## GENERAL INFORMATION:

Your Child's/Your Name: _____ Nickname: _____

Age: _____ Birthdate: _____ / _____ / _____ Sex: ☐ Male ☐ Female

Ethnicity: ☐ White ☐ Hispanic ☐ Asian ☐ Black ☐ Middle Eastern ☐ Other

Primary language: ☐ English ☐ Spanish ☐ Other: _____

Mother's Name: _____ Phone #: _____

Address: _____ Work #: _____

City: _____ State: _____ Zip Code: _____

Home e-mail address: _____ Work e-mail address: _____

Occupation: _____ Place of employment: _____

Primary language: ☐ English ☐ Spanish ☐ Other: _____

What is your mother's highest level of education?

☐ Elementary School ☐ Middle School ☐ Junior High School ☐ High School ☐ College ☐ Graduate Degree
☐ Professional Schooling

Father's Name: _____ Phone #: _____

Address: _____ Work #: _____

City: _____ State: _____ Zip Code: _____

Home e-mail address: _____ Work e-mail address: _____

Occupation: _____ Place of employment: _____

Primary language: ☐ English ☐ Spanish ☐ Other: _____

What is your father's highest level of education?

☐ Elementary School ☐ Middle School ☐ Junior High School ☐ High School ☐ College ☐ Graduate Degree
☐ Professional Schooling

Would you like/need an interpreter available during your appointment? ☐ Yes ☐ No
If yes, what language would be needed for translation? _____

## FAMILY/SOCIAL HISTORY:

Please tell us about your home/family:

Child lives with: ☐ Biological Parents ☐ Single Parent Mother ☐ Single Parent Father ☐ Foster Parent
☐ Adoptive Parents ☐ Parent and Step-Parent ☐ Two Separate Households ☐ Other: _____

Who else lives in the household?

| Name/Relationship to Child | Sex | Date of Birth | Special Health Needs or Medical Problems |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

How much time do you spend each week coordinating medical care needs? _____

## FAMILY/SOCIAL HISTORY continued:

Do you receive services from any of the following?

☐ WIC ☐ SSI ☐ BCMH ☐ Food Stamps ☐ Waiver
☐ Other: _____

There may be financial resource help available to your child based on their medical needs. How much money do you spend on out-of-pocket medical expenses monthly/yearly? _____

What supports are in place for you as your child's caretaker? (family/friends)

_____

Who can you count on to provide the following:

Childcare/parenting: _____ Emotional support: _____

Financial Support: _____ Information: _____

Help with everyday tasks (transportation, errands, meals): _____

In general, would you say you/your child's health is:

☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

How much time during the past month were you worried about your/your child's medical needs?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

In general, what concerns you most about your/your child's health? _____

_____

## FAMILY GOALS:

What are the reasons for your/your child's visit (check all that apply)?

Referred by another doctor: ☐ Yes ☐ No Seeking a second opinion: ☐ Yes ☐ No
Seeking medical treatment: ☐ Yes ☐ No Seeking surgical treatment: ☐ Yes ☐ No

Other: _____

How can the Hemangioma and Vascular Malformation Center team best help you/your child?

Provide an integrated program of care for my child/myself: ☐ Yes ☐ No

Establish a correct diagnosis: ☐ Yes ☐ No Provide an opinion for another physician: ☐ Yes ☐ No

Other: _____

## BIRTH AND DEVELOPMENTAL HISTORY:

My child is adopted:

☐ No
☐ Yes: history known ☐ Yes: history unknown ☐ Foster child: history known ☐ Foster child: history unknown

My child was born: ☐ Full term ☐ More than 4 weeks early

During pregnancy, did the mother have:
☐ Hypertension ☐ Gestational diabetes ☐ Preeclampsia ☐ Other complications: _____ ☐ Unknown

Delivery was: ☐ Vaginal ☐ Caesarean Section ☐ Unknown

Medications taken during pregnancy other than multi-vitamins (include any illegal drugs; such as cocaine):

_____

During pregnancy did the mother: ☐ smoke ☐ not smoke
During pregnancy did the mother: ☐ not drink alcohol ☐ drink 1-2 times per week Other: _____

