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:

<table>
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<tr>
<th>Name</th>
<th>Sex (M/F)</th>
<th>Date of Birth</th>
<th>Cleft (Y/N)</th>
<th>Type of Cleft</th>
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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