Cleft Lip and Palate Anomalies Questionnaire

General Info (mother of a child with cleft)

Name: _____
Last First Middle

Home Address: _____
Street City State Zip code

Telephone # : ( ) _____ Fax # : ( ) - _____

Work Address: _____
Street City State Zip code

Telephone # : ( ) _____ Fax # : ( ) - _____

Email: _____

Background Info:

How many children do you have? _____ Are any of your children adopted? _____

Please provide the following information for each child:

Name	Sex (M/F)	Date of Birth	Cleft (Y/N)	Type of Cleft

Did you have any miscarriages? _____ How many? _____

Are your planning to have another child?
If YES, when? _____
If NO, why? _____

If you had another child after the child with cleft, did you take vitamins and/or Folic Acid? _____
If YES, when did you begin and for how long? _____

At which Craniofacial Center is/was the child with cleft treated? _____

Name of Physician(s) who treated the child: _____

Do any of your relatives have a cleft? _____

If YES, please specify their relation to you, name, and date of birth:

_____

_____

Do any of your relatives have other birth defects?

If YES, please specify their relation to you, name, and date of birth:

_____

_____

Information regarding your pregnancy with the child with cleft:

(Please provide information regarding the period before and during the first trimester of the pregnancy)

Was the pregnancy planned? _____ At what point did you begin prenatal care? _____

Did you take vitamins and/or Folic Acid during this pregnancy? _____

If YES, when did you begin and for how long? _____

Did you take other prescription or over the counter medications? _____

If YES, what medications? _____

Did you suffer from morning sickness? _____

If YES, how often and how long? _____

Did you take any medication for the sickness? _____

If YES, what medication? _____

Describe the area in which you lived: _____

(Rural, Urban/Residential, Urban/Industrial, etc.)

What sort of water did you drink? (tap, bottled, well, etc.) _____

What was your occupation? _____

How often did you use the computer? (# hrs/wk) _____

Were you exposed to any chemicals in your home/work environment? _____

If YES, what sort of chemicals? _____

(Pesticides, gases, etc)

Thank you for your time and generosity. We appreciate your help in our research, as we continue our efforts to understand the etiology of cleft and craniofacial anomalies.

Please send this questionnaire by mail, email, or fax to the University of the Pacific School of Dentistry:

Address: **Marie M. Tolarova, MD, PhD, DSc**
Professor and Executive Director

or

Christine Phan
Program Coordinator

Pacific Craniofacial Team and Cleft Prevention Program
UOP School of Dentistry
2155 Webster Street
San Francisco, CA 94115

Fax # : **(415) 929-6549**

Email: **Cphan@pacific.edu**
Tolarova@pacific.edu