Maternal age at time of delivery: _____ years Previous pregnancies: ☐ No ☐ Yes If yes, how many? _____

DEVELOPMENTAL HISTORY:

Did you/your child required a stay of more than 2 days in the special nursery after birth: ☐ No ☐ Yes

When did you/your child start walking? _____ months

Are you/your child in a school program? ☐ Yes ☐ No

If yes, what grade:

☐ Preschool ☐ Elementary (K-2nd) ☐ Elementary (3rd-5th) ☐ Jr. High (6th-8th) ☐ High School (9th-12th) ☐ Other: _____

How many school days have you/your child missed in the last 30 days? _____

Is your/your child's level of education age-appropriate? ☐ Yes ☐ No

If no, describe: _____

Do you believe your/your child's needs are being met at school? _____

Do you think your child is developing normally? ☐ Yes ☐ No

If no, which areas are delayed? ☐ Cognitive ☐ Motor ☐ Speech ☐ Social

Do you/your child attend other programs related to health or developmental needs?

☐ Occupational Therapy Days/week attended: _____ Reason: _____

☐ Physical Therapy Days/week attended: _____ Reason: _____

☐ Speech Therapy Days/week attended: _____ Reason: _____

Do you/your child use any adaptive/supportive devices? _____

Communications/Learning: (Please check ALL that apply). My child or primary caregiver:

| | My Child | Primary Caregiver | | My Child | Primary Caregiver |
|---|---|---|---|---|---|
| Has/have difficulty speaking | | | Uses/use a special communication device | | |
| Has/have difficulty hearing | | | Uses/use TTY/TTD | | |
| Uses/use hearing aids | | | Learns/learn best with video | | |
| Has/have difficulty seeing | | | Learns/learn best with verbal instructions | | |
| Wears/wear glasses/contacts | | | Learns/learn best with demonstration | | |
| Primary language is not English | | | Learns/learn best with written instructions | | |
| Needs/need an interpreter | | | Other: | | |

What cultural/religious beliefs or values would you like us to know about you and/or your child?

_____

Is there anything else you feel we should know about you/your child? _____

_____

_____

_____

MEDICATIONS:

List all prescription medications, pain medications, over the counter medications, vitamins and herbal supplements that you/your child is currently taking.

| *Medications* | *Dose/Amount* | *Frequency* | *What is this medicine/supplement used for?* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

ALLERGIES:
Does your child have allergies? ☐ Yes ☐ No

Medications? ☐ Yes ☐ No
If yes, reaction: ☐ Rash ☐ Difficulty breathing ☐ Respiratory arrest ☐ Swelling ☐ Other: _____
Specify which medications: _____

_____

Foods? ☐ Yes ☐ No
If yes, reaction: ☐ Rash ☐ Difficulty breathing ☐ Respiratory arrest ☐ Swelling ☐ Other: _____
Specify which foods: _____

_____

Latex sensitivity? ☐ Yes ☐ No
If yes, reaction: ☐ Rash ☐ Difficulty breathing ☐ Respiratory arrest ☐ Swelling ☐ Other: _____
Specify which product(s): _____

_____

Other allergies?: ☐ Yes ☐ No
If yes, specify to what and the reaction: _____

_____

OVERVIEW OF VASCULAR ABNORMALITY:
My child's vascular abnormality is located?

| | Left | Right | Both |
|---|---|---|---|
| Head and/or neck | | | |
| Upper extremity | | | |
| Lower extremity | | | |
| Trunk and/or abdomen | | | |

My child's vascular abnormality first appeared?
☐ on a prenatal exam ☐ at birth ☐ within 2 weeks of birth ☐ within one month of birth ☐ at _____ years of age

Since then, the vascular abnormality has:
☐ become smaller ☐ stayed the same ☐ become larger

Does your child have a specific diagnosis? (Check all that have been told to you.)
☐ Hemangioma ☐ Port wine stain (capillary malformation) ☐ Arteriovenous malformation ☐ Venous malformation
☐ Lymphatic malformation/Lymphangioma ☐ Capillary lymphatic venous malformation (Klippel-Trenaunay Syndrome)
☐ Parks-Weber Syndrome ☐ Other: _____

