HEMANGIOMA RESEARCH SURVEY

This survey is to be completed by the parents of children with hemangioma. The information will be used to provide summary data and will prove useful for future work by VHF. All information will be kept in the strictest of confidence.

CHILD INFORMATION

(A1) Date: _____
(Month) (Day)(Year)

(A2) Name of Children: _____
(First) (Middle) (Last)

(A3) Date of Birth: _____(Month) _____(Day) _____(Year)

(A4) Sex (Circle ONE):
1. Female
2. Male

(A5) Birth Weight: _____lb. _____ oz

(A6.1) Is child a twin?
1. Yes
2. No

(A6.2) If yes, are the twins. Please circle.

1. Fraternal / Non Identical
2. Identical

(A6.3) AND are the twins

1. Same Sex
2. Different Sex

(A6.4) Are there other twins in the family?
1.Yes
2. No

(A6.5) If yes, explain how twins are related to the child:
1. Cousin on father's side
2. Cousin on mother's side
3. Aunt on father's side
4. Aunt on mother's side
5. Uncle on father's side
6. Uncle on father's side
8.
9.

PHYSICIAN INFORMATION

(B1). Who was the first to diagnose the "mark" as a hemangioma?
a. Pediatrician b. Dermatologist c. Self d. Other (Specify) e. No one

(B2). Whom do you consider to have given you the best information with regards to the condition:
a. Pediatrician b. Dermatologist c. Self d. Other (Specify) e. No one

(B3). Who referred you to a specialist?
a. Pediatrician b. Dermatologist c. Self d. Other (Specify) e. No one

(B4.0) If you were referred to a specialist:

(B4.1) Who was the specialist?_____

(B4.2) Where is the specialist located (City, State, Country) ?_____

(B4.3) What is his/her specialty?_____

HEMANGIOMA DESCRIPTION

(C1) How many hemangiomas do the child have?_____

(C2.0) If child has more than one hemangioma, describe the primary hemagioma in answering the following questions:

(C2.1) What type of hemagioma is it (Circle ONE)?
a. Superficial
b. Deep
c. Both

(C2.2) When did you first notice it (Age of Child)?
a. At birth?
b. Shortly after birth:____ days___weeks___months___

(C2.3) Where is it located
a. head?
b. neck?
c. trunk?
d. extremities?
e. Other? Please Specify _____

HEMANGIOMA TREATMENT

(D1.1) Has your child received treatment? Circle ONE
1. Yes
2. No

(D1.2) If you answered NO to D1.1, was COST a factor in NOT receiving treatment? Please circle
1. Yes
2. No

(D1.3) Was lack of proper insurance coverage the major factor in NOT receiving treatment?
1. Yes
2. No

(D1.4)) If you answered YES to D1.1, how old was your child when he/she was first treated (_____ yrs _____ mos.)

Was the treatment successful
1. Yes
2. No Explain_____

(D1.5) Which of this physician(s) type treated your child? Check all that apply.
1. Pediatrician
2. Pediatric Dermatologist
3. Plastic Surgeon
4. Vascular Specialist
5. Other (Please Specify) _____

(D1.6) What type(s) of treatment were used? Check all that apply.
1. Laser
2. Steroid
3. Interferon
4. Surgery
5. Other (Please Specify) _____

HISTORY OF HEMANGIOMA GROWTH AND FAMILY HISTORY:

(E1) At what stage is the hemangioma at this date?
1. Proliferation
2. Involution
3. No change
4. Completely Healed

(E2) If the hemangioma has just begun to involute OR if it has involuted, what was your child's age when it began to visibly involute? ___ yrs____ mos

(E3) Did the hemangioma ever have any drainage, ulceration or scabbing?
1. Yes
2. No

(E4) Was the hemangioma ever considered problematic or life threatening? Check appropriately
1. Problematic
2. Life Threatening

(E5) Has the hemangioma affected any of the following? Circle ALL that apply
a. Vision
b. Hearing
c. Eating
d. Breathing
e. Speaking
f. Walking
g. Other. Please Specify _____
_____

