Custom Fit Therapies

Compression Garment Fitting
Lymphedema Management

Custom Compression Garment Fitting and Treatment Questionnaire

Name: ____ Date: ______________________

History: (Circle all that apply) Date of BC Diagnosis: ____________________ Surgery: ______________

Type of surgery: Mastectomy Lumpectomy Auxiliary Node Dissection

Prostrate Ovarian Other: ________________________________

Treatment: Radiation: Completion Date: ____________________________________

Chemotherapy: Completion Date: ____________________________________

Tamoxifen: Taxol:

Reconstruction Surgery: Yes No Date (or scheduled date): _______________________

Type: ______________________________ Surgeon: ____________________________________

Phone: _______________________

Lymphedema Treatment: Date of onset: _______________ Date of treatment: _______________________

What other alternative treatments or therapies have you participated in since cancer diagnosis? (Please provide practitioner & phone number)

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What physical activities have been limited by the onset of Lymphedema?

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Describe your compliance with compression bandaging? Good Difficult Impossible

Have you experienced any skin conditions? No / Yes Describe:

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How would you describe you Lymphedema symptoms:

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Do you have any concerns regarding the compression garment or any other issue?

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