Print Form

Vascular.ae

Lymphedema Assessment Form

Patient Identification label

*Allergies: _____

PATIENT HISTORY

1. **Referring person:**

_____

_____

2. **Have you had any physical therapy for the same condition for which you are here today?** ☐ **YES** ☐ **NO**
If yes, please indication where and when:

_____

_____

3. **While you are treated with this facility, you will be asked to follow a program at home. This consists of wearing bandages 23 hours/day, meticulous skin care to avoid infections, and exercises and self massage to facilitate lymph flow. Are you prepared to follow such a program?** ☐ YES ☐ NO

4. **Do you have someone who can assist you with your home lymphedema treatment if you are unable to do it yourself?** ***(this will include bandaging the affected area(s), skin care and self massage)*** ☐ YES, ☐ NO

5. **CURRENT CONDITION(S)/CHIEF COMPLAINTS:** _____

_____

_____

6. **At what age did swelling first occur: At birth:** ☐ YES ☐ NO, **If** not at birth what year did the swelling begin? _____

7. **Did the swelling begin**: ☐ Gradually ☐ Suddenly

8. **Which area(s) is/are affected? Check all that apply**.

☐ Left arm ☐ Left leg ☐ Neck/face ☐ Breast ☐ Right arm ☐ Right leg ☐ Genitalia ☐ Trunk

9. **If you had breast cancer surgery please check/fill all that apply:** ☐ Lumpectomy ☐ Mastectomy

☐ Right ☐ Left ☐ Bilateral ☐ Not Applicable ☐ # lymph nodes removed: _____

☐ Surgery Date: _____ ☐ # positive: _____

10. **If you had surgery/treatment for other types of cancer, please check/fill that apply**: ☐ Yes ☐ No

if Yes then , Area: _____ **Surgery date**: _____

☐ # Lymph nodes removed: _____ ☐ **#Positive**: _____

11. **How long after surgery (breast or other) did your swelling begin?** _____

12. **Have you undergone any of the following treatments?** ☐ Yes ☐ None,

If 'yes' when, how much and what area? _____

13. Treatment type?	When?	How much?
☐ Radiation		
☐ Chemotherapy		
☐ Hormonal		
☐ Other		

14. **If you did NOT have cancer surgery, what do you think caused the onset of your swelling?**

☐ Infection ☐ Trauma/Injury ☐ Venous Insufficiency ☐ Post-surgery ☐ Weight gain ☐ Immobility

☐ Liposuction ☐ Primary/Congenital ☐ Post-childbirth ☐ Lipedema ☐ DVT/clot

☐ Congestive Heart Failure ☐ Others

15. **Have you had any test for this problem** : ☐ X-ray ☐ MRI ☐ Lymphoscintigraphy ☐ Doppler ☐ Ultrasound(abdominal)

16. **Labs**: ☐ eGFR , date: _____ ☐ LFT, date: _____ ☐ ECHO, date: _____

☐ Thyroid(TFT), T3: _____ T4: _____ ☐ TSH, date: _____ ☐ Others: _____

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17. **Since the first onset of your swelling have you had any infections in the affected limb(s)?** ☐ YES ☐ NO
    If yes # times: _____
18. **Ever been hospitalized to treat your infection**? ☐ YES ☐ NO
19. **If yes, # times hospitalized to treat the infection**? _____
20. **Are you currently taking preventive antibiotic?** ☐ YES ☐ NO
21. **Do you have any of the following issues in relation to your swelling?**
    ☐ Pain ☐ Numbness ☐ Limited motion ☐ Skin Changes ☐ Stiffness ☐ Heaviness ☐ Itching ☐ Weeping
22. **As a result of your edema are you having difficulties:**
    ☐ Dressing ☐ Bathing ☐ Sleeping ☐ Walking ☐ Driving ☐ Standing ☐ Sitting
23. **What decreases your swelling?** _____
24. **What increases your swelling?** _____
25. **Does your swelling ever go away?** ☐ YES ☐ NO
    If 'yes' what makes it go away? _____

TREATMENT

26. **Have you ever been treated previously for your swelling?** ☐ YES ☐ NO **If 'yes, when and how**?
    _____
27. **How are you currently managing your swelling?**
    ☐ Self-manual lymph draining ☐ Bandaging ☐ Exercise ☐ Compression garments ☐ Skin care ☐ Nothing

