

## Health Information

### Self-rate general health:

- excellent       fair       poor

### Do you get moderate exercise in your daily routine?

- never       1-2 days/week       3+ days/week

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

### What is your stress level?

- Low       Medium       High

Are you seeing any other health professionals for this condition? \_\_\_\_\_

## Surgical / Procedure History

- |  |  |
|--|--|
| <input type="checkbox"/> surgery for back/spine                                  | <input type="checkbox"/> surgery for abdominal organs                                |
| <input type="checkbox"/> surgery for head/neck                                   | <input type="checkbox"/> surgery for bones/joints                                    |
| <input type="checkbox"/> surgery for male organs                                 | <input type="checkbox"/> surgery for female organs                                   |
| <input type="checkbox"/> chemotherapy / port                                     | <input type="checkbox"/> radiation therapy<br>dates/# _____                          |
| <input type="checkbox"/> lumpectomy or mastectomy:<br>_R_____ _L_____            | <input type="checkbox"/> Sentinel Lymph Node Biopsy<br># removed _____<br>#(+) _____ |
| <input type="checkbox"/> Breast reconstruction                                   | <input type="checkbox"/> hormone therapy   |
| <input type="checkbox"/> Lymph Node Dissection<br># removed _____<br>#(+) _____  | <input type="checkbox"/> open wounds   |
| <input type="checkbox"/> # infections/hospitalizations<br>in the last year _____ |  |

## Previous Conditions / Diagnoses

Have you ever had any of the following? (check all that apply):

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> cancer                 | <input type="checkbox"/> organ or bone metastases              | <input type="checkbox"/> blood clots                |
| <input type="checkbox"/> heart problems         | <input type="checkbox"/> hearing loss/problems                 | <input type="checkbox"/> vision/eye problems        |
| <input type="checkbox"/> high blood pressure    | <input type="checkbox"/> stroke                                | <input type="checkbox"/> kidney disease             |
| <input type="checkbox"/> venous insufficiency   | <input type="checkbox"/> skin burns/sensitivity from radiation | <input type="checkbox"/> irritable bowel syndrome   |
| <input type="checkbox"/> arterial insufficiency | <input type="checkbox"/> neurologic conditions                 | <input type="checkbox"/> lung issues                |
| <input type="checkbox"/> low back pain          | <input type="checkbox"/> neuropathy (hands/feet)               | <input type="checkbox"/> acid reflux                |
| <input type="checkbox"/> anemia                 | <input type="checkbox"/> osteoporosis                          | <input type="checkbox"/> allergies                  |
| <input type="checkbox"/> alcohol/drug problems  | <input type="checkbox"/> low blood / platelet counts           | <input type="checkbox"/> latex/adhesive sensitivity |
| <input type="checkbox"/> smoking history        | <input type="checkbox"/> fibromyalgia                          | <input type="checkbox"/> hypothyroid/hyperthyroid   |
| <input type="checkbox"/> depression             | <input type="checkbox"/> arthritic conditions                  | <input type="checkbox"/> headaches                  |
| <input type="checkbox"/> open wounds            | <input type="checkbox"/> hepatitis                             | <input type="checkbox"/> diabetes                   |

## Occupational Information

### Occupation:

- |                                    |                                    |                                     |
|------------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> full time | <input type="checkbox"/> part time | <input type="checkbox"/> unemployed |
| <input type="checkbox"/> homemaker | <input type="checkbox"/> retired   | <input type="checkbox"/> student    |

### Work Activities (check all that apply)

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> sitting      | <input type="checkbox"/> phones             | <input type="checkbox"/> heavy equip op     |
| <input type="checkbox"/> standing     | <input type="checkbox"/> mod/heavy lifting  | <input type="checkbox"/> driving            |
| <input type="checkbox"/> computer use | <input type="checkbox"/> repetitive lifting | <input type="checkbox"/> repetitive motions |

