



**WOMEN'S CHOICE PHYSICAL THERAPY**

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**BREAST CANCER AND EDEMA QUESTIONNAIRE**

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

**AGE:** \_\_\_\_\_ **WORKING?:** \_\_\_\_\_

**CHILDREN AT HOME?:** \_\_\_\_\_

**MEDICATIONS:** \_\_\_\_\_

**GENERAL MEDICAL HYSTORY:** Check all that apply

<input checked="" type="checkbox"/> GENERAL	<input checked="" type="checkbox"/> PAIN	<input checked="" type="checkbox"/> OB/GYN	<input checked="" type="checkbox"/> SURGERIES
Anxiety	Arm	Pregnancies _____	Heart
Arthritis	Shoulder	Vaginal delivery:	Orthopedic
(Rheumatoid)	Chest/breast		Cancer-not breast
Depression	Neck	C-sections: _____	Abdominal
Diabetes	Back	“Falling out” feeling	Other:
Dizziness	Abdomen	Cystocele	
Fibromyalgia	Pelvis	Rectocele	
Heart Disease	Hip	Vaginal surgery:	
High blood press.	Knees	Hysterectomy – vag.	<b>Please list any</b>
Kidney disease	Ankle/foot	Hyst. - abdominal	<b>Other relevant</b>
Liver disease	Other:	Ovaries removed	<b>Medical history:</b>
Lung disease	No Pains	Vaginal cream	
Multiple Sclerosis	<b>BOWEL AND BLADDER</b>	Hormone replacement	
Muscle/Tendon	Leaking urine	PMS/menstrual pain	
Orthopedic	IBS		
Osteoporosis	Constipation	Stuck/pain scar	
Pacemaker	Diarrhea		
Parkinson’s	Bladder surgery		
Physical/Sex abuse			
Skin Disorder			
Stroke			

**BREAST CANCER HISTORY:**

**Surgery date:** \_\_\_\_\_

**Surgery:** \_\_\_ Lumpectomy \_\_\_ Simple Mastectomy \_\_\_ Modified Radical  
\_\_\_ Radical

**Lymph Nodes Taken:** \_\_\_yes \_\_\_no  
# of nodes Taken \_\_\_\_\_ # Positive \_\_\_\_\_

**Radiation** (type, when performed, still undergoing?)  
\_\_\_\_\_

**Chemo:** (drug, still receiving?) \_\_\_\_\_

**Swelling/Edema:**  
Where: \_\_\_\_\_  
When did it start? \_\_\_\_\_  
How did it start – any event? \_\_\_\_\_  
Is it getting: \_\_\_ Better \_\_\_ Worse \_\_\_ Staying the same

Previous Treatments ( P.T., bandages, pumps) \_\_\_\_\_

Were they effective? \_\_\_\_\_

**Daily Activities:**  
How is this impacting your daily life, work, etc?  
\_\_\_\_\_  
\_\_\_\_\_

**How would you describe your general health now?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What are your goals in coming to physical therapy?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Anything else you need your therapist to know?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_