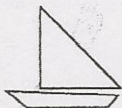

ANNAPOLIS LYMPHEDEMA THERAPY CENTER

PATIENT HISTORY

Date: ______________________ Referring Physician: ______________________

Patient: ______________ Age: ______ Surgeon: ______________________

Oncologist: ______________________ Radiation Oncologist: ______________________

MEDICAL HISTORY (Please check all that apply)

☐ Diabetes ☐ Vascular problems ☐ Respiratory Problems ☐ Hypertension
☐ Cancer ☐ Broken bones ☐ Kidney disease ☐ Pregnant ☐ History of Blood Clots
☐ Allergies ☐ Metal implant ☐ Heart disease (Type: ____________) ☐ Thyroid Disorder
☐ AIDS/HIV ☐ Pacemaker ☐ History of Lymphedema ☐ Other: ____________

Breast Surgery (Please check all that apply)

☐ Lumpectomy ☐ Simple/total mastectomy ☐ Mastectomy
☐ Right side ☐ Left side ☐ Both sides
☐ Lymph node dissection ☐ Sentinel node biopsy
Number of Lymph Nodes Removed: ________ Number of Lymph Nodes Positive: ________
Reconstruction: ☐ TRAM flap ☐ Expander ☐ Implant ☐ Other: ______________

Date of breast surgery: ______________ Date of reconstruction: ______________

Pelvic Surgery (Please check all that apply)

☐ Hysterectomy ☐ Oophrectomy ☐ Vulvectomy ☐ Other: ______________

Date of Pelvic Surgery: ______________

Dates/Description of Other Surgeries (Please list): ______________________

____

Chemotherapy: ☐ Yes ☐ No If yes, which drugs? ______________

Number of treatments: ________ Date completed: ______________

Radiation Treatment: ☐ Yes ☐ No Date completed: ______________

Please list any allergies: ______________________

List any medicines you are currently taking: ______________________

Dominant hand: ☐ Right ☐ Left Affected extremity: ☐ Right ☐ Left ☐ Arm ☐ Leg ☐ Other

PERSONAL HISTORY

Do you exercise regularly? ☐ Yes ☐ No Type of exercise: ____________ How often? ________

Do you smoke? ☐ Yes ☐ No Number of packs/day: ______________

Do you drink alcohol? ☐Yes ☐ No Number of drinks/week: ______________

Occupation: ______________ Job requirements: ______________________

Daily lifting activity: ☐ Light ☐ Moderate ☐ Heavy

Do you eat lots of salty foods? ☐ Yes ☐ No How many glasses of water do you drink daily? ________

Please list your hobbies and interests, and if they have been affected by your diagnosis.

____

2001 Tidewater Colony Drive • Suite 102 • Annapolis, Maryland 21401 • 410.266.8010 • Fax: 443.782.2498