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**Patient Intake Assessment**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_ Referring Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_ Work:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY: (Please check all that apply)**

**( ) Diabetes ( ) Vascular problem ( ) Hypertension ( ) Heart Disease**

**( ) Cancer ( ) Broken bones ( ) Pacemaker ( ) Pregnant**

**( ) Allergies ( ) Metal implants ( ) Pulmonary ( ) Kidney**

**CURRENT MEDICATIONS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***ALLERGIES/Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**( ) Chronic Venous Insufficiency**

**Breast Surgery/ Date:\_\_\_\_\_\_( ) Right side ( ) Left side ( ) Both**

**( ) Lumpectomy ( ) Simple/total mastectomy ( ) Modified/radical**

**( ) Have you had any lymph nodes removed and how many?\_\_\_\_\_\_**

**( ) Reconstruction Date\_\_\_\_\_\_\_\_\_\_**

**( ) Other surgeries, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Did you have: ( ) Chemotherapy # of treatments: \_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_**

**( )Radiation # of treatments: \_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_**

**( ) Infection Antibiotics: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Hospitalized due to infection: ( ) Y ( ) N**

**Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Do you know how the lymphedema developed? If so, describe how and why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **How long have you had lymphedema? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Have you had previous treatment for lymphedema? ( ) Yes ( ) No**

**( ) Compression Pump What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

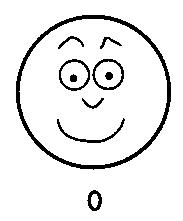
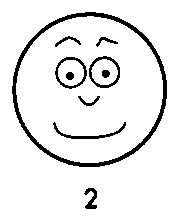
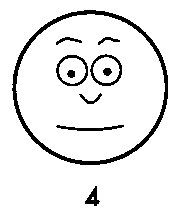
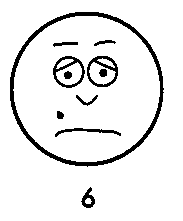
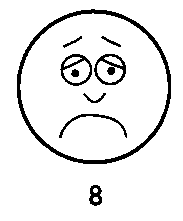
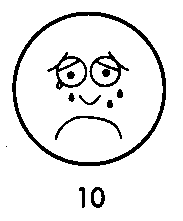
**( ) Garments What type? \_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) Diuretics\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4. Do you have any pain associated with the lymphedema?( ) Yes ( ) No**

**0 1 2 3 4 5 6 7 8 9 10**

**Current pain level\_\_\_\_\_\_ Least amount\_\_\_\_\_\_\_ At its worst\_\_\_\_\_\_\_**

**Duration of pain: ( ) Constant ( ) Intermittent**

**What kind of pain do you feel? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What relieves the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What aggravates the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5. Do you wear a compression sleeve/garment at present? ( ) Yes ( ) No**

**6. Have you ever leaked lymphedema fluid? ( ) Yes ( ) No**

**7. Have you ever had open sores on your affected limb? ( ) Yes ( ) No**

**8. What tests/studies have been done for the lymphedema\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**9. Have you recently traveled by air? ( ) Yes ( ) No**

**10. Do you exercise regularly? ( ) Yes ( ) No**

**11. Do you smoke or drink? ( ) Yes ( ) No**

***Occupational-Social***

**12. Marital status\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lives ( ) alone ( )w/spouse ( )w/family**

**Are currently employed? Yes\_\_\_\_ No\_\_\_\_ If yes, where?\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What type of work do you do?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you missed work because of this?\_\_\_\_ If yes, how much?\_\_\_\_\_\_\_\_**

**Are you able to work now? Yes\_\_\_\_ No\_\_\_**

**13. What is your daily lifting activity? ( ) Light ( ) Moderate ( ) Heavy**

**14. What is your daily walking/standing activity? ( ) Light ( ) Moderate**

**( ) Heavy**

**15. Please list your hobbies and interests and if they have been affected by the lymphedema.**

**16. Do you feel tired all the time? ( ) Yes ( ) No**

**17. Has the lymphedema affected any of your relationships?( ) Yes ( ) No**

**Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**18. Other concerns, comments, questions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**19. Are you currently receiving ANY home health services (nursing, therapy, etc)? Yes ( ) No ( )**

***Nutritional***

**Please answer the following questions by checking a “yes” or “no”**

**YES NO NA**

**I have had significant unplanned weight loss or gain recently \_\_\_ \_\_\_ \_\_\_**

**I have eaten less than ½ of my usual intake in the past 5 days \_\_\_ \_\_\_ \_\_\_**

**I have an open non-healing wound \_\_\_ \_\_\_ \_\_\_**

**I have healthy eating habits including water intake \_\_\_ \_\_\_ \_\_\_**

**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_**