HPI LYMPHEDEMA

History of Present Illness

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

- ☐ a surgery
- ☐ cancer treatment
- ☐ decreased mobility
- ☐ 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
- ☐ squatting
- ☐ standing
- ☐ sitting
- ☐ walking
- ☐ stair climbing
- ☐ prolonged sitting
- ☐ bending
- ☐ driving
- ☐ overhead reaching
- ☐ repetitive movement
- ☐ swallowing
- ☐ sidelying
- ☐ lying on back
- ☐ lying on stomach
- ☐ chewing
- ☐ medication

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

- ☐ nothing
- ☐ rest
- ☐ ice
- ☐ heat
- ☐ immobilization
- ☐ sitting
- ☐ pain medication
- ☐ bracing
- ☐ 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
- ☐ EMG
- ☐ 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? (Select all that apply)

- ☐ partial mastectomy/lumpectomy
- ☐ mastectomy
- ☐ sentinel lymph node biopsy
- ☐ axillary lymph node dissection
- ☐ history of breast cancer
- ☐ chemotherapy
- ☐ radiation therapy
- ☐ blood clot
- ☐ infection
- ☐ wounds

If so, which side? (Select all that apply) ☐ 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? (Select all that apply)

- ☐ tissue expanders
- ☐ implants
- ☐ TRAM flap
- ☐ latissimus flap
- ☐ DIEP flap
- ☐ nipple reconstruction

Do you currently have edema? Yes No

If yes, where is the edema located? (Select all that apply)

- ☐ 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? (Select all that apply)

- ☐ nothing
- ☐ physical therapy
- ☐ occupational therapy
- ☐ elevation
- ☐ bandaging
- ☐ compression pump
- ☐ manual lymphatic drainage
- ☐ compression garments
- ☐ elastic taping

How have you managed this condition previously? (Select all that apply)

- ☐ nothing
- ☐ physical therapy
- ☐ occupational therapy
- ☐ elevation
- ☐ bandaging
- ☐ compression pump
- ☐ manual lymphatic drainage
- ☐ compression garments
- ☐ elastic taping

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)

- ☐ none
- ☐ 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
- ☐ cellulitis
- ☐ open wounds
- ☐ 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
- ☐ thrush
- ☐ difficulty eating
- ☐ hypersensitivity
- ☐ decreased scar mobility
- ☐ neck stiffness
- ☐ neck weakness
- ☐ skin changes
- ☐ dental issues
- ☐ dry mouth
- ☐ difficulty swallowing
- ☐ difficulty communicating
- ☐ mouth infection
- ☐ nerve damage
- ☐ shoulder stiffness
- ☐ shoulder weakness
- ☐ bone loss
- ☐ 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
- ☐ occupational therapy
- ☐ manual lymphatic drainage
- ☐ elastic taping
- ☐ physical therapy
- ☐ speech therapy
- ☐ compression garments

How have you managed this condition previously? (Select all that apply)

- ☐ nothing
- ☐ occupational therapy
- ☐ manual lymphatic drainage
- ☐ elastic taping
- ☐ physical therapy
- ☐ speech therapy
- ☐ compression garments

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: