

Lymphedema Health History

Name: _____ Date: _____ Age: _____

How long have you had swelling? _____

Signs & Symptoms *(check all that apply)*

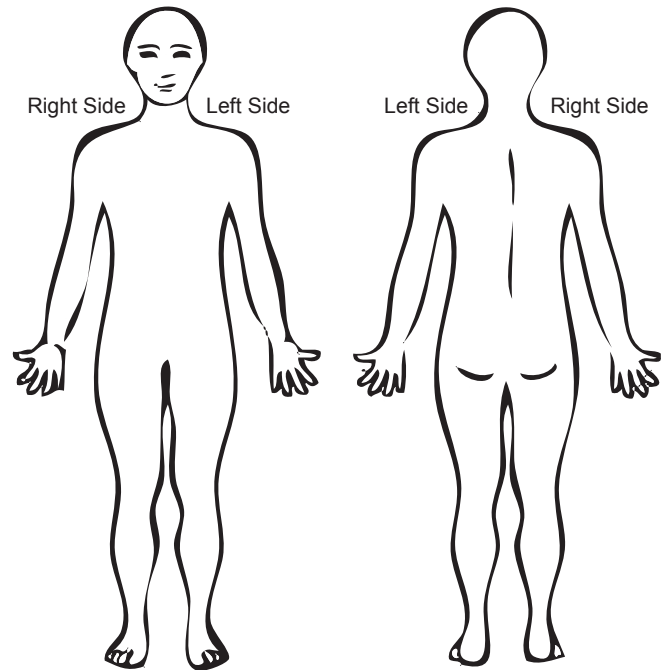
- Received prior treatment for lymphedema
- Leaking Fluid: _____
- Take Diuretics
- High Blood Pressure
- Bronchial Asthma
- Cardiac Issues: _____
- Diabetes
- Kidney Issues
- Cancer Treatment *(list why, where, what)*

- Circulation Issues: Venous Arterial
- Scars or Areas of Scarring
- Experiencing Physical Pain
- Family History of Lymphedema

Pain, Discomfort & Scarring Location(s)

Mark all the areas you are having symptoms on the drawing below.

Pain: X Swelling: O Scarring: *



Infection History *(list any infections)*

Surgical History *(include date and reason)*

Allergies *(include medication(s) and the reaction)*

Current Medications & Antibiotics *(include dose and any specific to lymphedema)*

Other Concerns or Questions

