Heartland Women's Healthcare

LYMPHEDEMA/BREAST CANCER PATIENT HISTORY

Name: _____

What problem brings you here? _____

_____

Type of Surgery and Date: _____

Date this problem began: _____

# of lymph nodes removed _____ # positive for cancer _____

Chemotherapy Dates: _____ Radiation Dates: _____

Do you have any work or activity related restrictions from your doctor? _____

_____

Occupation/Activity level: _____

Any difficulties with work or daily activities? ☐ No ☐ Yes _____

_____

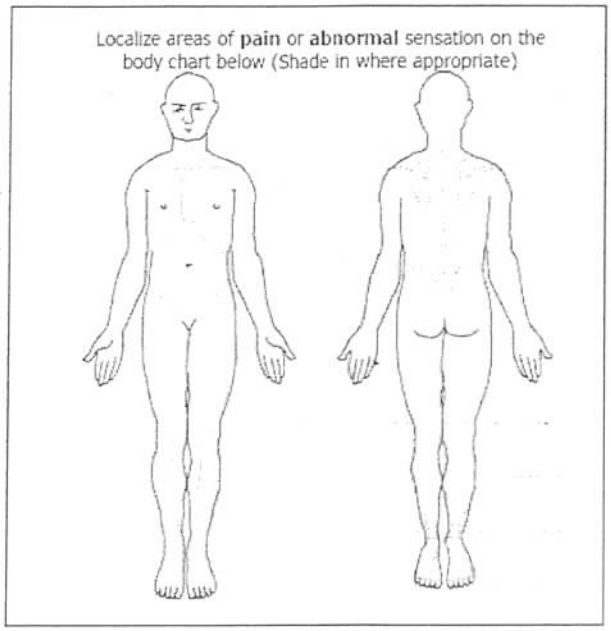
Shade in your pain area on the Body Chart and describe your pain:

Stabbing/Burning = Pins/Needles # Throbbing //

Numbness X Aching < Soreness > Sharp ||| Dull 0

Other: _____

_____



Please rate your pain intensity according to a 0-10 pain scale

(0-none 5-moderate 10- extreme agony)

Best: ____ Worst: _____ Average: _____ Now: _____

Pain worsens with: ☐ dressing ☐ housework ☐ sleeping

☐ other: _____

_____

What makes your symptoms better? _____

_____

Please list your medications: _____

_____

Your Physical Therapy Goals: _____

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____ Time: _____

MEDICAL HISTORY

Name: _____

Pregnant	**Yes/No**
Pacemaker/Defibrillator	Yes/No
Surgically Implanted Device/Metal	**Yes/No**
Cancer	Yes/No
Cardiovascular Condition	**Yes/No**
Cholesterol	Yes/No
Hypertension/Hypotension	**Yes/No**
Diabetes	Yes/No
Osteoporosis/Osteopenia	**Yes/No**
History of Falls	Yes/No
Respiratory Conditions	**Yes/No**
Recent Bowel/Bladder Changes	Yes/No
Unexplained Weight Loss	**Yes/No**
Fever, sweats, chills	Yes/No
Night Pain	**Yes/No**
Recent or Major Surgery	Yes/No
Depression, Anxiety, Psychological	**Yes/No**
Glasses/Hearing Aids	Yes/No
Latex Allergy	**Yes/No**

Hand Dominance: Right Left

Please list any other medical problems, major surgeries, illnesses or past hospitalizations: _____

_____

_____

_____

Drug/Food Allergies: _____

Recent medical tests: _____

_____

Treatments/Procedures for this diagnosis/injury: _____

Current Home Health Treatment: ☐Yes ☐No Current Chiropractic Care: ☐ Yes ☐ No

Medicare patients – Have your received therapy since January ? : ☐ No ☐ Yes If Yes, # of visits _____

Medicaid patients – Have your received therapy since July? : ☐ No ☐ Yes If Yes, # of visits _____

	Contact Physician if :
Blood Pressure_____	>160/90 or < 90/50
Resting Pulse Rate_____	> 100 or < 60 bpm
O2 Sats_____	< 90%

_____

Therapist Signature/Date/Time