



**HEMANGIOMA AND VASCULAR MALFORMATION CENTER  
QUESTIONNAIRE**

**GENERAL INFORMATION:**

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CHILD'S NAME: \_\_\_\_\_ Nickname: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_

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

**Primary language:**  English  Spanish  French  German  Italian  Other

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**Mother's Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

Address: \_\_\_\_\_ Work #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home E-mail: \_\_\_\_\_ Work E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of employment: \_\_\_\_\_

Primary language:  English  Spanish  French  German  Italian  Other

What is mother's highest level of education?  
 Elementary School  
 High School  
 College  
 Graduate Degree  
 Professional Schooling

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**Father's Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

Address: \_\_\_\_\_ Work #: \_\_\_\_\_

Home E-mail: \_\_\_\_\_ Work E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of employment: \_\_\_\_\_

Primary language:  English  Spanish  French  German  Italian  Other

What is father's highest level of education?  
 Elementary School  
 High School  
 College  
 Graduate Degree  
 Professional Schooling

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**Name of Person Completing this Form:** \_\_\_\_\_

**Relationship to patient:**  mother  father  relative  caregiver  Self  Other

**Signature:** \_\_\_\_\_ **Today's Date:**        /        /

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**FAMILY/SOCIAL HISTORY:**

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*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?

<i>Name/Relationship to Child</i>	<i>Sex</i>	<i>Date of Birth</i>	<i>Special Health Needs or Medical Problems</i>

Do you receive services from any of the following?

- WIC     SSI     BCMH     Food Stamps     Waiver  
 Other State Programs: \_\_\_\_\_

**FAMILY GOALS:**

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*What are the reasons for your visit (check all that apply)?*

- Referred by another doctor:  Yes     No    Seeking a second opinion:  Yes     No  
Seeking medical Treatment:  Yes     No    Seeking surgical removal:  Yes     No  
 Other: \_\_\_\_\_

*How can the Hemangioma and Vascular Malformation Center team best help you?*

- 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: \_\_\_\_\_
-



**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): \_\_\_\_\_

**Doctors**

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Focus of Treatment:

Check here to have information sent to this provider.

Primary Physician

Referring Physician

Subspecialties:

Derm  Plas. Surg.

ENT  \_\_\_\_\_

Surg  \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Focus of Treatment:

Check here to have information sent to this provider.

Primary Physician

Referring Physician

Subspecialties:

Derm  Derm

ENT  ENT

Surg  Surg

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Focus of Treatment:

Check here to have information sent to this provider.

Primary Physician

Referring Physician

Subspecialties:

Derm  Derm

ENT  ENT

Surg  Surg

**Attach COPY of front and back side of all INSURANCE CARDS.**

**Insurance Information**

Primary Ins. Co.: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Policy Subscriber #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ CO-PAY: \$ \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_ Contact: \_\_\_\_\_

Secondary Ins. Co.: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Policy Subscriber #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ CO-PAY: \$ \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_ Contact: \_\_\_\_\_

## MEDICATIONS:

List all medications your child takes. Include all prescriptions, current pain medications, over the counter medications and all vitamins and herbal substances.

<i>Medication/Herbal Supplements</i>	<i>Dose/Amount</i>	<i>Frequency</i>	<i>What is this medicine used for?</i>

## ALLERGIES:

Does your child have allergies?

**Medications:**  No  Yes

If yes, reaction:

- Rash
- Difficulty breathing
- Respiratory arrest
- Swelling
- Other:

Specify which medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Foods:**  No  Yes

If yes, reaction:

- Rash
- Difficulty breathing
- Respiratory arrest
- Swelling
- Other:

Specify which Foods:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Latex**

**Sensitivity:**  No  Yes

If yes, reaction:

- Rash
- Difficulty breathing
- Respiratory arrest
- Swelling
- Other:

Specify which products:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other:**  No  Yes

If yes, specify to what and the reaction:



## BIRTH AND DEVELOPMENTAL HISTORY:

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### BIRTH 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 you have?  
 Hypertension  
 Gestational diabetes  
 Preeclampsia  
 Other complications:

Delivery was:  Vaginal  Cesarean Section

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

During pregnancy I:  smoked  did not smoke

During pregnancy I:  did not drink alcohol  drank 1-2 times per week

Maternal age at time of delivery: \_\_\_\_\_ years

Previous pregnancies:  No  Yes If yes, how many?

### DEVELOPMENTAL HISTORY:

My child required a stay of more than 2 days in the special nursery after birth:  No  Yes

My child walked at \_\_\_\_\_ months.

