



Physical Therapy  
Occupational Therapy  
Speech Pathology

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**Lymphedema History Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Occupation: \_\_\_\_\_

Approximate date swelling first started: \_\_\_\_\_

**Gradual** or **Sudden Onset** of swelling? Circle One

Is your swelling **Getting Worse** or **Staying the Same**? Circle One

- Do you have a family history of swelling in the arms or legs? YES NO
- Does your swelling return to normal with elevation: YES NO
- Do you experience significant pain in the area of swelling? YES NO
- Do you have a history of recent or repeated infections? YES NO
- Do you experience numbness in the affected area? YES NO
- Do you feel weakness in the affected arm or leg? YES NO
- Are you in active treatment for cancer? YES NO

Type \_\_\_\_\_ Stage (if known): \_\_\_\_\_

Past or Present Treatment:

Chemotherapy Started: \_\_\_\_\_ Finished: \_\_\_\_\_

Radiation Started: \_\_\_\_\_ Finished: \_\_\_\_\_

Please List Medical History: \_\_\_\_\_

\_\_\_\_\_

Please List Current Medications: \_\_\_\_\_

\_\_\_\_\_

Please List Other Treatments you have tried previously: \_\_\_\_\_

\_\_\_\_\_

Please list any household, work, or recreational activities you are unable to perform or that take additional time to perform due to your symptoms: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Therapist Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Therapist Signature

Date