THE MASSAGE CLINIC
HEALTH CENTRES

Lymphedema Management – Health History

Contact Information

Please Circle: Mr. Mrs. Miss Ms. Dr. Sir

Name:_____ Address:_____

City:_____ Province:_____ Postal Code:_____

Phone # Home:_____ Work:_____ Cell:_____

Email:_____ Date of Birth: Day_____ Month_____ Year_____

Gender (please circle) Male Female

Occupation:_____ Hrs/week:_____ Work Posture:_____

Emergency Contact Name:_____Phone #:_____Relationship:_____

Medical Doctor:_____Address:_____Phone:_____

Medical Information

Have you been diagnosed with primary Lymphedema? Please circle: **Yes / No** Secondary Lymphedema? Please circle: **Yes / No**

Which areas are affected by swelling? Please circle all that apply.

Left Arm Left Leg Right Arm Right Leg Right Breast Left Breast Trunk Genitalia Neck/Face

How long have you had lymphedema?_____

Did the swelling appear suddenly or gradually?_____

If you have had **breast cancer**, please fill out this box.

Please circle affected area(s) below:

Right Breast Left Breast Bilateral Not Applicable

Lumpectomy? Please circle: **Yes / No** Mastectomy? Please circle: **Yes / No**

Surgery Date(s):_____

# of lymph nodes removed:_____ # of positive nodes:_____

If you have had surgery/treatment for other types of cancer, please fill out all that apply:

Area:_____ Surgery Date:_____

# of lymph nodes removed:_____ # of positive nodes:_____

How long after surgery (breast or other) did the swelling occur?_____

Have you undergone any of the following treatments? Please circle.

Radiation **Chemotherapy** **Hormonal** **Other:**_____

If you circled any of the above treatments, please specify how much and for which area? _____

_____

_____

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Medical Information Continued…

Have you received any of the below treatments for lymphedema? If yes, please specify dates for each.

Lymphedema Medication:_____

Combined Decongestive Therapy:_____

Compressive Garments:_____

Pneumatic Pump:_____

Surgery:_____

Other:_____

On a scale of 0 (non-existent) to 10 (most severe), please indicate a rating for the area affected by lymphedema for the following:

Pain:_____ Mobility:_____ Increased temperature:_____ Numbness:_____

Have you ever had an infection in the limb? Please indicate date(s):_____

If yes, was it treated with antibiotics? Please circle**: Yes / No** Which type?_____

Have you been hospitalized due to an infection in the limb? Please circle: **Yes / No**

Have you recently noticed any changes in the skin or nails? Please explain. _____

_____

Are any areas of the limb noticeably harder than usual?_____

Does the swelling ever decrease? If yes, what causes it to decrease?_____

_____

At Home: Do you have someone to help you with day-to-day functions? Please circle: **Yes / No**

Please fill out their name and relationship to you:_____

Patient Conditions

Please check off all that apply.

Family History							
	Arthritis		Cardiovascular		Respiratory		
Area of Complaint							
	Abdomen		Chest		Left Ankle		Left Arm
	Left Elbow		Left Foot		Left Hand		Left Hip
	Left Knee		Left Leg		Left Shoulder		Left Side of Low Back
	Left Side of Mid Back		Left Side of Neck		Left Side of Upper Back		Left Wrist
	Right Ankle		Right Arm		Right Elbow		Right Foot
	Right Hand		Right Hip		Right Knee		Right Leg
	Right Shoulder		Right Side of Low Back		Right Side of Mid Back		Right Side of Neck
	Right Side of Upper Back		Right Wrist				
Headaches							
	Chronic Daily Headache		Cluster		Headaches		Migraines
	Rebound		Sinus		Tension		
Blood							
	Anemia		Bleeding Disorder		Haemophilia		Hepatitis
	Thrombosis/Embolism		HIV/AIDS		Hypercoagulability		Polycythemia
Cardiovascular							
	Acute Coronary Syndrome		Aneurysm		Angina		Atherosclerosis
	Blood Clots		Cardiac Arrhythmia		Cardiovascular Accident		Cardiovascular Conditions
	Chronic Ischemic Heart Disease		Chronic Venous Insufficiency		Cold Feet		Cold Hands
	Congenital Heart Defect		Congestive Heart Failure		Coronary Artery Disease		Heart Attack
	Heart Disease		High Blood Pressure		Hyperlipidemia		Low Blood Pressure
	Lymphedema		Myocardial Infarction		Pacemaker		Pericarditis
	Phlebitis		Raynaud Disease		Rheumatic Heart Disease		Valve Disorders
	Varicose Veins						
Emotion & Memory							
	Alzheimer Disease		Anxiety Disorder		Mood Disorder		Schizophrenia
	Stress		Substance Use Disorder				
Endocrine							
	Acute Pancreatitis		Diabetes		Hyperthyroidism		Hypothyroidism
	Pituitary and Growth Disorder						
Gastrointestinal							
	Celiac Disease		Constipation		Crohn's Disease		Diarrhea
	Digestive Conditions		Diverticulitis		Eating Disorder		Esophageal Disorder
	Fecal Impaction		Intestinal Polyps		Irritable Bowel Syndrome		Poor Appetite
	Stomach Disorder		Ulcerative Colitis				
Hearing							
	Conductive Hearing Loss		Ear Problems		Hearing Loss		Meniere Disease
	Motion Sickness		Tinnitus		Vertigo		
Immune							
	Allergies		Anaphylaxis		Cancer		Hodgkin Lymphoma
	Infectious Mononucleosis		Leukemia		Lupus		Non-Hodgkin Lymphoma
	Rheumatoid Arthritis						