Is your child in a school program?  No  Yes

If yes, what grade:  Preschool  Jr. High (6<sup>th</sup> – 8<sup>th</sup>)  
 Elementary (K-2<sup>nd</sup>)  High School (9<sup>th</sup> – 12<sup>th</sup>)  
 Elementary (3<sup>rd</sup> – 5<sup>th</sup>)

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

If no, describe:

Do you think your child is developing normally?  Yes  No

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

## BIRTH AND DEVELOPMENTAL HISTORY, continued...

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Does your child attend other programs related to health or developmental needs?

- |   |                     |         |
|---|---------------------|---------|
| <input type="checkbox"/> Occupational Therapy | Days/week attended: | Reason: |
| <input type="checkbox"/> Physical Therapy     | Days/week attended: | Reason: |
| <input type="checkbox"/> Speech Therapy       | Days/week attended: | Reason: |

Does your child use any adaptive/supportive devices?

## OVERVIEW OF VASCULAR ABNORMALITY:

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My child's vascular abnormality is located?

- |   |                               |                                |                               |
|---|-------------------------------|--------------------------------|-------------------------------|
| <input type="checkbox"/> Head and/or neck     | <input type="checkbox"/> left | <input type="checkbox"/> right | <input type="checkbox"/> both |
| <input type="checkbox"/> Upper extremity      | <input type="checkbox"/> left | <input type="checkbox"/> right | <input type="checkbox"/> both |
| <input type="checkbox"/> Lower extremity      | <input type="checkbox"/> left | <input type="checkbox"/> right | <input type="checkbox"/> both |
| <input type="checkbox"/> Trunk and/or abdomen | <input type="checkbox"/> left | <input type="checkbox"/> right | <input type="checkbox"/> both |

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:

- gotten smaller       stayed the same       gotten larger

Does your child have a specific diagnosis? (Check all that have been told to you.)

- Hemangioma
- Port wine stain (capillary malformation)
- Arteriovenous malformation
- Lymphatic malformation/Lymphangioma
- Venous malformation
- Capillary lymphatic venous malformation (Klippel-Trenaunay syndrome)
- Parks-Weber
- Other

At what age was this diagnosis made?

Who made this diagnosis?

- Pediatrician
- Other Medical Doctor
- Family Member
- Friend
- Other



**OVERVIEW OF VASCULAR ABNORMALITY, continued...**

**PAIN:**

Does your child experience any discomfort with the vascular abnormality?  No  Yes

Does your child require pain medication:  No  Yes

What, if any, pain medications do you give your child?  Tylenol  
 Motrin  
 Prescription drugs

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

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

<i>Treatment</i>	<i>For What?</i>	<i>Date(s)</i>	<i>Results</i>
<b>Medication</b>			
<b>Sclerotherapy</b>			
<b>Embolization</b>			
<b>Laser</b>			
<b>Surgery</b>			

Has your child ever been treated at Cincinnati Children's Hospital Medical Center, Ohio?

No  Yes  Unsure

<i>Date</i>	<i>Inpatient</i>	<i>Outpatient</i>	<i>Emergency Room</i>	<i>Reason for Hospitalization</i>

Has your child ever been hospitalized for their vascular abnormality?  No  Yes

If yes, describe:

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

<i>Test/Procedure</i>	<i>Date(s)</i>	<i>Location/Facility</i>	<i>Results (if known)</i>
<b>MRI</b>			
<b>CT Scan</b>			
<b>Ultrasound</b>			
<b>X-Ray</b>			
<b>Angiogram</b>			
<b>Other</b>			

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

If yes, describe:

Does your child have other medical problems?

**OVERVIEW OF VASCULAR ABNORMALITY continued...**

My child has experienced problems with:

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

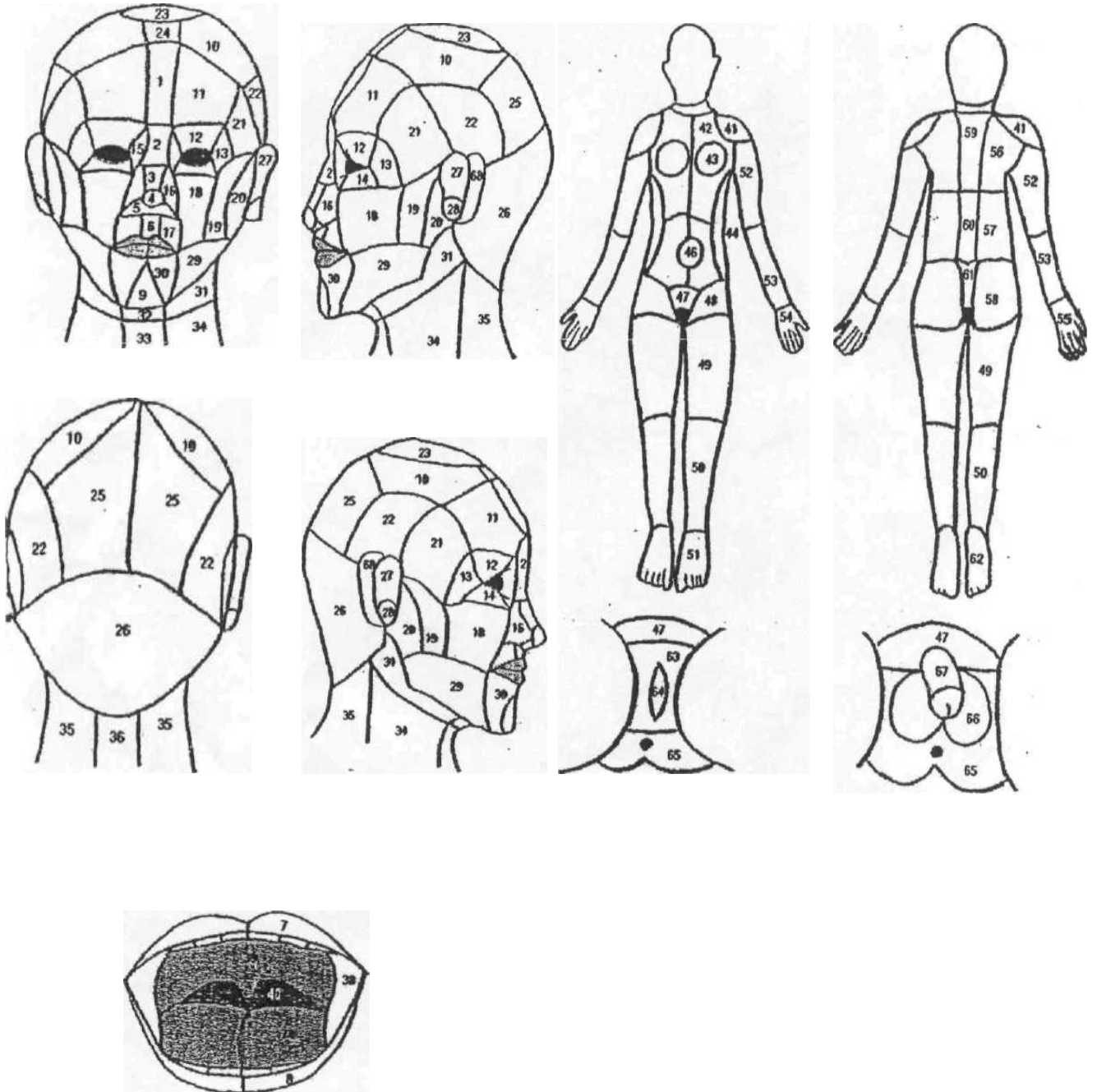
Does your child have any problems with anesthesia?  Yes  No

Does your child need antibiotics before surgery?  Yes  No

Overall my child's general state of health has been:  Excellent  Good  Fair  Poor

**OVERVIEW OF VASCULAR ABNORMALITY continued...**

Please color in affected area(s) and note size of abnormality: \_\_\_\_\_ inches x \_\_\_\_\_ inches.





**OVERVIEW OF VASCULAR ABNORMALITY continued...**

Communications/Learning: (*Please check all that apply.*) My child or I.....

	<i>My Child</i>	<i>I</i>		<i>My Child</i>	<i>I</i>
Have difficulty speaking			Use a special communication device		
Have difficulty hearing			Use TTY/TTD		
Use hearing aids			Learn best with video		
Have difficulty seeing			Learn best with verbal instructions		
Wear glasses/contacts			Learn best with demonstration		
Primary language is not English			Learn best with written instructions		
Need an interpreter			Other:		

Would you like/need an interpreter available during your appointment with the Hemangioma and Vascular Malformation Center team?     Yes     No

If yes, what language would be needed for translation?

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



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

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The following doctors have reviewed the HVMC Intake Questionnaire:

<b><u>PHYSICIAN'S NAME:</u></b>	<b><u>SIGNATURE</u></b>	<b><u>DATE</u></b>
Denise Adams, MD	_____	_____
Richard G. Azizkhan, MD	_____	_____
Roshni Dasgupta, MD	_____	_____
Ravi Elluru, MD	_____	_____
John H. Greinwald, MD	_____	_____
George H. Haney, MD	_____	_____
Anne W. Lucky, MD	_____	_____

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