



## Individuals Treated with Radiation for a Vascular Birthmark

.....www.birthmark.org

*If you are an adult who was treated with radiation (especially pellets), during the 1950's-1970's, please fill out the following questionnaire and mail to VBF, attn: Linda Shannon, P.O. Box 106, Latham, NY 12110.*

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

Phone Number: \_\_\_\_\_

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

\_\_\_\_\_

Email : \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_ M \_\_\_ F Country Born In: \_\_\_\_\_

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What was the diagnosis of type of vascular birthmark/tumor? \_\_\_\_\_

\_\_\_\_\_

Location of vascular birthmark/tumor: \_\_\_\_\_

Your age when birthmark/tumor was diagnosed: \_\_\_\_\_

List type of radiation treatment (e.g. pellets): \_\_\_\_\_

How many treatments did you have? \_\_\_\_\_

What was your age during treatment: \_\_\_\_\_

What was your age when treatment was completed? \_\_\_\_\_

What is your current diagnosis, type of cancer? \_\_\_\_\_

Where is the location of your cancer? \_\_\_\_\_

Do you have any other health related problems? \_\_\_\_\_

**Please List:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I hereby give VBF permission to use this information for research purposes :

Signature \_\_\_\_\_

Date \_\_\_\_\_