PATIENT INTAKE FORM

Date:____________________

Name:____
Last First

Address:____

City:____________________________ State: _____ Zip Code: __________

Telephone (Home): ( ) ________________ Fax: ( )________________

Telephone (Office): ( ) ____________________ ext. _______

Cell Phone: ( ) ________________ Email: ____________________

Date of Birth: __________ Age: ________ Social Security No.: _____ - ____ - _______

Marital Status: ❑ Single ❑ Married ❑ Other

Referral source: ______________________________

Employer: ___________________________________

Type of Business: ____

Please describe your position, the nature of your work and your activity level on the job:

____

Name of Person to notify in case of emergency: ____________________________

Relationship: __________________________ Home Phone #: ( ) ______________

Work: ( ) _______________ ext. ______ Cell Phone: ( ) __________________

Name of Primary Care Physician: __________________________________

Specialty: ___________________________ Tel: ( ) ____________ ext. ______

Address: _____________________________ Fax: ( ) __________________

Hospital Affiliation: ____

Name of Oncologist: ______________________ Tel: ( ) ____________ ext. ______

Address: _____________________________ Fax: ( ) __________________

Nurse/Nurse Practitioner: ______________________ Tel: ( ) ____________ ext. ______

Hospital Affiliation: ____

Name of Surgeon: ________________________________ Specialty: ____________

Address: _____________________________ Fax: ( ) __________________

Hospital Affiliation: ________________________ Tel: ( ) ____________ ext. ______

Nurse/Nurse Practitioner: ______________________ Tel: ( ) ____________ ext. ______

Insurance Information

Insurance Provider:______________________________ Relation to Policy Holder:

Provider's Phone #:______________________________ ❑ self ❑ other: __________

Provider's Address #:____

Policy Holder's Name:________________ Policy Holder's ID: ______________________

Certified Lymphedema Therapist
97 New Dorp Lane, Suite D,
Staten Island, NY 10306
Phone: 718-980-5161
Fax:718-980-7068

Name: ______________________________ Date: ______________

GENERAL MEDICAL HISTORY

Do you have any of the following conditions:

- ❑ bronchial asthma
- ❑ diabetes
- ❑ hypertension
- ❑ herpes
- ❑ osteoarthritis
- ❑ rheumatoid arthritis
- ❑ HIV/AIDS
- ❑ allergies ______________________
- ❑ cardiac problems______________________
- ❑ kidney problems ______________________
- ❑ circulatory problems______________________
- ❑ vascular disorders______________________
- ❑ varicose veins (where?)______________________
- ❑ spider veins (where?) ______________________
- ❑ other ______________________

____

Are any of the following a part of your diet or lifestyle?

- ❑ caffeine
- ❑ alcohol
- ❑ salt
- ❑ smoking
- ❑ exercise ______________________

____

Do you bruise easily? Yes__ No__
where? ______________________

Medications (non-cancer related): ______

____
____
____

Surgeries (non-cancer related): ________

____
____

CANCER HISTORY

TYPE	SURGERIES	DATE(S)
❑Breast Left_____ Right_____	❑ mastectomy ❑ lumpectomy	
❑ Melanoma location: ______________		
❑ Other		

Reconstructive procedures:

____
____
____
____

Have you had or are you presently receiving **CHEMOTHERAPY**? Yes__ No__

TYPE	DATES	FREQUENCY	MODE OF INFUSION
________	________	________	Subclavian Port__ IV__
________	________	________	Subclavian Port__ IV__
________	________	________	Subclavian Port__ IV__

Do you presently have a port? Yes__ No__

Have you had or are you presently receiving **RADIATION** treatment? Yes__ No__

DATES	FREQUENCY
________	________
________	________

LYMPH NODE DISSECTIONS

TYPE	DATE	PERFORMED AS SENTINEL NODE BIOPSY?	No. NODES DISSECTED	No. NODES POSITIVE
❑ axillary	________	Yes__ No__	____	____
❑ groin	________	Yes__ No__	____	____
❑ pelvic/illiac	________	Yes__ No__	____	____

Name: ________________________________ Date: ______________

LYMPHEDEMA PROFILE

Are you seeking ❑ preventive care ❑ treatment for established Lymphedema?

Preventive Care

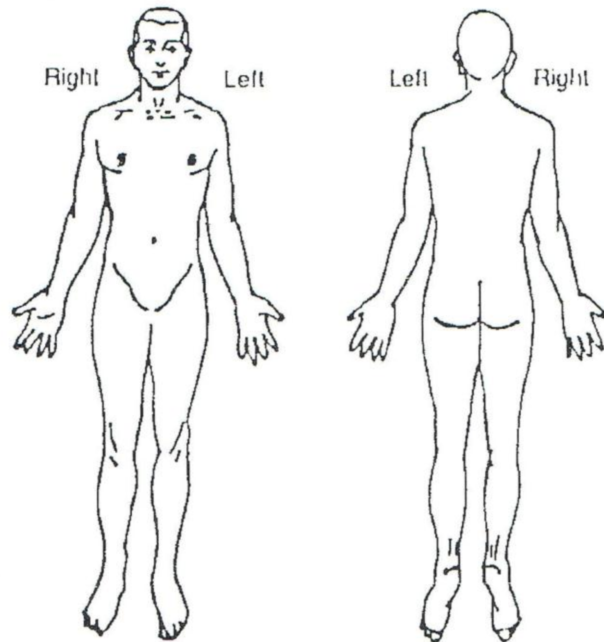
Are you experiencing any of the following symptoms in the limb at risk?

❑ heaviness ❑ heat
❑ fatigue ❑ loss of sensation
❑ fullness/distension
❑ restricted movement____________________
____
❑ pain. where? ____________________
❑ swelling. please describe: ______________
____
❑ other ____________________________
____

Established Lymphedema

Date of initial swelling: ____________
Time to date: ______________
Date first diagnosed with Lymphedema:______________
Did your Lymphedema result form any of the following?
❑ airline travel________________________
❑ extended rigorous activity______________
❑ infection____________________________
❑ insect bite___________________________
❑ trauma (e.g. accident)_________________
❑ cancer treatment______________________
❑ other_______________________________
Have you experienceed any of the following?
❑ weeping or leaking of fluid through the skin
❑ fungal infections______________________

Nature of swelling:
❑ reduces in the morning
❑ increases in the evening
❑ constant
❑ no specific pattern
❑ other ________________________



Which extremity(ies) is at risk or has Lymphedema?
❑ Left arm ❑ Right arm
❑ Left leg ❑ Right leg
❑ Other________________________

Please describe any previous **TRAUMA** to the affected extremity or limb at risk, such as fractures, dislocations, deep wounds, scars:
____
____
____
____

Does anyone in your family have primary or congenital Lymphedema? Please describe.______________________
____

Have you experienced episodes of **CELLULITIS**? Please indicate dates/frequency, symptoms of onset, and treatment received.____
____

Have you been treated for Lymphedema with any of the following?
❑ prophylactic antibiotics ❑ other medications______________ ❑ Manual Lymphatic Drainage
❑ diuretics ❑ debulking surgeries______________ ❑ compression bandaging____________
❑ Complex Decongestive Therapy ❑ pneumatic pumps
facility: ________________________________; dates of treatment: ______________________
❑ compression garments: manufacturer____________; ready-made__ custom-fit__; compression class: ________