

Pediatric Dermatology
Hemangioma Patient History Form

Patient Name _____ DOB _____ Age _____
Pediatrician _____ Did this doctor refer you? _____
If the answer was "no", who did refer you? _____

Please tell us the main reason you came to see the pediatric dermatology team: _____

Was this birthmark present at birth? NO () YES () if no, when did it appear? _____

Has it changed (enlarged, grown as child grows, bled, ulcerated)? _____

Please list all medications oral and topical you are currently using including nonprescription items: _____

Has your child been previously diagnosed with or treated for any of the following:

Wheezing	Y	N
Trouble breathing	Y	N
Asthma	Y	N
Heart murmur	Y	N
Heart block	Y	N
Arrhythmia	Y	N
Heart Disease	Y	N
Poor Feeding	Y	N

Please list other illnesses, surgeries, and hospitalizations: _____

Is there any Family history of the following?

Heart block	Y	N
Arrhythmia	Y	N

Please list any family history (skin cancer, melanoma, eczema, psoriasis, etc.) that may be relevant to your child's condition and care: _____

Parent/Guardian signature and date: _____