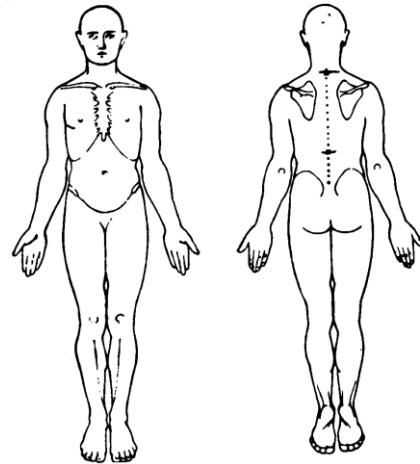
## PATIENT QUESTIONNAIRE ONCOLOGY / LYMPHEDEMA HEALTH HISTORY

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

## Present Condition History

1. Describe the current problem that brought you here? \_\_\_\_\_

Mark areas of **pain, abnormal sensation, weakness or swelling** on the body chart below (shade in where appropriate)



2. When did your symptoms related to this problem begin? (Date of diagnosis and surgeries if applicable) \_\_\_\_\_

3. Since onset, are your symptoms getting: (check one)  
 staying the same     getting worse     getting better

2. Which of the following **best** describes how your symptoms occurred? (check one)

- |   |  |
|---|--|
| <input type="checkbox"/> unknown                | <input type="checkbox"/> trauma                  |
| <input type="checkbox"/> cancer treatments      | <input type="checkbox"/> degenerative process    |
| <input type="checkbox"/> a fall                 | <input type="checkbox"/> cellulitis or infection |
| <input type="checkbox"/> medication side effect | <input type="checkbox"/> lifting                 |
| <input type="checkbox"/> post surgery           | <input type="checkbox"/> other                   |

5. Rate your fatigue level from 0-10 (0 being no problem and 10 being the worst): \_\_\_\_\_

6. Nature of pain/symptoms (check all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> constant           | <input type="checkbox"/> sharp / stabbing | <input type="checkbox"/> heavy           |
| <input type="checkbox"/> intermittent       | <input type="checkbox"/> burning          | <input type="checkbox"/> tight / swollen |
| <input type="checkbox"/> weakness           | <input type="checkbox"/> fatigue          | <input type="checkbox"/> poor balance    |
| <input type="checkbox"/> aching / throbbing | <input type="checkbox"/> memory problems  | <input type="checkbox"/> numbness        |

7. Do your symptoms wake you at night?     yes     no  
If yes, is it present:

- while lying still     only when changing positions     both

8. Since the onset of your current symptoms, have you had?:

- |   |  |                                   |
|---|--|-----------------------------------|
| <input type="checkbox"/> fever / chills     | <input type="checkbox"/> numbness                                    | <input type="checkbox"/> weakness |
| <input type="checkbox"/> night pain/sweats  | <input type="checkbox"/> change in control of bowel/bladder          |                                   |
| <input type="checkbox"/> unusual fatigue    | <input type="checkbox"/> numbness in genital / anal areas            |                                   |
| <input type="checkbox"/> nausea             | <input type="checkbox"/> any dizziness or fainting attacks           |                                   |
| <input type="checkbox"/> vomiting           | <input type="checkbox"/> unexplained weight change                   |                                   |
| <input type="checkbox"/> headaches          | <input type="checkbox"/> malaise--vague feeling of bodily discomfort |                                   |
| <input type="checkbox"/> swallowing trouble | <input type="checkbox"/> problems with vision / hearing              |                                   |

# kitsap physical therapy

9. Have you experienced any new or unresolved swelling since cancer treatments, surgery or, unknown cause? Yes/No: (check all regions that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> none               | <input type="checkbox"/> left arm          |
| <input type="checkbox"/> right arm          | <input type="checkbox"/> left leg          |
| <input type="checkbox"/> right leg          | <input type="checkbox"/> left chest/breast |
| <input type="checkbox"/> right chest/breast | <input type="checkbox"/> neck/face         |
| <input type="checkbox"/> genitals           |  |

