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PATIENT QUESTIONNAIRE ONCOLOGY / LYMPHEDEMA HEALTH HISTORY

NAME: _____ **DATE:** _____

Health Information

Self-rate general health:

☐ excellent ☐ fair ☐ poor

Do you get moderate exercise in your daily routine?

☐ never ☐ 1-2 days/week ☐ 3+ days/week

Weight: _____ **Height:** _____

What is your stress level?

☐ Low ☐ Medium ☐ High

Are you seeing any other health professionals for this condition?_____

Surgical / Procedure History

☐ surgery for back/spine _____

☐ surgery for abdominal organs _____

☐ surgery for head/neck _____

☐ surgery for bones/joints _____

☐ surgery for male organs _____

☐ surgery for female organs _____

☐ chemotherapy / port

☐ radiation therapy dates/#_____

☐ lumpectomy or mastectomy: _R_____ _L_____

☐ Sentinel Lymph Node Biopsy _# removed_____ _#(+)_____

☐Breast reconstruction

☐ Lymph Node Dissection _# removed_____ _#(+)_____

☐ hormone therapy

☐ # infections/hospitalizations in the last year _____

☐ open wounds

Previous Conditions / Diagnoses

Have you ever had any of the following? (check all that apply):

☐ cancer	☐ organ or bone metastases	☐ blood clots
☐ heart problems	☐ hearing loss/problems	☐ vision/eye problems
☐ high blood pressure	☐ stroke	☐ kidney disease
☐ venous insufficiency	☐ skin burns/sensitivity from radiation	☐ irritable bowel syndrome
☐ arterial insufficiency	☐ neurologic conditions	☐ lung issues
☐ low back pain	☐ neuropathy hands/feet)	☐ acid reflux
☐ anemia	☐ osteoporosis	☐ allergies
☐ alcohol/drug problems	☐ low blood / platelet counts	☐ latex/adhesive sensitivity
☐ smoking history	☐ fibromyalgia	☐hypothyroid/hyperthyroid
☐ depression	☐ arthritic conditions	☐ headaches
☐ open wounds	☐ hepatitis	☐ diabetes

Occupational Information

Occupation: _____

☐ full time ☐ part time ☐ unemployed

☐ homemaker ☐ retired ☐ student

Work Activities (check all that apply)

☐ sitting ☐ phones ☐ heavy equip op

☐ standing ☐ mod/heavy lifting ☐ driving

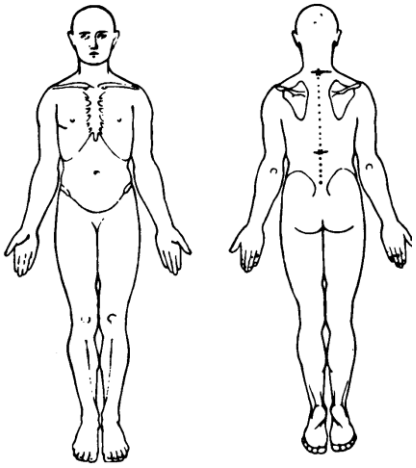
☐ computer use ☐ repetitive lifting ☐ repetitive motions

Present Condition History

1. Describe the current problem that brought you here?

_____

Mark areas of **pain, abnormal sensation, weakness** or **swelling** on the body chart below (shade in where appropriate)



2. When did your symptoms related to this problem begin? (Date of diagnosis and surgeries if applicable) _____

3. Since onset, are your symptoms getting: (check one)

☐ staying the same ☐ getting worse ☐ getting better

2. Which of the following **best** describes how your symptoms occurred? (check one)

☐ unknown	☐ trauma
☐ cancer treatments	☐ degenerative process
☐ a fall	☐ cellulitis or infection
☐ medication side effect	☐ lifting
☐ post surgery	☐ other

5. Rate your fatigue level from 0-10 (*0 being no problem and 10 being the worst*): _____

6. Nature of pain/symptoms (check all that apply)

☐ constant	☐ sharp / stabbing	☐ heavy
☐ intermittent	☐ burning	☐ tight / swollen
☐ weakness	☐ fatigue	☐ poor balance
☐ aching / throbbing	☐ memory problems	☐ numbness

