

ID LABEL

You and Your Child

Mother's questionnaire Antenatal recruitment

This questionnaire is for the child's mother.



About this research

You are being asked to complete this questionnaire because you have chosen to participate in The Cleft Collective Cohort Studies. This research is taking place in collaboration with every cleft team in the UK to investigate the causes of cleft, the best treatments for cleft and the long-term impact of cleft on the family and the individual.

About this questionnaire

This questionnaire has six sections:

1. **About You** - this section asks for information such as your ethnicity.
2. **Work and Education** - this section asks for information including your educational achievements and your current employment status.
3. **Family Life** - this section asks you questions about where you live, your marital status and your other children (if applicable).
4. **Health and Illness** - this section asks about your family's health history.
5. **Your Lifestyle** - this section asks questions about your diet, alcohol use, cigarette smoking and exercise.
6. **Your Wellbeing** - the last section asks about how you have been feeling recently.

Please try to answer all of the questions, even if some of them sound strange to you. As so little is known about the causes of cleft, we need to ask a broad range of questions about your environment and family history to help us understand what causes cleft and how we can help to support families.

When we ask questions about 'your pregnancy' and 'your child' please answer in relation to your child who has been diagnosed with a cleft. Please fill in the information you can remember!





There are no right or wrong answers. If you do not want to answer a question then just leave it blank.

Some of the questions ask about your health and your lifestyle. We need to know this information to find out if any of these factors could be related to cleft lip and palate, but this does not necessarily mean that any of these factors were involved in the development of your child's cleft.

All of the answers you give us in this questionnaire will be kept anonymous.

How to fill in this questionnaire

Please use a black pen. To answer the questions please put a cross in the box like this:



If you make a mistake, shade the box in like this:



then cross the correct box.

If you are answering questions which ask you to give further details, please make sure you write inside the boxes.

Who to contact for support.

If you have any questions or if you feel concerned or distressed before/after completing this questionnaire and would like some extra support, please refer to the contact details in your starter pack of people who can help.

Thank you for completing this questionnaire!





SECTION A - ABOUT YOU

A1. Please tell us your ethnicity, your mother's ethnicity and your father's ethnicity

a) White	i) You	ii) Your mother	iii) Your father
British	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other White background (please cross box and specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>

b) Mixed	i) You	ii) Your mother	iii) Your father
White and Black Caribbean	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White and Black African	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White and Asian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other mixed background (please cross box and specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>

c) Asian or Asian British	i) You	ii) Your mother	iii) Your father
Indian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pakistani	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bangladeshi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other Asian background (please cross box and specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>





A1 continued...

d) Black or Black British

i) You

ii) Your mother

iii) Your father

Caribbean

African

Any other Black background

(please cross box and specify)

e) Chinese or other ethnic group

i) You

ii) Your mother

iii) Your father

Chinese

Any other background

(please cross box and specify)

A2. Your country of birth:

A3. How long have you lived in the UK?

a) Since Birth

b) If not since birth, number of years:

A4. What is your religion?

None

Christian (Including Church of England, Catholic, Protestant and all other Christian denominations)

Buddhist

Hindu

Jewish

Sikh

Any other religion (please specify)





A5. How old were you at the time your child was conceived? years

A6. If known, how old were **YOUR parents** at the time **YOU** were conceived?

Your mother

Your father

A7. What is the name of the hospital in which your child received a diagnosis of cleft?

A8. What is the name of the hospital (or place) in which your child will be born (if different to the above)?

A9. What is the name of the hospital in which your cleft team is based?

A10. How many weeks pregnant are you / is your partner now?

A11. If known, please tell us your due date? ^D^D / ^M^M / ^Y^Y



SECTION B - WORK AND EDUCATION

B1. What is the highest educational qualification you have obtained? (**Cross one box only**)

- One or more O Levels/CSEs/GCEs (any grades)
- Five or more O Levels/CSEs (grade 1)/GCSEs (grades A*-C)/School Certificate
- One or more A Levels/AS Levels
- Two or more A Levels/Four or more AS Levels/Higher School Certificate
- NVQ Level 1/Foundation GNVQ
- NVQ Level 2/Intermediate GNVQ
- NVQ Level 3/Advanced GNVQ
- NVQ Levels 4-5/HNC/HND
- First degree (e.g. BA/BSc)
- Higher degree (e.g. MA, PhD, postgraduate PGCE)
- Other qualifications (e.g. City and Guilds, RSA/OCR, BTEC/Edexcel)
- Overseas qualifications (please specify)
- No qualifications
- Don't know
- Other (please specify)

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B2. Overall, how would you rate your school experience?

- Poor Fair Good Excellent

B3. Overall, how would you rate your school academic performance?

- Poor Fair Good Excellent

B4. Overall, how would you rate your school enjoyment?

- Poor Fair Good Excellent

B5. Overall, how would you rate your relationships with your school teachers?

- Poor Fair Good Excellent

B6. Overall, how would you rate your relationships with your school friends?

- Poor Fair Good Excellent

B7. a) Have you ever experienced teasing and bullying? Yes No

b) If yes, how bad do you feel this teasing and bullying was?

- Not very bad Moderate Very bad

The following questions ask about your employment status. If you are currently on maternity leave, please answer the questions in relation to your current / most recent job.

B8. What is your current employment status? (**Cross one box only**)

- | | |
|--|---|
| <input type="checkbox"/> Student | <input type="checkbox"/> Rehabilitation/disabled |
| <input type="checkbox"/> Homemaker | <input type="checkbox"/> Employed in public sector |
| <input type="checkbox"/> Intern/apprentice | <input type="checkbox"/> Employed in private sector |
| <input type="checkbox"/> Military Service | <input type="checkbox"/> Self-employed |
| <input type="checkbox"/> Unemployed/laid off | <input type="checkbox"/> Other (please specify below) |





B9. What is your current/most recent occupation? (**Cross one box only**).

