PATIENT MEDICAL HISTORY

LIPOEDEMA SURGICAL SOLUTION

PERSONAL DETAILS:

TITLE (circle): MS MR MRS DR PROF UNSPECIFIED

SURNAME:		FIRST NAME:		DOB:	
STREET:		SUBURB:		P/CODE:	
MOBILE:		HOME:		EMAIL:	

TYPES OF COVER:

MEDICARE:		REF NO:		EXPIRY:	
DVA GOLD CARD:		CONCESSION CARD NO.:			
PRIVATE HEALTH INSURER:		POLICY NO.:			
		LEVEL:		EXCESS:	

NEXT OF KIN:

NAME:		RELATIONSHIP:		MOBILE:	
ADDRESS:		SUBURB:		P/CODE:	

YOUR HEALTHCARE TEAM: please provide details of all doctors or therapists who care for you, including physios, MLD therapists, podiatrist, dieticians etc. By providing the contact details of your health care team, you give our Doctors permission to contact them and keep them informed regarding your condition / treatments.

PRIMARY GP

GP NAME:		GP CLINIC:			
ADDRESS:		SUBURB:		P/CODE:	

DOCTORS & THERAPIST (OTHER THAN PRIMARY GP):

NAME:		PROFESSION:		CLINIC:	
ADDRESS:		SUBURB:		P/CODE:	
NAME:		PROFESSION:		CLINIC:	
ADDRESS:		SUBURB:		P/CODE:	
NAME:		PROFESSION:		CLINIC:	
ADDRESS:		SUBURB:		P/CODE:	
NAME:		PROFESSION:		CLINIC:	
ADDRESS:		SUBURB:		P/CODE:	
NAME:		PROFESSION:		CLINIC:	
ADDRESS:		SUBURB:		P/CODE:	
NAME:		PROFESSION:		CLINIC:	
ADDRESS:		SUBURB:		P/CODE:	

HOW DID YOU HEAR ABOUT US?

FACEBOOK / INSTAGRAM / GOOGLE SEARCH / FRIEND / WORD OF MOUTH / DOCTOR REFERRAL / THERAPIST REFERRAL / DIGITAL BILLBOARD / SIGNAGE / MAGAZINE / NEWSPAPER / EDUCATION EVENT /

WHEN DID YOU FIRST HEAR ABOUT LIPOEDEMA? ____________________

ARE YOU PART OF ANY FACEBOOK GROUPS OR FORUMS ABOUT LIPOEDEMA? IF SO, WHICH ONES? ____________________

SOCIAL HISTORY

RELATIONSHIP STATUS: **LIVING ARRANGEMENTS:**

EMPLOYMENT STATUS: **OCCUPATION:** _____

HAVE YOU EVER SMOKED: **DO YOU TAKE RECREATIONAL DRUGS:** YES / NO

IF YES, HAVE QUIT:
WHEN DID YOU QUIT: _____

IF YES, WHICH DRUGS? _____

IF YOU STILL SMOKE, HOW MANY CIGARETTES PER DAY? _____

DO YOU DRINK ALCOHOL? YES / NO

IF YES HOW MANY PER DAY? _____

HOW MANY PREGNANCIES HAVE YOU HAD? _____ **DO YOU HAVE CHILDREN?** YES / NO

HOW MANY MISCARRIAGES HAVE YOU HAD? _____ **IF YES HOW MANY CHILDREN?** _____

DO YOU PLAN ON FALLING PREGNANT? YES / NO

IF YES, WHEN: _____

HOW MUCH DOES THE APPEARANCE OF YOUR LEGS CONCERN YOU? 0 1 2 3 4 5 6 7 8 9 10

HOW MUCH DOES THE APPEARANCE OF YOUR ARMS CONCERN YOU? 0 1 2 3 4 5 6 7 8 9 10

IS THE COSMETIC APPEARANCE YOUR LIMBS THE MOST IMPORTANT CONSIDERATION FOR YOUR APPOINTMENT? YES / NO

IF NOT, PLEASE EXPLAIN THE MOST IMPORTANT CONSIDERATION: _____

DO YOU SUFFER FROM ANY SPECIFIC PAIN? KNEE PAIN | CALF PAIN | ANKLE PAIN | BACK PAIN | JOINT PAIN

IF YES, PLEASE GIVE DETAILS _____

IF APPLICABLE, EXPLAIN HOW LIPOEDEMA AFFECTS YOUR MOVEMENT AND MOBILITY:

CONSERVATIVE MANAGEMENT

DO YOU WEAR COMPRESSION? YES / NO **DO YOU HAVE MLD?** YES / NO

IF YES, WHAT BRAND & CLASS: _____ **HOW OFTEN** _____

WHEN DID YOU START COMPRESSION: _____ **WHO IS YOUR THERAPIST?**

DO YOU HAVE A COMPRESSION PUMP? YES / NO _____

IF YES, WHAT BRAND & CLASS:

ARE YOU CONTEMPLATING SURGERY FOR YOUR LIPOEDEMA? YES / NO / Unsure

DIETS AND WEIGHT

CURRENT DIET: _____ **HEIGHT** _____ cm **CURRENT WEIGHT** _____ kg **HEAVIEST (NOT PREG)** _____ kg

WHAT DIETS HAVE YOU TRIED & WHAT WERE THE RESULTS

DIET: _____ **WEIGHT PRE-DIET:** _____ **WEIGHT POST DIET:** _____

DIET: _____ **WEIGHT PRE-DIET:** _____ **WEIGHT POST DIET** _____

DIET: _____ **WEIGHT PRE-DIET:** _____ **WEIGHT POST DIET:** _____

DIET: _____ **WEIGHT PRE-DIET:** _____ **WEIGHT POST DIET** _____

DIET: _____ **WEIGHT PRE-DIET:** _____ **WEIGHT POST DIET** _____

LIPOEDEMA HISTORY:

WHAT WERE YOUR FIRST SYMPTOMS OF LIPOEDEMA?

WHEN YOUR SYMPTOMS FIRST BECOME APPARENT, HOW OLD WERE YOU & WHAT WERE THE TRIGGERS?

WERE THERE SPECIFIC POINTS IN TIME THAT YOU NOTICED AN ACCELERATION IN FAT GROWTH?

DO YOU BELIEVE SOMEONE IN YOUR FAMILY HAS LIPOEDEMA ALSO? PLEASE SPECIFY:

WHICH BODY PARTS DO YOU FEEL ARE AFFECTED?

HAVE YOU PREVIOUSLY HAD A FORMAL DIAGNOSIS OF LIPOEDEMA? IF SO, BY WHOM & WHEN?

LIPOEDEMA SYMPTOMS:	Please indicate the severity of your symptoms 0 = NO SYMPTOMS 10 = WORST IMAGINABLE	Please indicate frequency of these symptoms NEVER, RARELY, SOMETIMES, ALWAYS
HEAVINESS IN YOUR LEGS	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
HEAVINESS IN YOUR ARMS	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
BURSTING PAIN IN THE CALF	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
BURSTING PAIN IN THE ARMS	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
NIGHT CRAMPS IN THE LEGS	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
NIGHT CRAMPS IN THE ARMS	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
SWELLING IN THE LEGS	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
SWELLING IN THE ARMS	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
TIREDNESS IN THE LEGS	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
TIREDNESS IN THE ARMS	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
RESTLESSNESS IN THE LEGS	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
RESTLESSNESS IN THE ARMS	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
BRUISING THAT OCCURS EASILY	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
SENSITIVITY TO TOUCH/PRESSURE	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
DIFFICULTY WALKING	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
IS YOUR GENERAL MOBILITY AFFECTED?	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
RATE THE PAIN IN YOUR LEGS	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
CALF PAIN AFTER EXERCISE THAT SETTLES FOLLOWING REST	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always
THE AFFECT OF LIPOEDEMA ON YOUR QUALITY OF LIFE	0 1 2 3 4 5 6 7 8 9 10	Never Rarely Sometimes Always