At what age was this diagnosis made? _____

Who made this diagnosis?
☐ Pediatrician ☐ Other Medical Doctor ☐ Family Member ☐ Friend ☐ Other: _____

Does your child experience any discomfort with the vascular abnormality? ☐ Yes ☐ No
Does your child require pain medication? ☐ Yes ☐ No

If yes, what pain medications do you give your child? ☐ Tylenol® ☐ Motrin® ☐ Prescription drugs

How much? _____ How often? _____ Does it work? ☐ Yes ☐ No

TREATMENT/EVALUATION:

Has your child ever received treatment for his/her vascular abnormality? ☐ Yes ☐ No

| *Treatment* | *For What?* | *Date(s)* | *Results* |
|---|---|---|---|
| Medication | | | |
| Sclerotherapy | | | |
| Embolization | | | |
| Laser | | | |
| Surgery | | | |

Has your child ever been treated at Cincinnati Children's Hospital Medical Center? ☐ Yes ☐ No ☐ Unsure

| *Date* | *Inpatient* | *Outpatient* | *Emergency Room* | *Reason for Hospitalization* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Has your child ever been hospitalized for his/her vascular abnormality? ☐ Yes ☐ No

If yes, describe: _____

Has your child had any of these procedures to evaluate their abnormality?

| *Test/Procedure* | *Date(s)* | *Location/Facility* | *Results (if known)* |
|---|---|---|---|
| MRI | | | |
| CT Scan | | | |
| Ultrasound | | | |
| X-Ray | | | |
| Angiogram | | | |
| Other | | | |

Are any other family members affected by a vascular abnormality? ☐ Yes ☐ No

If yes, describe: _____

Does your child have other medical problems? ☐ Yes ☐ No

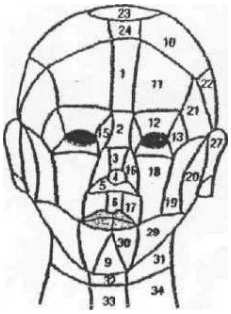
Does your child have any problems with anesthesia? ☐ Yes ☐ No

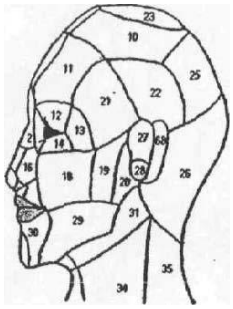
Does your child need antibiotics before surgery? ☐ Yes ☐ No

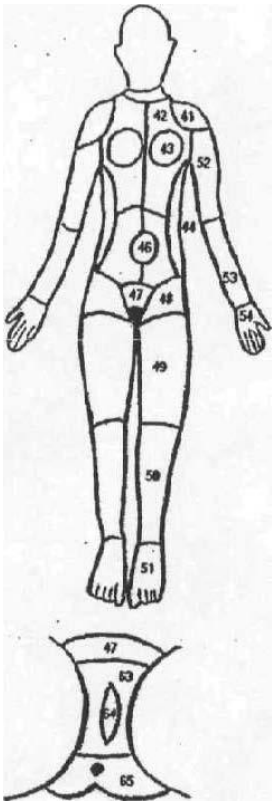
My child has experienced problems with:

