MLD THERAPY.ca

Lymphedema Patient Health History

Date: _____

First Name: _____ Last Name: _____

Address: _____

Phone Number: _____ Date of Birth: (D) ___ (M) ____ (Y) _____

Medical Doctor: _____

Address: _____

Phone Number: _____

What type of Lymphedema has your doctor diagnosed? _____
How long have you had the diagnosis? _____
Did it appear suddenly or gradually? _____
Do you know the cause of the Lymphedema? _____
Have you been treated for cancer or malignant disease? _____when? _____
What type of treatment did you receive (indicate dates)
_____
_____

What type of treatment have you received for your Lymphedema and when?
_____
Medication?
_____
Combined Decongestive Therapy? _____
Compressive Garments: _____
Pneumatic pump: _____
Surgery: _____
Other: _____
On a scale of 1 (non-existent) to 10 (severe)
Pain: _____ Mobility: _____ Bursting: _____ Increased Temp: _____
Numbness: _____ Loss of Sensation: _____
Have you ever had an infection in the limb (date)? _____
Was it treated with antibiotics? _____ Which type? _____
Have you recently noticed any changes in: Skin_____ Nails: _____
Are any areas of the limb noticeably harder than usual?
_____
At home: Do you have someone to help you with day-to-day functions? Yes____ No___
Name: _____

Are you prepared to make a commitment to the treatment program explained to you by the therapist? YES _____ NO _____

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 and initial: YES _____ NO _____

If you have a 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 and initial: YES _____ NO _____

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

Signed: _____

Date: _____