Total Health
OFFERED BY STILLWATER MEDICAL CENTER

Lymphedema Assessment
405.624.6592

The information you provide is very important to your health and will help our staff determine the care you need as well as any further assessments. Please take time to fully and completely fill out this very important information.

DATE: ____ /____ /_____

NOTE: If you are currently receiving any type of home health care services, please see the receptionist before completing this form.

GENERAL INFORMATION:

NAME:	EMAIL:
HOME #:	CELL #:
REFERRING PHYSICIAN:	PRIMARY CARE PHYSICIAN:
RETURN TO DOCTOR DATE:	ONSET DATE OF SYMPTOMS:

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY

Reason for being referred to therapy:

_____

_____

LYMPHEDEMA HISTORY:

Do you have swelling? ☐ Yes ☐ No

Where? _____

Genital swelling? ☐ Yes ☐ No

If yes, when did the swelling begin? _____

What have you tried to manage the swelling?

☐ Elevation ☐ Exercise
☐ Bandaging ☐ Compression pump
☐ Compression Garment ☐ Massage
☐ Compression Wraps ☐ Other _____

What relieves/improves the swelling?

☐ Elevation ☐ Exercise
☐ Bandaging ☐ Compression pump
☐ Compression Garment ☐ Massage
☐ Compression Wraps ☐ Other _____

WOUNDS

Do you currently have any open wounds?

☐ Yes ☐ No

If yes, where is it located? _____

_____

If yes, how is the wound being treated? _____

_____

_____

_____

MEDICAL HISTORY

Blood Clot	☐ No	☐Yes – Explain _____
Cardiac Problems	☐ No	☐Yes – Explain _____
Circulation Problems	☐ No	☐Yes – Explain: _____
Diabetes	☐ No	☐Yes – Explain: _____
Falls	☐ No	☐Yes – Explain: _____
High Blood Pressure	☐ No	☐Yes – Explain: _____
Kidney Problems	☐ No	☐Yes – Explain: _____
Respiratory Problems	☐ No	☐Yes – Explain: _____
Infections	☐ No	☐Yes – Explain: _____
Neurologic Disorders	☐ No	☐Yes – Explain: _____
Stroke	☐ No	☐Yes – Explain: _____
Surgery	☐ No	☐Yes – If yes:

Circulatory System (Veins/Arteries/Cardiac) - Explain: _____

_____

_____

Orthopedic - Explain: _____

_____

_____

Abdominal - Explain: _____

_____

_____

CANCER TREATMENT

Include chemotherapy, cancer surgeries, radiation and other interventions:

	Date Intiated:	Date Completed:
Chemotherapy: _____		
Radiation Therapy: _____		
Surgery: _____		
Other Interventions: _____		

MEDICATION:

Please list your medications or attach a list:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES:

Latex Allergy: ☐ Yes ☐ No

Medication Allergies: ☐ Yes ☐ No

If yes, please list: _____

_____

_____

_____

MEDICAL TEST

Medical test within the last year: (check all that apply)

☐ ABI
☐ Angiogram
☐ Biopsy of _____
☐ Bone Scan
☐ CT Scan
☐ Bronchoscopy
☐ Echocardiogram
☐ EEG
☐ EKG
☐ Lymphscintigraphy
☐ Mammogram
☐ MRI
☐ Nerve Conduction Velocity
☐ Pap Smear
☐ PET Scan
☐ Pulmonary Function Test
☐ Stool Tests
☐ Stress test
☐ Ultrasound of Veins

PAIN ASSESSMENT

Do you have pain? ☐ Yes ☐ No

If yes, where is it located? _____

_____

Please mark areas of pain on the diagrams below.

What makes the pain better: _____

_____

_____

What makes the pain worse: _____

_____

_____

Pain Intensity:

0 1 2 3 4 5 6 7 8 9 10

< NO PAIN WORST POSSIBLE PAIN >

Duration of Pain: ☐ Constant ☐ Intermittent ☐ NA

Describe the pain: _____

_____

Numbness/Tingling/Altered Sensation? ☐ Yes ☐ No

If yes, describe: _____

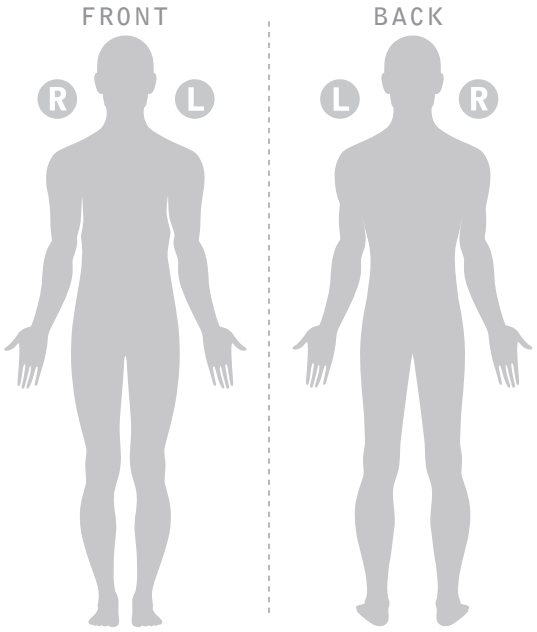
_____

_____

PAIN INDICATOR

KEY

X = Sharp Sensation
O = Numbness or Tingling
 # = Dull Aching
+ = Burning Sensation
> = Radiating Pain



ACTIVITY

Exercise:

Do you exercise beyond normal daily activities and chores?

☐ Yes ☐ No

Describe the exercise: _____

_____

On average, how many days per week do you exercise or do physical activity? _____

For how many minutes, on an average day? _____

Other:

What activities are you not able to do now that you could do before the problems started? Please be as specific as you can, for instance: "unable to wear shoes."

_____

_____

_____

Current Limitations (check all that apply)

- ☐ Difficulty or pain using hands
- ☐ Difficulty reaching feet or bending
- ☐ Transfers (moving from bed to chair; bed to toilet)
- ☐ Difficulty with self care (bathing, dressing, toileting)
- ☐ Difficulty with home management (household chores)
- ☐ Difficulty sleeping
- ☐ Difficulty with community and work activities
  - ☐ Work/School
  - ☐ Recreational/Play activity
- ☐ Changes with sensation
- ☐ Difficulty with ambulation on
  - ☐ Level Surfaces
  - ☐ Stairs
  - ☐ Ramps
  - ☐ Uneven terrain

DEMOGRAPHIC INFORMATION

Dominant Hand: ☐ Right ☐ Left

How would you rate your health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Major life changes in the past year?

☐ Yes ☐ No

If yes, describe: _____

_____

_____

Living with:

- ☐ Alone
- ☐ Spouse/Significant other only
- ☐ Spouse/Significant others
- ☐ Other relative(s) (not spouse or children)
- ☐ Group Setting
- ☐ Personal care attendant
- ☐ Child (not spouse)

Caregiver Status: Do you have a family member or friend willing and able to assist with:

- ☐ Personal care
- ☐ Housekeeping
- ☐ Dressing
- ☐ Transportation

GOALS

Patient/Family Concerns and Goals:

Please describe your goals for treatment. List them in order of importance to you.

1. _____
2. _____
3. _____
4. _____

The information I provided is true and correct to the best of my belief.

Patient Name: _____

Patient (or Legal Guardian) signature:

_____

Date: _____