

Compression Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Date: _____

Patients Name: _____ Date of Birth: _____

Referring Doctor: _____ Weight: _____ Height: _____

Fitter: _____

MEDICAL HISTORY

Have you ever worn compression garments before? Yes No
If yes, please list the type of brand: _____

Have you ever been diagnosed with lymphedema? Yes No
If yes, when: _____

Have you ever been treated for lymphedema by a therapist? Yes No
If yes, when: _____

Have you ever been bandaged? Yes No

Has your Therapist performed MLD "Manual Lymph Drainage"? Yes No

Any history of Chemotherapy? Yes No
If yes, when: _____

Any history of Radiation? Yes No
If yes, when: _____

Do you have a caretaker or someone to help you with the compression garments? Yes No

How long has your swelling been present? _____

When is swelling worse (time of day, certain activities, etc)? _____

What other medical problems seem to affect it (if any)? _____

What makes it better? _____

Are you currently using any alternative methods to decrease swelling (if so please list them)? _____

Check the box if you have or have had any symptoms in the following areas to a significant degree.

Blood Clots in the Legs

Pulmonary Embolism

Acute D.V.T.

Phlebitis

CHF (Cardiac Edema)

Renal Dysfunction

Hypertension

Paralysis

Diabetes

Cardiac Arrhythmia (A-V Block)

Other Heart Condition: _____

Circulation Problems

Skin Condition

Fibromyalgia

Decrease Energy Level

Stroke

Other pain/discomfort: _____

Lymph Nodes Removed: Yes No

How Many? _____