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

Sugical 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	____/____	______	______	______	______	______
Blood Clot	____/____	______	______	______	______	______
Breast Cancer	____/____	______	______	______	______	______
Chest Pain	____/____	______	______	______	______	______
Cancer	____/____	______	______	______	______	______
Cold Numb Feet	____/____	______	______	______	______	______
Congestive Heart Failure	____/____	______	______	______	______	______
Convulsions/Seizures	____/____	______	______	______	______	______
Cirrhosis of Liver	____/____	______	______	______	______	______
Congenital Heart	____/____	______	______	______	______	______
Chronic Wounds	____/____	______	______	______	______	______
Diabetes	____/____	______	______	______	______	______
Emphysema	____/____	______	______	______	______	______
Epilepsy	____/____	______	______	______	______	______
Edema/Leg Swelling	____/____	______	______	______	______	______
Enlarged Heart	____/____	______	______	______	______	______
Fainting Spells	____/____	______	______	______	______	______
Gynecological Problems	____/____	______	______	______	______	______
Heart Attacks	____/____	______	______	______	______	______
Hepatitis	____/____	______	______	______	______	______
High Blood Pressure	____/____	______	______	______	______	______
Heart Murmur	____/____	______	______	______	______	______
Jaundice	____/____	______	______	______	______	______
Kidney Disease	____/____	______	______	______	______	______
Leukemia	____/____	______	______	______	______	______
Liver Disease	____/____	______	______	______	______	______
Leg Pain When Walking	____/____	______	______	______	______	______
Migraine	____/____	______	______	______	______	______
Obesity	____/____	______	______	______	______	______
Overnight Urine more 2x	____/____	______	______	______	______	______
Sickle-Cell Anemia	____/____	______	______	______	______	______
Stroke	____/____	______	______	______	______	______
Shortness of Breath	____/____	______	______	______	______	______
On Exertion__Lying Flat	____/____	______	______	______	______	______
Swollen Ankles/leg/arm	____/____	______	______	______	______	______
Thyroid Disease	____/____	______	______	______	______	______
Tuberculosis	____/____	______	______	______	______	______
Tumor	____/____	______	______	______	______	______
Varicose Veins	____/____	______	______	______	______	______
Weight Loss___ Recent	____/____	______	______	______	______	______
M-Prostate Problems	____/____	______	______	______	______	______
W-Date of last Pap smear	___/____	______	______	______	______	______
Do you wear a prosthesis	____/____	______	______	______	______	______

PATIENT'S SIGNATURE:____ **DATE:_________________________**

SOCIAL HISTORY

Circle One: Single Married Widowed Divorced

Do you have children? Yes_______ No_______

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:**_____________________

PATIENT EDEMA QUESTIONAIRE

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 an 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. **Have you ever had problems with diabetes? YES NO**
    Explain: ____
13. **Who referred you to the Center? __________________________________**

PATIENT'S SIGNATURE: ______________________________Date:____________

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:**_____________