7. Do your symptoms wake you at night? ☐ yes ☐ no

If yes, is it present:

☐ while lying still ☐ only when changing positions ☐ both

8. Since the onset of your current symptoms, have you had?:

☐ fever / chills	☐ numbness ☐ weakness
☐ night pain/sweats	☐ change in control of bowel/bladder
☐ unusual fatigue	☐ numbness in genital / anal areas
☐ nausea	☐ any dizziness or fainting attacks
☐ vomiting	☐ unexplained weight change
☐ headaches	☐ malaise--vague feeling of bodily discomfort
☐ swallowing trouble	☐ problems with vision / hearing

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9. Have you experienced any new or unresolved swelling since cancer treatments, surgery or, unknown cause? Yes/No: (check all regions that apply)

- ☐ none
- ☐ right arm
- ☐ right leg
- ☐ right chest/breast
- ☐ genitals
- ☐ left arm
- ☐ left leg
- ☐ left chest/breast
- ☐ neck/face

10. Previous treatments for edema (check all that apply)

- ☐ lymphatic massage
- ☐ compression wrapping
- ☐ compression garments
- ☐ exercise
- ☐ self-care
- ☐ medication
- ☐ elevation
- ☐
- ☐

11. Were those treatments effective? (circle Yes or No)

12. If no, why were those treatments ineffective?

- ☐ I could not put on compression garments
- ☐ Compression garments were too expensive
- ☐ I did not understand long term self-care

13. What relieves your edema or symptoms?: (check all that apply)

- ☐ sitting
- ☐ heat
- ☐ cold
- ☐ stretching
- ☐ lying down
- ☐ rest
- ☐ standing
- ☐ walking
- ☐ exercise
- ☐ other_____
- ☐ lymphatic massage
- ☐ medication
- ☐ elevation
- ☐ compression wrapping/garments

14. What aggravates your edema or symptoms? (check all that apply)

- ☐ sitting longer than __ minutes
- ☐ standing greater than __ minutes
- ☐ walking greater than __ minutes
- ☐ light activity (light housework)
- ☐ vigorous activity (run/lift/jump)
- ☐ with cold weather
- ☐ with hot weather
- ☐ with nervousness/anxiety
- ☐ lying down
- ☐ laughing / yelling
- ☐ talking / chewing / yawning
- ☐ going to/rising from sitting
- ☐ coughing / sneezing
- ☐ taking a deep breath
- ☐ with lifting / bending
- ☐ with sexual activity
- ☐ household activities
- ☐ no activities affect problem

15. How has lifestyle/quality of life been altered/changed because of this problem (please specify)?

- ☐ work_____
- ☐ social activities_____
- ☐ hobbies, recreation, exercise_____
- ☐ intimate / sexual activities_____
- ☐ other_____

Support Network (Circle Yes / No)

16. Do you live alone?	Yes	No
17. Are you a care giver for someone else?	Yes	No
18. Do you have family/friends that can help with your care on a daily basis?	Yes	No
19 Do you receive care from family, friends, or hired person at present with your regular activities?	Yes	No
19. Do you drive?	Yes	No
20. Do you at present use any assistive devices at home such as a walker, cane, wheel chair, raised toilet seats, splits, etc?	Yes	No
21. Have you fallen in the last year?	Yes	No
22. Are you fearful of falling?	Yes	No
23. Do you have any difficulty getting in or out of your home at present?	Yes	No

Home Program Logistics

To best tailor your home program to you check all that apply

24. I prefer a program performed inside the home	☐
25. I prefer a program performed outside the home	☐
26. I have my own home exercise equipment (aerobic machine: treadmill, recumbent bike, etc, and weights or resistance bands)	☐
27. I am willing to purchase small exercise equipment	☐
28. I am not willing to purchase small exercise equipment	☐
29. I am interested in a community group exercise program	☐

Medications

List all medications including over-the-counter, vitamins, and supplements.

Med name **Start Date** **Reason for taking**

_____
_____
_____
_____
____

Your goals or concerns for physical therapy:

_____
_____