**HPI LYMPEDEMA**

### History of Present Illness

**Why are you here today? (Select all that apply)**

- [ ] a surgery  
- [ ] decreased mobility  
- [ ] cancer treatment  
- [ ] decreased range of motion  
- [ ] pain  
- [ ] swelling  
- [ ] weakness  
- [ ] other

Additional Comments:

**On what date did this occur?**

**Do you have pain?**

- [ ] Yes  
- [ ] No

**Which side? (Select all that apply)**

- [ ] left  
- [ ] right

**Where is this pain located? (Select all that apply)**

- [ ] neck  
- [ ] arm  
- [ ] hand  
- [ ] hip  
- [ ] ankle  
- [ ] upper back  
- [ ] lower back  
- [ ] mid back  
- [ ] leg  
- [ ] foot  
- [ ] shoulder  
- [ ] chest  
- [ ] buttock  
- [ ] genital/groin  
- [ ] mouth  
- [ ] throat

**What makes this pain worse? (Select all that apply)**

- [ ] twisting  
- [ ] sitting  
- [ ] prolonged sitting  
- [ ] overhead reaching  
- [ ] sidelying  
- [ ] chewing

- [ ] squatting  
- [ ] walking  
- [ ] bending  
- [ ] repetitive movement  
- [ ] lying on back  
- [ ] medication

- [ ] standing  
- [ ] stair climbing  
- [ ] driving  
- [ ] swallowing  
- [ ] lying on stomach

**What makes this pain better? (Select all that apply)**

- [ ] nothing  
- [ ] rest  
- [ ] heat  
- [ ] immobilization  
- [ ] pain medication  
- [ ] sitting

- [ ] ice  
- [ ] rest  
- [ ] immobilization  
- [ ] sitting  
- [ ] elevation

- [ ] standing  
- [ ] walking

**How would you describe this pain? (Select all that apply)**

- [ ] dull  
- [ ] sharp  
- [ ] aching  
- [ ] throbbing

- [ ] shooting  
- [ ] constant  
- [ ] intermittent

**Have you had any diagnostic tests done?**

- [ ] Yes  
- [ ] No

If yes, select all that apply.

- [ ] Xray
- [ ] MRI
- [ ] CT
- [ ] PET scan
- [ ] stress test
- [ ] bone scan
- [ ] doppler/US
- [ ] ankle brachial index

**Do you currently have numbness and tingling?**

- [ ] Yes  
- [ ] No

If yes, where? (Select all that apply)

- [ ] right arm
- [ ] left arm
- [ ] right leg
- [ ] left leg
- [ ] trunk/chest
- [ ] face
- [ ] neck

**Additional Comments:**
Have you experienced an unintended weight loss?  
Yes  No

If yes, how many pounds and in what time period?  

Have you experienced an unintended weight gain?  
Yes  No

If yes, how many pounds and in what time period?  

**Upper Body** - Please complete this section if you have swelling anywhere in your upper body, or a diagnosis of breast cancer.

Do you have swelling in your upper body or a diagnosis of breast cancer?  
Yes  No

Have you had any of the following?  
- [ ] partial mastectomy/lumpectomy
- [ ] sentinel lymph node biopsy
- [ ] history of breast cancer
- [ ] radiation therapy
- [ ] infection
- [ ] mastectomy
- [ ] axillary lymph node dissection
- [ ] chemotherapy
- [ ] blood clot
- [ ] wounds

If so, which side?  
- [ ] right
- [ ] left

Have you had lymph nodes removed?  
Yes  No

If yes, how many?  

Have you had reconstruction?  
Yes  No

If yes, what has been involved with this process?  
- [ ] tissue expanders
- [ ] TRAM flap
- [ ] DIEP flap
- [ ] implants
- [ ] latissimus flap
- [ ] nipple reconstruction

**Do you currently have edema?**  
Yes  No

If yes, where is the edema located?  
- [ ] right arm
- [ ] right hand
- [ ] left arm
- [ ] left hand
- [ ] upper back
- [ ] right breast
- [ ] left breast
- [ ] abdomen

If yes, when did it begin?  

How do you manage this condition currently?  
- [ ] nothing
- [ ] occupational therapy
- [ ] bandaging
- [ ] manual lymphatic drainage
- [ ] elastic taping
- [ ] physical therapy
- [ ] elevation
- [ ] compression pump
- [ ] compression garments

How have you managed this condition previously?  
- [ ] nothing
- [ ] occupational therapy
- [ ] bandaging
- [ ] manual lymphatic drainage
- [ ] elastic taping
- [ ] physical therapy
- [ ] elevation
- [ ] compression pump
- [ ] compression garments

Do you have any other symptoms?  


