MIDWEST COMPRESSION
Pneumatic Compression Devices

Compression Pump Intake Form

Please fill out the following information to the best of your ability. Answer only those questions that are applicable to you.

Name:_____ **Birthdate:**___/___/_____ **Date:** ___/___/_____

Referring Physician: _____ **Reason for visit:** _____

SOCIAL HISTORY

Home Environment: ☐ Apartment ☐ One story home ☐ Multi-level home ☐ Assisted living/Nursing Facility
☐ Lives alone ☐ Lives with_____ ☐ Other:_____

Occupation: ☐ Retired ☐ Employed as_____ ☐ Other:_____

Leisure Activities/Hobbies:_____

Do you have any limitations in range of movement? *Yes / No* What are they?_____

Do you have any limitations in doing your daily activities because of your condition? *Yes / No*

If yes, what are they?_____

Do you require assistance with getting washed/dressed? *Yes / No*

CURRENT and PAST MEDICAL HISTORY (Check all that apply)

☐ Infection in affected limb/area *(ie. Cellulitis)* *If current, are you taking antibiotics: Yes / No*	☐ Blood Clot / Pulmonary Embolism *Where?*_____*When?*_____
☐ Aortic Aneurysm	☐ Epilepsy / Seizure Disorder
☐ Arthritis: *Osteo Rheumatoid Gout*	☐ Kidney Problems
☐ Asthma / COPD / Respiratory Problems	☐ Thyroid Problems: *Hyper/High Hypo/Low*
☐ Blood Pressure: *High Low Controlled*	☐ Pregnancy *C-Section(s): Yes / No*
☐ Cancer: *Where*_____	☐ Stroke *When?*_____
☐ Circulatory Problems: *Arterial Venous* *Raynaud's syndrome Varicose Veins*	☐ Connective Tissue Disorder (*ie. Lupus, scleroderma, etc.)*
☐ Diabetes: *Controlled Uncontrolled*	☐ Gastrointestinal (GI) Problems
☐ Heart Problems: ☐ *Congestive Heart Failure: When?*_____ ☐ *Heart Attack: When?*_____ ☐ *Bypass surgery / Stents: When?*_____ ☐ *Irregular heartbeat / A-fib* ☐ *Pacemaker*	☐ Surgeries: *List type and date:* _____ _____ _____ ☐ Depression / Anxiety ☐ Hearing or Vision Problems
☐ Infections/Chronic Diseases *(ie. Hepatitis, TB, HIV/AIDS)*	☐ History of fractures, burns, or other injuries to affected limb(s)/area: *Yes / No*
☐ Pain Syndrome: *RSD/Chronic Regional Pain Syndrome* *Shingles* *Neuropathy: Where?*_____ *Other:*_____	☐ Other health conditions/problems not listed: _____ _____ _____

If you have a history of cancer:

Type:_____ Location:_____ Surgery? *Yes / No*

If surgery, type of surgery/date(s):_____ Reconstruction? *Yes / No*

Lymph nodes removed? *Yes / No* _____# of nodes removed _____# of nodes positive for cancer

Have you had: Chemotherapy: *Yes / No* *If yes, dates:*_____

Radiation: *Yes / No* *If yes, # of treatments:*_____ *Date completed:*_____

List all current Medications and Allergies: ☐ *See attached list* ☐ LATEX ALLERGY ☐ ADHESIVE ALLERGY

_____

_____

EDEMA/LYMPHEDEMA HISTORY

Do you have swelling? *Yes / No* Location of swelling: _____

When did your swelling begin?_____ Does it go down at night? *Yes / No*

What makes it worse?_____ Better?_____

Have you had previous treatment for your swelling? *Yes / No* *When/Where?*_____

Do you use, or have you used, any of the following to manage your swelling:

☐ Compression garment (ie. socks, sleeve, etc.)	☐ Diuretics/ "water pills"
☐ Compression pump	☐ Elevation/Exercise
☐ Bandaging, self-massage	☐ MLD Manual Lymphatic Drainage

Do you have any wounds? *Yes / No* Where?_____

Who is currently treating your wounds? _____

OTHER INFORMATION

Do you have any pain? *Yes / No* If yes, where? _____ Duration of pain: *Constant* *Intermittent*

Severity of pain (Circle selection: 0=no pain, 10=worst possible): 0 1 2 3 4 5 6 7 8 9 10

Describe the pain: _____

What makes your pain better? _____ What makes your pain worse? _____

How do you rate your overall health status: ☐ Excellent ☐ Very good ☐ Fair ☐ Poor

How do you learn best? ☐ Reading ☐ Listening ☐ Demonstration ☐ Pictures ☐ Other_____

What are your goals for therapy?_____

Do you have any family/friends that can help you with therapy if needed? *Yes / No*

Are you being treated by any other medical professionals? *Yes / No*
If Yes, please list: _____

Are you <u>currently</u> receiving Home Health Services (ie. Home nurse, therapist, nursing aide)? Yes / No

Patient Signature:_____ **Phone:**_____ **Email:** _____