(E6.0) Has there been any permanent damage as a result of the hemangioma ?
1 Yes
2. No

(E6.1) If yes, please explain: _____

(E7) Check if any in the child's family has ever had any of the following (Circle all that apply).
a. malignant tumor b. skin disease (psoriasis, eczema etc)
c. skin cancer
d. non-hemangioma (port-wine stains, malformation, vascular lesions etc.)
e. Other (please specify) _____

FOR MOTHER

(F1) How many weeks pregnant were you when you delivered this child?
_____ Weeks

(F2) Did you have any of the following conditions during the pregnancy?
1.) Toxemia?
2.) Edema
3.) High blood pressure?
4.) Infection?
5.) Did you have any skin conditions?
(Explain)_____

(F3) During the pregnancy were told that you had protein in your urine?
1.) Yes?
2.) No?

(F4) Did you have complications during this pregnancy?
If yes, explain_____

(F5) What type of delivery did you have?
1.) Natural?
2.) Cesarian?

(F5) If natural, was the baby born,
1.) Head first?
2.) Feet first?
3.) Other, (explain)_____

(F6) Did you or the baby suffer any injuries during this pregnancy?
1.) Yes?
2.) No
3.) If yes, explain_____

(F7) Were you exposed to any x-rays during the pregnancy?
1.) Yes?
2.) No?
3.) If yes, please explain_____

(F8) Were you exposed to any radiation or did you receive any radiation treatment (direct or indirect) during your lifetime?
1.) Yes?
2.) No?
3.) If yes, explain when & what KIND,
_____

(F9) Do you or your husband work in a job or service that comes in contact with chemicals or exposure to harardous substanses (i.e. miliary, fire fighter, coal miner, etc.)
1.) Yes?
2.) No?
3.) If yes, Please explain_____

(F10)Did you have an ultrasound during this pregnancy?
1.) Yes
2.) No
3.) If yes, when during the pregnancy _____months _____weeks.

(F11)Were you on any medication during the pregnancy?
1.) Yes
2.) No
3.) If yes, what medication did you take?_____

(F12) Did you take any vitamins just prior to or during the pregnancy?
1.) Yes
2.) No

(F12.2) If yes, what kinds? _____

(F13) Did you consume any alcohol just prior to or during the pregnancy?
1.) Yes?
2.) No?

(F13.2.) If yes, explain_____

(F14) Did you have any illnesses or infections during the pregnancy?
1.) Yes
2.) No

(F14.2) If yes, explain_____

(F15) How old were you when this child was born? _____ Years. _____ Months.

(F16) How many FULL pregnancies did you have? Circle appropriately
____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ more than 5

(F17) Which pregnancy was this for you?
1st ___ 2nd ____ 3rd _____ 4th _____ more than 4

(F18) Any subsequent births?
1. Yes

2. No

(F18.2)If yes, How many ? _____

(F19) Have you had any of the following conditions? Check all that apply.

a. Allergies. Explain _____
b. Anemia. Explain _____
c. Kidney Problems. Explain _____
d. Hormonal Imbalance. Explain _____
e. Thyroid Problems. Explain _____
f. Menstrual Problems. Explain _____

(F20) Did you ever take birth control pills ?
a. Yes.
b. No

(F20.2) If Yes, when (duration): 19 ____ TO 19 _____

(F21) Did you ever take fertility drugs ?
a. Yes.
b. No

(F21.2) If yes, please explain. _____

(F22) Were you ever treated for any of the following sexually treated disease ? Check all that apply.
a. gonorrhea
b. syphillis
c. herpes genitalis
d. chlamydia
e. viral b hepatitis
f. Other. Please Specify

Please provide comments, suggestions, experience that you fel would be helpful with this research.

_____

_____

_____

_____

Contact Information

Home Tel: ( ) _____
Work Tel: ( ) _____

Correspondence Address:

_____
_____
State: _____
Zip/Postal Code: _____

THANK YOU FOR COMPLETING THIS SURVEY

Please mail all correspondence to:

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