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Kidney							
	Bladder Disorder		Chronic Kidney Disease		Congenital Kidney Disease		Electrolyte Imbalance
	Kidney Stones		Renal Cysts		Urinary Incontinence		Urinary Tract Infection
Musculoskeletal							
	Amyotrophic Lateral Sclerosis (ALS)		Ankylosing Spondylitis		Arthritis		Artificial Joints/Special Equipment
	Bone Disease		Compartment Syndrome		Dislocation		Fibromyalgia
	Fracture		Gout		Hereditary/Congenital Deformity		Jaw Pain (TMJD)
	Joint Injury		Muscular Dystrophy		Myasthenia Gravis		Osgood-Schlatter Disease
	Osteoarthritis		Osteomalacia		Osteoporosis		Paget Disease
	Psoriatic Arthritis		Scleroderma		Scoliosis		Sinus Problems
	Strain/Sprain		Sciatica		Bulged Disc		Herniated Disc
Neurological							
	Brain Disorder		Brain Injury		Burning		Cerebral Palsy
	Cerebral Vascular Accident (Stroke)		Cerebral-Vascular Accident		Chronic Pain Disorder		Dizziness
	Epilepsy		Herniated Disc		Huntington Disease		Loss of Sensation
	Multiple Sclerosis		Numbness		Parkinson's		Seizure Disorder
	Shingles		Stabbing		Stroke		Tingling
	Transient Ischemic Attacks (TIA)		Vertebral and Spinal Cord Injury				
Reproductive							
	Breast Disorder		Ectopic Pregnancy		Endometriosis		Gynaecological Conditions
	Menopause		Menstrual Cycle Disorder		Ovarian Cysts/Tumors		Pelvic Inflammatory Disease
	Pregnancy		Premenstrual Syndrome		Uterine Disorder		
Respiratory							
	Asthma		Bronchitis		Chronic Cough		COPD
	Cystic Fibrosis		Emphysema		Infectious Respiratory Conditions		Respiratory Conditions
	Respiratory Tract Infection		Shortness of Breath				
Skin							
	Acne		Allergic Dermatosis		Athlete's Foot		Rash
	Bruise Easily		Chemical Burn		Herpes		UV Burn
	Hypersensitive Reactions		Infectious Skin Conditions		Melanoma/Carcinoma		Pigmentary Disorder
	Skin Irritations		Plantar's Wart		Psoriasis		Skin Conditions
	Rosaceea						
Miscellaneous							
	Insomnia		Mental Illness		Other Diagnosed Diseases		Other Medical Conditions
	Surgical Pins or Wire		Vision Loss		Vision Problems		

Authorization/Consent

Please answer the following questions, and initial beside each statement.

Are you prepared to make a commitment to the treatment program explained to you by the therapist? Please circle: **Yes / No** **Initial**:_____

If you have an arm lymphedema, the therapist will need to work on the chest area in order to provide effective care. Are you willing to consent to the treatment of your chest area? Please circle: **Yes / No** **Initial**:_____

If you have leg lymphedema, the therapist will need to work on the upper medial thigh and buttock area. Are you willing to consent to the treatment of these areas? Please circle: **Yes / No** **Initial**:_____

I have read this Case History Form and answered all the questions. The therapist may contact my referring medical doctor and I hereby give permission to do so.

Name:_____ Date:_____

Signature:_____