FAMILY HISTORY:

28. **Do you have a family history of limb swelling?** ☐ YES ☐ NO
29. **Please list any major health problems of your blood relatives**

Relationship to you	Problem/Disease	Relationship to you	Problem/Disease

30. **Current medications**(prescriptions and over the counter)

    _____

    _____

31. **Occupation**:_____
32. **Living status:** ☐ **Alone**: ☐ YES ☐ No ☐ **Live with Family**: ☐ YES ☐ No ☐ **Roommate**(s): ☐ YES ☐ No
33. **Do you use any of the following assistive devices/orthotics**?
    ☐ Cane (☐ single point, ☐ quad) ☐ Walker (type:_____ ☐ Ankle foot orthosis/brace
    ☐ Crutches ☐ Manual ☐ Power wheelchair or cart ☐ Foot orthotics/Custom shoes
34. **Where are you living?** ☐ House ☐ Apartment
35. **If your household layout is part of your concern please list the following**:_____

    _____

    # of Entry steps:
    FRONT _____ Handrail ☐ YES, ☐ NO BACK _____ Handrail ☐ YES, ☐ NO
    GARAGE _____ Handrail ☐ YES, ☐ NO BASEMENT : ☐ YES ☐ NO
    SECOND FLOOR: ☐ YES ☐ NO
36. **If your household layout is part of your concern please list the following**:_____

    _____

37. **OtherIssues:**_____

    _____

Patient Signature:_____ **Date & Time:**_____

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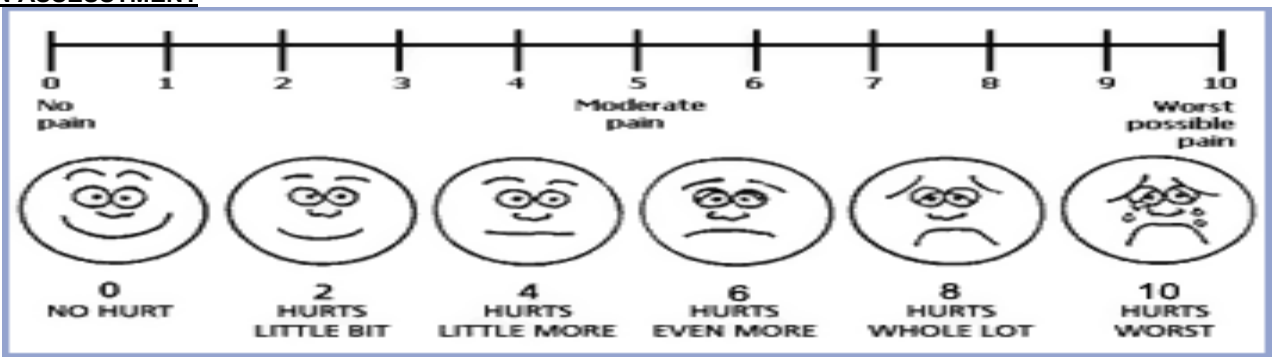
(To be Used by Physiotherapist)

REVIEW OF SYSTEMS

Constitutional	☐ Fever/chills ☐ Poor sleep ☐ Change in appetite ☐ Night sweats	☐ Fatigue ☐ HIV/AIDS ☐ Tuberculosis ☐ Wt loss/gain	☐ Cancer ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes
Ears/Throat/Nose	☐ Hard of hearing ☐ Difficulty swallowing	☐ Headaches ☐ Difficulty chewing	☐ Sore throat ☐ Difficulty talking
Cardiovascular	☐ Lightheadedness ☐ Pacemaker ☐ Poor circulation ☐ Chest pain/angina ☐ Palpitations	☐ Hypotension ☐ Fainting ☐ Hypertension ☐ Swelling in hands/feet ☐ Peripheral vasc.dis.	☐ Cardiac edema ☐ Arrhythmia ☐ Blood clot/DVT ☐ Aortic aneurysm ☐ Others
Respiratory	☐ Shortness of breath ☐ Cough	☐ Wheezing ☐ Asthma	☐ Congestive heart failure ☐ Acute bronchitis
Gastrointestinal	☐ Heartburn ☐ Diarrhea ☐ Nausea/vomiting	☐ Constipation ☐ Black tarry stools ☐ Loss of bowel control	☐ Ileus ☐ Diverticulosis ☐ Bowel inflam. conditions
Genitourinary	☐ Kidney problems ☐ Catheter program	☐ Loss of bladder control ☐ Urinary frequency/urgency	☐ Burning with urination ☐ Sexual difficulty
Musculoskeletal	☐ Joint pain/swelling ☐ Muscle spasm ☐ Osteoporosis ☐ Muscle pain	☐ Back pain ☐ Gout ☐ Muscle weakness ☐ Arthritis	☐ Infections ☐ Regional Pain syndrome ☐ Spasticity ☐ Paralysis
Neuroskeletal	☐ Numbness ☐ Tingling ☐ Weakness/paralysis	☐ Head injury ☐ Dizziness ☐ Tremors	☐ Seizures ☐ MS/MD ☐ Stroke/TIA
Psychiatric	☐ Anxiety ☐ Memory problems	☐ Depression ☐ Thinking problems	☐ Hallucinations ☐ Fluctuating emotions

