Mankato Clinic

(Patient Label)

Patient Name:

DOB:

Age:

Date:

PHYSICAL THERAPY LYMPHEDEMA QUESTIONNAIRE

Do you currently experience swelling/lymphedema? (Please circle all that apply)
Right arm left arm both arms breast right leg left leg both legs genital head/neck

How long have you had swelling/lymphedema? _____

Was there a triggering event which caused the swelling/lymphedema? _____
_____

Have you had lymph nodes removed? □ Yes □ No
If so, how many? _____

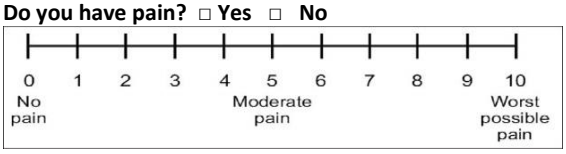
Have you ever received radiation therapy for cancer? □ Yes □ No
If yes, list area of radiation and dates here: _____
_____

Have you had chemotherapy? □ Yes □ No
If yes, how long ago? _____

Have you had any skin infections (cellulitis)? □ Yes □ No
If yes, when was the last one? _____

Is there a family history of lymphedema? □ Yes □ No
If yes, please explain: _____

Do you have pain? □ Yes □ No



Do you have any difficulties with any of the following?
□ Walking □ Dressing □ Reaching feet and toes □ Bathing/Showering □ Preparing meals □ Other
□ Functional limitation from regular routine

Are you allergic to: □ Latex □ Surgical tape □ Foam products
If other, please explain:
_____

Have you had previous treatment for swelling/lymphedema? □ Yes □ No
If yes, check all that apply:
□ Manual Lymph Drainage (MLD) □ Compression Pump □ Compression garments □ Compression bandaging
□ Flexitouch □ Lymphedema exercise □ Low level laser

Do you currently wear a compression sleeve or stocking? □ Yes □ No
If yes, how often do you wear it and how old is it? _____

Do you currently use a compression at night? □ Yes □ No

Key:

Lymphedema: /// Radiation Fibrosis: # # #

Scar(s): ÷÷÷ Numbness/tingling: *

Node removal: ◆ Pain: (0= no pain; 10=worst pain)

Radiation field: ▪