10. Previous treatments for edema (check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> lymphatic massage | <input type="checkbox"/> compression wrapping | <input type="checkbox"/> compression garments |
| <input type="checkbox"/> exercise          | <input type="checkbox"/> self-care            | <input type="checkbox"/> medication           |
| <input type="checkbox"/> elevation         | <input type="checkbox"/>                      | <input type="checkbox"/>                      |

11. Were those treatments effective? (circle Yes or No)

12. If no, why were those treatments ineffective?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> I could not put on compression garments | <input type="checkbox"/> Compression garments were too expensive | <input type="checkbox"/> I did not understand long term self-care |
|--|--|---|

13. What relieves your edema or symptoms?: (check all that apply)

- |                                     |                                      |  |
|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> sitting    | <input type="checkbox"/> rest        | <input type="checkbox"/> lymphatic massage             |
| <input type="checkbox"/> heat       | <input type="checkbox"/> standing    | <input type="checkbox"/> medication                    |
| <input type="checkbox"/> cold       | <input type="checkbox"/> walking     | <input type="checkbox"/> elevation                     |
| <input type="checkbox"/> stretching | <input type="checkbox"/> exercise    | <input type="checkbox"/> compression wrapping/garments |
| <input type="checkbox"/> lying down | <input type="checkbox"/> other _____ |  |

14. What aggravates your edema or symptoms? (check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> sitting longer than __ minutes    | <input type="checkbox"/> laughing / yelling           |
| <input type="checkbox"/> standing greater than __ minutes  | <input type="checkbox"/> talking / chewing / yawning  |
| <input type="checkbox"/> walking greater than __ minutes   | <input type="checkbox"/> going to/rising from sitting |
| <input type="checkbox"/> light activity (light housework)  | <input type="checkbox"/> coughing / sneezing          |
| <input type="checkbox"/> vigorous activity (run/lift/jump) | <input type="checkbox"/> taking a deep breath         |
| <input type="checkbox"/> with cold weather                 | <input type="checkbox"/> with lifting / bending       |
| <input type="checkbox"/> with hot weather                  | <input type="checkbox"/> with sexual activity         |
| <input type="checkbox"/> with nervousness/anxiety          | <input type="checkbox"/> household activities         |
| <input type="checkbox"/> lying down                        | <input type="checkbox"/> no activities affect problem |

15. How has lifestyle/quality of life been altered/changed because of this problem (please specify)?

- work \_\_\_\_\_
- social activities \_\_\_\_\_
- hobbies, recreation, exercise \_\_\_\_\_
- intimate / sexual activities \_\_\_\_\_
- other \_\_\_\_\_

## Support Network (Circle Yes / No)

- |  |     |    |
|--|-----|----|
| 16. Do you live alone?   | Yes | No |
| 17. Are you a care giver for someone else?   | Yes | No |
| 18. Do you have family/friends that can help with your care on a daily basis?  | Yes | No |
| 19. Do you receive care from family, friends, or hired person at present with your regular activities?                         | Yes | No |
| 19. Do you drive?  | Yes | No |
| 20. Do you at present use any assistive devices at home such as a walker, cane, wheel chair, raised toilet seats, splits, etc? | Yes | No |
| 21. Have you fallen in the last year?  | Yes | No |
| 22. Are you fearful of falling?  | Yes | No |
| 23. Do you have any difficulty getting in or out of your home at present?  | Yes | No |

## Home Program Logistics

To best tailor your home program to you check all that apply

- |  |                          |
|--|--------------------------|
| 24. I prefer a program performed inside the home   | <input type="checkbox"/> |
| 25. I prefer a program performed outside the home  | <input type="checkbox"/> |
| 26. I have my own home exercise equipment (aerobic machine: treadmill, recumbent bike, etc, and weights or resistance bands) | <input type="checkbox"/> |
| 27. I am willing to purchase small exercise equipment  | <input type="checkbox"/> |
| 28. I am not willing to purchase small exercise equipment  | <input type="checkbox"/> |
| 29. I am interested in a community group exercise program  | <input type="checkbox"/> |

## Medications

List all medications including over-the-counter, vitamins, and supplements.

Med name	Start Date	Reason for taking

Your goals or concerns for physical therapy:

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