ALLERGIES

DO YOU HAVE ANY ALLERGIES / SENSITIVITIES? YES / NO

IF YES, DO YOU HAVE ANY ALLERGIES TO FOOD? YES / NO

Provide details:

IF YES, DO YOU HAVE ANY ALLERGIES TO MEDICATION? YES / NO

Provide details:

IF YES, DO YOU HAVE ANY OTHER ALLERGIES? YES / NO

Provide details:

MEDICATIONS AND SUPPLEMENTS

DO YOU TAKE ANY MEDICATIONS OR SUPPLEMENTS? YES / NO

MEDICATION:	DOSAGE:	FREQUENCY:	MEDICATION:	DOSAGE:	FREQUENCY:
1			7		
2			8		
3			9		
4			10		
5			11		
6			12		

HEALTH CONCERNS – HAVE YOUR EXPERIENCED ANY OF THE BELOW HEALTH CONCERNS?

WHICH OF THE FOLLOWING HEALTH CONCERNS HAVE YOU EXPERIENCED?

- ☐ Dercums disease
- ☐ Hypermobility
- ☐ Fibromyalgia
- ☐ History of DVT (blood clot in deep vein)
- ☐ Pulmonary embolism
- ☐ Leg ulcers
- ☐ Coeliac disease
- ☐ Lupus or other collagen disorder
- ☐ Connective tissue disorder
- ☐ Polycstic Ovary Disease
- ☐ Cardiac events
- ☐ Breathing difficulties
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Using CPAP
- ☐ Bleeding disorder
- ☐ Blood diseases
- ☐ Hepatitis
- ☐ HIV
- ☐ History of blood tranfusions
- ☐ High blood pressure
- ☐ Renal dysfunction
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Vitamin D deficiency
- ☐ Cellulitis
- ☐ Glandular / Ross River Fever
- ☐ Chronic fatigue
- ☐ Heaviness in the lower abdomen
- ☐ Pain in lower abdomen
- ☐ Burning sensation in the groin
- ☐ Difficult and painful intercourse
- ☐ Frequent urination
- ☐ Frequent urination in the night

MIGRAINES? YES / NO

If yes, how often?

Do you experience vision disturbance with your migraine? YES / NO

DIABETES? YES / NO

If yes, what type? _____

PREVIOUS OR CURRENT CANCER YES / NO

If yes, please give details? _____

THYROID ISSUES? YES / NO

If yes, please describe?

DEPRESSION/ANXIETY? YES / NO

Have you consulted a psychologist / psychiatrist? YES / NO

If yes, please give details of condition and management below?

ANY OTHER HEALTH CONCERNS OR QUESTIONS NOT ALREADY ADDRESSED IN THIS QUESTIONNAIRE? YES / NO

PAST SURGICAL HISTORY

HAVE YOU HAD WEIGHT LOSS SURGERY? YES / NO

	SURGERY TYPE:	DATE:	DOCTOR:	WEIGHT PRIOR TO SURGERY:	WEIGHT POST SURGERY:
1					
2					

HAVE YOU HAD ANY PREVIOUS GENERAL OR COSMETIC SURGERIES? YES / NO

	SURGERY TYPE:	YEAR:	SURGEON:	COMMENTS
1				
2				
3				
4				
5				
6				

HAVE YOU HAD VEIN TREATMENT / SURGERIES? YES / NO

	DATE:	DOCTOR:	TREATMENT: (e.g Stripping, Laser, Radiofrequency, sclerotherapy injections, cosmetic injections, medical superglue, other)	LEGS (circle):	WAS HOSPITAL ADMISSION REQUIRED (circle)
1				Left Right Bilateral	Outpatient Inpatient
2				Left Right Bilateral	Outpatient Inpatient
3				Left Right Bilateral	Outpatient Inpatient