Lower Body - Please complete this section if you have swelling anywhere in your lower body, abdomen, and/or genitalia.

Do you have swelling in your lower body, abdomen or genitalia? [Yes] [No]

Have you had any of the following? (Select all that apply)
- [ ] prostate surgery
- [ ] vulvectomy
- [ ] history of pelvic or abdominal cancer
- [ ] radiation therapy
- [ ] blood clot
- [ ] hysterectomy
- [ ] oophrectomy
- [ ] arterial/venous bypass
- [ ] chemotherapy
- [ ] infection
- [ ] wounds

If so, which side? (Select all that apply) [ ] right [ ] left

Have you had lymph nodes removed? [Yes] [No]

If yes, how many?

Do you currently have edema? [Yes] [No]

If yes, where is your edema located? (Select all that apply)
- [ ] right leg
- [ ] right foot
- [ ] left leg
- [ ] left foot
- [ ] abdomen
- [ ] genital area

If yes, when did it begin?

How do you manage this condition currently? (Select all that apply)
- [ ] nothing
- [ ] occupational therapy
- [ ] bandaging
- [ ] manual lymphatic drainage
- [ ] elastic taping
- [ ] physical therapy
- [ ] elevation
- [ ] compression pump
- [ ] compression garments

How have you managed this condition previously? (Select all that apply)
- [ ] nothing
- [ ] occupational therapy
- [ ] bandaging
- [ ] manual lymphatic drainage
- [ ] elastic taping
- [ ] physical therapy
- [ ] elevation
- [ ] compression pump
- [ ] compression garments

Do you have any other symptoms, currently and/or within the last 2 weeks?
- [ ] urinary incontinence
- [ ] open wounds
- [ ] cellulitis
- [ ] blood clots

Additional Comments:

Head and Neck - Please complete this section if you have swelling in your head, neck or face.

Do you have swelling in the head, neck or face? [Yes] [No]

Have you had any of the following? (Select all that apply)
- [ ] neck dissection
- [ ] feeding tube
- [ ] history of head or neck cancer
- [ ] radiation therapy
- [ ] tracheostomy
- [ ] modified diet
- [ ] chemotherapy
Are you experiencing any of the following symptoms?  
Yes  No

If yes, select all that apply:
- hoarseness
- dry mouth
- thrush
- difficulty swallowing
- difficulty eating
- difficulty communicating
- hypersensitivity
- mouth infection
- decreased scar mobility
- nerve damage
- neck stiffness
- shoulder stiffness
- neck weakness
- shoulder weakness
- skin changes
- bone loss
- dental issues
- altered taste

Do you currently have any edema?  
Yes  No

If yes, where is your edema located?  
- face
- mouth
- neck

When did it begin?  

How do you manage this condition currently?  (Select all that apply)
- nothing
- physical therapy
- occupational therapy
- speech therapy
- manual lymphatic drainage
- compression garments
- elastic taping

How have you managed this condition previously?  (Select all that apply)
- nothing
- physical therapy
- occupational therapy
- speech therapy
- manual lymphatic drainage
- compression garments
- elastic taping

Addiional Comments:  

Home Environment

How would you rate your health?  
- excellent
- good
- fair
- poor

Do you exercise regularly?  
- does
- does not

How many falls have you had in the past 6 months?  
- 0
- 1 to 2
- >3

Do you use a walking aid?  
Yes  No

If yes, what?  (Select all that apply)
- cane
- walker
- rollater
- wheelchair
- crutches

What is your employment status?  
- employed
- unemployed
- retired

What do you do for a living?  


Do you live alone?  
- □ alone  
- □ with someone  

If you live with someone, in which setting do you live?  
- □ assisted living facility  
- □ nursing home  
- □ group home  
- □ private residence with caregiver/family  

Do you require assistance at home?  
- □ Yes  
- □ No  

Do you have stairs at home?  
- □ Yes  
- □ No  

If yes, how many?  
- □ 1-8  
- □ 9-15  
- □ >15  

Where is the railing as you go up the stairs?  (Select all that apply)  
- □ left  
- □ right  

Goals/Followup  

What are your goals for therapy?  

When are you scheduled to return to the doctor for follow-up?  
- □ as needed  
- □ within 1 month  
- □ after completion of therapy  

Additional Comments: