	_____	_____	_____
Jaundice/Hepatitis	___/___	_____	_____	_____	_____	_____
Migraine	___/___	_____	_____	_____	_____	_____
Obesity	___/___	_____	_____	_____	_____	_____
Overnight Urine more 2x	___/___	_____	_____	_____	_____	_____
Sickle-Cell Anemia	___/___	_____	_____	_____	_____	_____
Stroke	___/___	_____	_____	_____	_____	_____
Shortness of Breath	___/___	_____	_____	_____	_____	_____
On Exertion ___ Lying Flat	___/___	_____	_____	_____	_____	_____
Swollen Ankles/leg/arm	___/___	_____	_____	_____	_____	_____
Thyroid Disease	___/___	_____	_____	_____	_____	_____
Tuberculosis	___/___	_____	_____	_____	_____	_____
Varicose Veins, Blood Clot	___/___	_____	_____	_____	_____	_____
Weight Loss ___ Recent	___/___	_____	_____	_____	_____	_____
Men						
Prostate Problems	___/___	_____	_____	_____	_____	_____
Women						
Date of last Pap Smear	___/___	_____	_____	_____	_____	_____
Do you wear a prosthesis	___/___	_____	_____	_____	_____	_____

PATIENT'S SIGNATURE: _____

DATE: _____

LYMPHEDEMA & WOUND CARE INSTITUTE

SOCIAL HISTORY

Circle One: **Single** **Married** **Widowed** **Divorced**

Highest grade finished in school? _____

Employed: _____ **Retired:** _____ **Disabled:** _____ **What year:** _____

If employed, what is your occupation? _____

Years of employment? _____

If not employed, what is your main source of income? _____

Type of Home? **House** _____ **Apartment** _____ **Mobile Home** _____

Do you have to walk upstairs to your home? _____

Do you have a walking aid? **Cane** _____ **Walker** _____ **Wheel Chair** _____

Have you ever smoked or chewed tobacco? **Yes** _____ **No** _____

What age did you start smoking? _____

What is your average pack per day? _____

Do still smoke? **Yes** _____ **No** _____ **Age stopped** _____

Alcohol: **Never** _____ **Occasional** _____ **Regular** _____
Beer _____ **Wine** _____ **Whiskey** _____ **Other Liquor** _____

Have you ever used recreational drugs? **Yes** _____ **No** _____
Circle one: **cocaine** **crack** **heroin** **marijuana**
 Ecstasy **amphetamines** **other**

PATIENT'S SIGNATURE: _____

DATE: _____

**LYMPHEDEMA & WOUND CARE INSTITUTE
PATIENT PSYCHOSOCIAL ASSESSMENT**

PATIENT EDEMA QUESTIONNAIRE

Please answer the following questions as fully as possible. Please circle your answer to the YES or NO questions, and provide any fill in the blank areas. (USE BACK OF PAGES TO CORRESPOND AND CLARIFY ANY ANSWERS. PLEASE NUMBER CORRESPONDING ANSWERS.)

NAME: _____

AFFECTED AREA: **right/left ARM** **right/left LEG**

1. Please give a brief description of how and why the swelling develop:

2. Have you had surgery on the affected extremity? YES NO
If so, when: _____

3. What type of surgery have you had? _____

4. How long have you had the swelling? _____

5. Have you had chemotherapy? YES NO

6. Have you had radiation therapy? YES NO

7. Have you had infection in the affected extremity? YES NO

8. Have you had previous treatment? YES NO

a. Pump? YES NO

b. Garments? YES NO

c. Other? YES NO

Explain: _____

9. Are you currently being treated for swelling? YES NO

Explain: _____

10. Family History of swelling? YES NO

11. Previous education about swelling? YES NO

12. Who referred you to the Center? YES NO

13. Have you ever had problems/diabetes? YES NO

Explain: _____

**LYMPHEDEMA & WOUND CARE INSTITUTE
PATIENT PSYCHOSOCIAL ASSESSMENT**

1. Do you have hearing problems? _____
2. Do you have difficulty reading English? _____
3. Do you have visual problems? _____
4. With whom do you live? _____
5. Who helps you with your care (groceries, driving, daily activities)? _____

6. How will you get to appointments? Do you drive yourself, does someone drive, or do you take the bus? _____
7. How has your illness wound/lymphedema affected your life and/or normal routine? _____

8. What is your expectation of this treatment at Lymphedema & Wound Care Institute? _____

9. Is there anyway we may be of assistance to you? _____

**Additional
Comments:** _____

Patient's Signature: _____ **Date:** _____