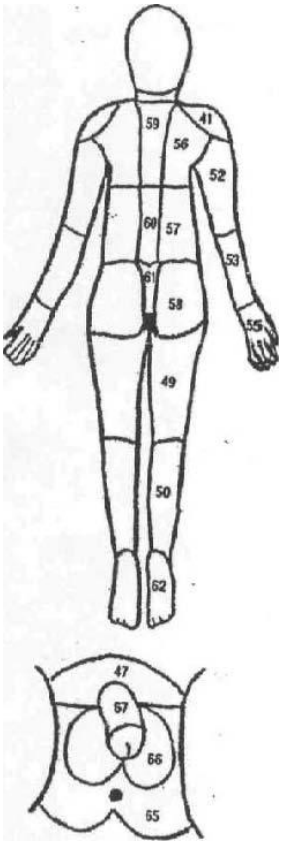
| | *Never* | *Past* | *New* | *Unknown* | | *Never* | *Past* | *New* | *Unknown* |
|---|---|---|---|---|---|---|---|---|---|
| Pain | | | | | Poor Growth | | | | |
| Chest Pain | | | | | Poor Weight Gain | | | | |
| Abdominal Pain | | | | | Paleness | | | | |
| Joint/Muscle Pain | | | | | Low Iron | | | | |
| Headaches | | | | | Weight Loss | | | | |
| Ulcerations | | | | | Lack of Appetite | | | | |
| Visual Problems | | | | | Facial Swelling | | | | |
| Hearing Problems | | | | | Tracheotomy | | | | |
| Bleeding | | | | | Oxygen | | | | |
| Easy Bruising | | | | | Limb Deformity | | | | |
| Heart Problems | | | | | Heart Murmur | | | | |
| Respiratory Problems | | | | | Seizures | | | | |
| Recurrent Pneumonia | | | | | Bronchitis | | | | |
| Isolation Needed | | | | | Rapid Breathing | | | | |
| Skin Rashes | | | | | Frequent Fevers | | | | |
| Kidney Disease | | | | | High Blood Pressure | | | | |
| Apnea | | | | | Turning Blue | | | | |
| Problems with Spinal Cord | | | | | Limp | | | | |
| Fatigue | | | | | Weakness | | | | |
| ADHD | | | | | List Others | | | | |
| Other | | | | | | | | | |

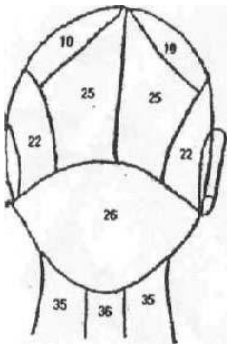
Please color in affected area(s) and note size of abnormality: _____ inches X _____ inches.

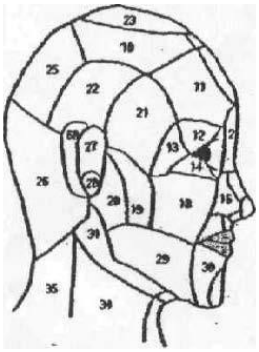


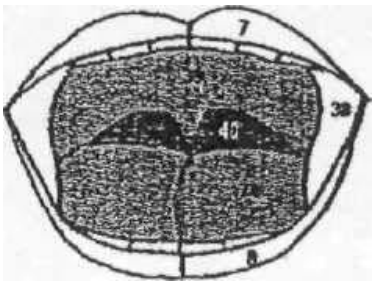












REFERRAL INFORMATION:

Name of referring physician: _____ Phone #: _____

Address: _____ E-mail: _____

I would like copies of the report from Cincinnati Children's HVMC sent to:

☐ Myself ☐ Pediatrician ☐ Referring Physician ☐ Other Physician ☐ Other (specify): _____

☐ Subspecialties: ☐ Dermatology ☐ Plastic Surgery ☐ ENT ☐ Surgery ☐ Other: _____

DOCTORS:

Name: _____

Specialty: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone #: _____

Primary focus of treatment: _____

☐ Primary Physician ☐ Referring Physician

DOCTORS continued:

Name: _____

Specialty: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone #: _____

Primary focus of treatment: _____

☐ Primary Physician ☐ Referring Physician

Name: _____

Specialty: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone #: _____

Primary focus of treatment: _____

☐ Primary Physician ☐ Referring Physician

☐ Check here to have information sent to this provider.

INSURANCE INFORMATION:

Primary Insurance Company: _____ Phone #: _____

Subscriber Name: _____ Policy Subscriber #: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone: _____ Contact: _____

CO-PAY: _____

Secondary Insurance Company: _____ Phone #: _____

Subscriber Name: _____ Policy Subscriber #: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone: _____ Contact: _____

CO-PAY: _____

Third Insurance Company: _____ Phone #: _____

Subscriber Name: _____ Policy Subscriber #: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone: _____ Contact: _____

CO-PAY: _____

_____

Parent/Patient/Guardian Signature Print Name Date

**Please attach a photograph of your child along with a photo of their vascular abnormality for our files.**