Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

PATIENT'S NAME _____

MED. REC. # _____

DOB _____

Patient Identification

PATIENT QUESTIONNAIRE: CHRONIC LYMPHEDEMA

Lymphatic Center

MR3379

Date: _____ / _____ / _____ Preferred language for healthcare discussions: _____

Name you would like us to use: _____ DOB: _____/_____/_____ Email: _____

Pronouns you would like us to use: ☐ She / Her / Hers ☐ He / Him / His ☐ They / Them / Theirs ☐ Other: _____

What sex were you assigned at birth? ☐ Male ☐ Female ☐ Prefer not to say

What is your current gender identity?

☐ Female ☐ Male ☐ Non-binary ☐ Genderqueer ☐ Genderfluid
☐ Transgender Female / Transwoman / Transfeminine ☐ Transgender Male / Transman / Transmasculine
☐ Questioning / unsure ☐ Prefer not to say ☐ Other: _____

Age: _____ Height: _____ feet _____ in Weight: _____ lbs Body Mass Index (BMI): _____

How did you hear about us? (*Check all that apply*):

☐ Referring Provider: Name: _____
Hospital / Office: _____

☐ Boston Lymphatic Symposium ☐ LE&RN Centers of Excellence Website

☐ Word of Mouth ☐ Recommended by another patient ☐ News article (specify): _____

Pharmacy: Name: _____ Address: _____

Pharmacy phone number: _____

Reason for referral (*Check all that apply*): ☐ Lymphedema related ☐ Non-lymphedema related ☐ Unsure

Location: Leg: ☐ Left ☐ Right Arm: ☐ Left ☐ Right Breast: ☐ Left ☐ Right
☐ Pelvis ☐ Other: _____

PART 1: CAUSE OF LYMPHEDEMA

☐ **I am unsure if I have lymphedema**.
(*Skip to* **PART 2: UNDERSTANDING SYMPTOMS)**

Lymphedema may or may not be caused by a previous cancer treatment. To your best knowledge, is the lymphedema (*Choose one*):

☐ **Cancer Related** (*Answer below*) ☐ **Not Cancer Related** (*Skip to* **Not Cancer Related**)

Cancer Related:

What type of cancer? _____

Did you receive any surgical treatment? ☐ **No** ☐ **Yes**

If Yes, what type of procedure did you have? _____

Last surgical treatment **Date:** _____/_____/_____

Which side of the body? ☐ Left ☐ Right

Number of lymph nodes removed: _____ ☐ Unknown ☐ N/A

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PART 1: CAUSE OF LYMPHEDEMA (Continued)

Did you receive any of the following treatment(s) (*Check all that apply*):

- ☐ Radiation therapy Last treatment **Date:** _____/_____/_____
- ☐ Chemotherapy Last treatment **Date:** _____/_____/_____
  - Do you have a history of numbness or tingling with chemotherapy? ☐ **No** ☐ **Yes**
- ☐ Hormone therapy Last treatment **Date:** _____/_____/_____
- ☐ Reconstructive surgery Last treatment **Date:** _____/_____/_____
- ☐ None – I did not receive any of the treatments listed above.

When did you develop lymphedema? **Date:** _____/_____/_____

Did you receive all of your cancer care and treatment at Beth Israel Deaconess Medical Center (BIDMC)?

☐ **Yes** ☐ **No:** What other hospital(s) / clinic(s) have you received care? _____

_____

Please bring any records of the cancer care you received outside of BIDMC to your next appointment.

<u>Not Cancer Related</u>:

Age when you were first diagnosed with lymphedema: _____

What was the cause of the lymphedema (*Check all that apply*):

- ☐ Infection (for example: filariasis)
- ☐ Congenital (I was born with it)
- ☐ Non-cancer surgery (*Describe*): _____
- ☐ Other: _____

PART 2: UNDERSTANDING SYMPTOMS

Do you have any of the following symptoms? *Check either "**No**" or "**Yes**" for each of the following.*

	No	Yes
Fatigue	☐	☐
Can't fit into clothing	☐	☐
Numbness / tingling	☐	☐
Heaviness	☐	☐
Achiness	☐	☐
Pain	☐	☐
Tightness	☐	☐

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PART 2: UNDERSTANDING SYMPTOMS (Continued)

Swelling: ☐ **No** ☐ **Yes:** Does swelling improve when your arm or leg is raised? ☐ **No** ☐ **Yes**

Have you ever had other swelling in your body that went away? ☐ **No** ☐ **Yes:** where: _____

Infection: ☐ **No** ☐ **Yes:** Where does the infection start? _____

How often does the infection happen? _____

What type of treatment or care do you need when an infection happens? _____

Do you take any antibiotics to treat the infection? ☐ **No** ☐ **Yes**

How long have you had these symptoms?

☐ Less than 6 months ☐ 6 months to 1 year ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 4 years
☐ 4 to 5 years ☐ 5 to 10 years ☐ 10 to 15 years ☐ More than 15 years

Location of symptoms (what areas bother you the most): _____

Have you received physical therapy treatments? ☐ **No** ☐ **Yes** **If Yes**, (*Check all that apply*):

☐ Manual lymphatic drainage ☐ Compression wraps / sleeves ☐ Exercise

☐ Pneumatic devices ☐ Gauntlet ☐ Other: _____

Name of occupational / physical therapist: _____

Have you received any other treatment(s) for your symptoms (for example: medicines, acupuncture, etc.)?