PAIN ASSESSTMENT



Duration of pain: ☐ Constant ☐ Intermittent ☐ N/A **Pain Score**:_____

Site of pain:_____ **Just Started**: ☐ Yes ☐ No , **If Yes ,then How long**_____

Over all condition: ☐ Improving ☐ Worsening ☐ Static

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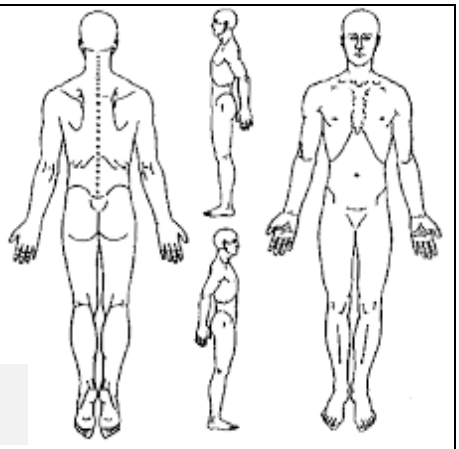
Current location of swelling



O **Swelling** ▨ Pitting ▩ Tissue Thickening

Dominant Side: upper limb R/L; lower limb R/L

Tissues in swollen area are predominantly: soft/firm

Swelling is predominantly: pitting/non pitting

Sensory changes :

Stemmer sign: **Hand:** **R+/-** **L+/-** **Foot:** **R+/-** **L** **+/-**

ABPI/ **R leg** **L leg**

RANGE OF MOVEMENT/STRENGTH (Full/Limited)

UPPER LIMB	**ROM**	**STRENGTH**	**LOWER LIMB**	**ROM**	**STRENGTH**
Neck			Hip		
Shoulder			Knee		
Elbow			Ankle/Foot		
Wrist/Hands			L/SP		

Limb Circumference Measurements		**UPPER LIMB**		**LOWER LIMB**		**Short term goals:** ☐ Reduce limb volume ☐ Improvement in edema
		R	**L**	**R**	**L**	☐Restore normal limb shape ☐Improve AROM
HAND	MCP					☐Improve Strength of UE/LE ☐Pain reduction
	Wrist					☐Patient Education-skincare, HEP, Adherence to precautions
FOOT	Midfoot					☐Other functional goals_____
	Ankle/heel					
STARTING POINT (cm)						**Long term goals:** ☐ Reduce limb volume ☐Improvement in edema
A	10 (cm)					☐ Restore normal limb shape ☐Reduce pain ☐Tissue softening
B	20(cm)					☐Improve AROM of UE/LE ☐Improve strength of UE/LE
C	30(cm)					☐Patient to be independent with self bandaging
D	40(cm)					☐Patient to be independent with lymphedema management/skin
E	50(cm)					☐Patient to be independent with home exercise programme
F	60(cm)					☐Referral for compression garment and instructions for
G	70(cm)					Donning/doffing garments
H	80(cm)					☐Other/functional goals_____
I	90(cm)					
J						

DIAGNOSIS: Primary/Secondary Lymphedema/Lipoedema: _____

ETIOLOGY: _____

Signature of Physiotherapist: _____ **Date & Time:**_____