Cleft Lip and Palate Anomalies Questionnaire

General Info

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:

At which Craniofacial Center were you treated for your cleft? _____

Name of Physician(s) who treated you: _____

Do any of your other relatives have a cleft? _____

If YES, please fill out the table below:

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

Do any of your relatives have other birth defects? _____

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

_____

_____

Are your planning to have child?

If YES, when? _____

If NO, why? _____

Are you aware of the importance of Folic Acid in your diet? _____

Are you currently taking any vitamins? _____

Are you taking prescription or over the counter medication? _____
If YES, what medication(s)? _____

Describe the area in which you live: _____
(Rural, Urban/Residential, Urban/Industrial, etc.)

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

What is your current occupation? _____

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

Are 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

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