☐ **No** ☐ **Yes** **If Yes**, *list*: _____

Which is your dominant hand (for example: which hand do you write with?):

Choose one: ☐ Left ☐ Right ☐ Ambidextrous (both hands)

Are you currently working? ☐ **No** ☐ **Yes** **If Yes:** ☐ Full time ☐ Part time

What is your current job: _____

Have these symptoms affected your job? ☐ No ☐ Yes **If Yes,** *(Describe):* _____

_____

GOALS

Being there is no cure for Lymphedema, what are a few goals for your visit? We want to make your experience successful one. Below, you will find six of the most common goals. Let us know your top 3 goals. Put a "1" next to your first goal, "2" next to your second goal, and "3" next to your third goal.

____ Reduce time or level of compression
____ Prevent condition getting worse
____ Fit into clothing better
____ Improve the look of your arm or leg
____ Prevent Infections
____ Improve symptoms (e.g. heaviness, tightness, achiness)

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MEDICAL HISTORY

*Check either "**No**" or "**Yes**" for each of the following. For each "**Yes**", leave a comment.*

	No	Yes	Comment:
HIV / AIDS	☐	☐	_____
Diabetes	☐	☐	_____
Asthma	☐	☐	_____
Lung disease	☐	☐	_____
Heart murmur	☐	☐	_____
Anemia / abnormal bleeding	☐	☐	_____
Thyroid disease	☐	☐	_____
Hepatitis / liver disease	☐	☐	_____
Arthritis	☐	☐	_____
High blood pressure	☐	☐	_____
Heart disease / angina / chest pain	☐	☐	_____
Kidney disease	☐	☐	_____
Depression / anxiety	☐	☐	_____
Skin cancer	☐	☐	_____
Other type of cancer	☐	☐	_____
Other health problems	☐	☐	_____
Have you ever had a blood clot(s)?	☐	☐	_____
Have you ever used a blood thinner?	☐	☐	_____
Have you ever had a blood transfusion?	☐	☐	_____

ADDITIONAL SURGICAL HISTORY

Have you ever had any other operations or surgical procedures? ☐ **No** ☐ **Yes** **If Yes,** list below.

Date:	Operation / Procedure:	Date:	Operation / Procedure:
____/____/____	_____	____/____/____	_____
____/____/____	_____	____/____/____	_____
____/____/____	_____	____/____/____	_____
____/____/____	_____	____/____/____	_____
____/____/____	_____	____/____/____	_____
____/____/____	_____	____/____/____	_____

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ALLERGY

☐ **I have no allergies or sensitivities that I know of.** ☐ **Yes If Yes,** list below.

Allergy / Sensitivity / Medication Reaction:	**Type of Reaction:**
Latex: _____	_____
Medicines: _____	_____
Contrast / dye: _____	_____
Vaccines: _____	_____
Food: _____	_____
Other: _____	_____

MEDICATION

☐ **I take no medications or supplements.** ☐ **See attached list.**

List all the prescription and over-the-counter medications that you take at home (such as cold medication, herbals, vitamins, nutritional supplements or hormones). If you have received a printed medication list, please add here anything that is not on your printed list.

Medication / Supplement Name:	**Dose:**	**How you take it:** (by mouth, injection, etc.)	**Time of day / How often:**	**Why you take it:**

FAMILY HISTORY

Have any of your blood relatives had the following?

	Unknown	**No**	**Yes**		**If Yes**, explain who:
Breast cancer	☐	☐	☐	:	_____
Ovarian cancer	☐	☐	☐	:	_____
Melanoma (skin cancer)	☐	☐	☐	:	_____
High blood pressure	☐	☐	☐	:	_____
Depression	☐	☐	☐	:	_____
Heart disease	☐	☐	☐	:	_____
Stroke	☐	☐	☐	:	_____
Diabetes	☐	☐	☐	:	_____
Kidney disease	☐	☐	☐	:	_____
Blood clots	☐	☐	☐	:	_____
Swelling	☐	☐	☐	:	_____

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SOCIAL HISTORY

Ethnicity *(Choose one)*: ☐ White ☐ Black or African American ☐ Asian ☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaskan Native ☐ Multi-racial
☐ Unknown ☐ Other (specify): _____

Cigarette Smoking (*Check all that apply*): ☐ Never smoker (*Skip to **next question***)
☐ Unknown if ever smoked ☐ Smoker, current status unknown
☐ Former smoker: ☐ Less than 10 per day ☐ 10 or more per day # of yrs: ___
☐ Current smoker: ☐ Less than 10 per day ☐ 10 or more per day ☐ Everyday ☐ Some days # of yrs: ___

Do you use any nicotine products? ☐ No ☐ Yes **If Yes**, how often: ☐ Everyday ☐ Some days

Type (*Check all that apply*):
☐ Patches ☐ Gum ☐ Vape ☐ E-cigarettes ☐ Hookah ☐ Other: _____

Drugs: Do you use, or have you ever used, recreational drugs? ☐ No ☐ Yes **If Yes,** *(Check all that apply):*
☐ Marijuana ☐ Opioids ☐ Heroin ☐ Cocaine
☐ Other: _____ How often: _____

Alcohol: Do you drink alcohol? ☐ No ☐ Yes **If Yes,** how many drinks per week: ___ # of yrs: ___

PERSONAL SAFETY

Do you ever feel afraid in any of your relationships? ☐ Yes ☐ No
Do you feel physically and emotionally safe where you currently live? ☐ Yes ☐ No
Would you like to speak to a Social Worker Advocate about your personal safety? ☐ Yes ☐ No
(Center for Violence Prevention & Recovery (CVPR): 617-667-8141)

Patient Certification: I have answered these questions to the best of my ability. I understand that this information will be used to guide my care.

X_____ _____ **OR**
Patient's Signature Print Name

X_____ _____ **and** _____
Signature of Person authorized to sign for patient Print Name Relationship to patient

Date: ___ / ___ / ___ **Time:** __ __ : __ __ ○ a.m. ○ p.m.