Do you have any *position restrictions* due to:

____incision ____medication ____ostomy ____tumor site ____breathing difficulties ____tender skin
____swelling or risk of swelling *(any body area need elevating?)*
____medical devices ____discomfort

Please describe _____

Has cancer or cancer treatment affected any of the following functions in your body?

____Lungs ____Liver ____ Nervous System ____Heart ____Kidney ____Blood counts
____Energy Levels

Please check any that you are currently experiencing and describe _____
_____

Check "yes/no' and add comments if you have had or have any of the following:	Yes	No	Comments
Any *tendency to swell anywhere on your body?*			
Any sites ***of pain*** or ***tenderness*** anywhere in your body?			
Any sites of ***numbness*** or ***reduced sensation*** anywhere?			
Any areas of ***inflammation?***			

Other Medical Conditions

Check "yes/no' and add comments if you have had or have any of the following:	Yes	No	Comments
Skin conditions (rashes, infections, itching)			
Known ***allergies*** or ***sensitivity*** *(if you are using a doctor approved lotion, please bring it)*			
Cardiovascular conditions (heart disease, high blood pressure, angina, hardening of the arteries, stroke, varicose veins, blood clots)			
Liver or Kidney conditions *(kidney failure, hepatitis, portal hypertension, etc.)*			
Respiratory or Lung conditions			
Diabetes (describe type, medications, blood sugar control, complications)			
Injuries *back, neck, knee problems, disc injuries, fractures, etc.)*			
Surgeries			
Gastrointestinal Problems			
Arthritis or Joint Problems			