See below for examples of occupation types.

- | | |
|--|---|
| <input type="checkbox"/> Professional/executive | <input type="checkbox"/> Unskilled worker |
| <input type="checkbox"/> Small business, proprietor, sales | <input type="checkbox"/> Student/school pupil |
| <input type="checkbox"/> Clerical/administrative | <input type="checkbox"/> Homemaker |
| <input type="checkbox"/> Skilled worker | <input type="checkbox"/> Volunteer worker |
| <input type="checkbox"/> Semi-skilled worker | <input type="checkbox"/> Other (please specify below) |

EXAMPLES OF OCCUPATION TYPES

Professional/Executive: An expert in the field in which you work, with education beyond an undergraduate degree (e.g. masters degree or doctorate) OR an individual with a top level position in a business setting with over 100 employees, e.g. lawyer, doctor.

Small business, proprietor, sales: Working in a business with under 100 employees.

Clerical/administrative: Working in an office and performing day-to-day business-related tasks such as organising meetings, typing, writing proposals, and budgeting.

Skilled worker: Any worker who has some special knowledge in his/her work and who has usually attended a college, university, or technical school and may have a diploma, or undergraduate degree. Or a skilled worker who may have learned their skills on the job, e.g. teacher, nurse, plumber, electrician.

Semi-skilled worker: A semi-skilled worker who has received little specialised training to do their work.

Unskilled worker: An unskilled worker who has received no special training to do their work.



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B10. What is your current/most recent job title?

B11. How long have you worked/did you work in your current/most recent job?

years months

B12. a) In the last year, have you been absent from work for more than two weeks in a row (apart from maternity leave)?

Yes No

b) If yes, what was the reason for your absence? (**Cross one box only**)

Medical leave

Leave of absence

Child was ill

Other (please specify below)

B13. On average, how many hours do you currently work per week?

hours per week





B14. What are your current working hours? (**Cross one box only**)

- Permanent day work
- Permanent evening work
- Permanent night work
- Shift work or shift rotations
- No set times (e.g. temporary employment)
- Other (please specify)

B15. How do the following statements describe your current work situation?

Disagree Agree
Disagree Mostly Mostly Agree

a) I do physically heavy work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) My work is very stressful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I learn a lot at work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) My work is very monotonous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) My work demands a lot of me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I am able to decide how my work is carried out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) There is a good team spirit at my place of work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) I enjoy my work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



B16. This table shows income in weekly, monthly and annual amounts. Which of the amounts on this list represents **YOUR** individual total income from all jobs, tax credits, benefits and other sources **after tax** when added together? (**Cross one box only**)

Weekly Income after Tax	Monthly Income after Tax	Annual Income after Tax	
Less than £25	Less than £108	Less than £1,299	<input type="checkbox"/>
£25 - £39	£109 - £175	£1,300 - £2,099	<input type="checkbox"/>
£40 - £59	£176 - £259	£2,100 - £3,099	<input type="checkbox"/>
£60 - £79	£260 - £350	£3,100 - £4,199	<input type="checkbox"/>
£80 - £99	£351 - £433	£4,200 - £5,199	<input type="checkbox"/>
£100 - £124	£434 - £542	£5,200 - £6,499	<input type="checkbox"/>
£125 - £149	£543 - £650	£6,500 - £7,799	<input type="checkbox"/>
£150 - £179	£651 - £775	£7,800 - £9,299	<input type="checkbox"/>
£180 - £209	£776 - £917	£9,300 - £10,999	<input type="checkbox"/>
£210 - £259	£918 - £1,125	£11,000 - £13,499	<input type="checkbox"/>
£260 - £299	£1,126 - £1,333	£13,500 - £15,999	<input type="checkbox"/>
£300 - £379	£1,334 - £1,667	£16,000 - £19,999	<input type="checkbox"/>
£380 - £479	£1,668 - £2,083	£20,000 - £24,999	<input type="checkbox"/>
£480 - £577	£2,084 - £2,500	£25,000 - £29,999	<input type="checkbox"/>
£578 - £769	£2,501 - £3,333	£30,000 - £39,999	<input type="checkbox"/>
£770 - £962	£3,334 - £4,167	£40,000 - £49,999	<input type="checkbox"/>
£963 - £1,154	£4,168 - £5,000	£50,000 - £59,999	<input type="checkbox"/>
£1,155 - £1,346	£5,001 - £5,833	£60,000 - £69,999	<input type="checkbox"/>
£1,347 - £1,538	£5,834 - £6,667	£70,000 - £79,999	<input type="checkbox"/>
£1,539 or more	£6,668 or more	£80,000 or more	<input type="checkbox"/>



B17. Which of these credits/allowances/benefits do **YOU** receive as an individual?
(Cross all that apply)

- a) Child benefit
- b) Child tax credit
- c) Working tax credit
- d) Income support
- e) Disability living allowance/personal independence payment (PIP)
- f) Income tested job seeker's allowance
- g) Housing benefit/rent rebate/council tax benefit/council tax reduction
- h) Incapacity benefits/employment and support allowance (ESA)
- i) Pension credit
- j) Carer's allowance
- k) None
- l) Don't know
- m) Other (please specify below)

B18. Approximately how much of **YOUR** total individual income comes from benefits?

- None
- A small amount (less than 25%)
- A fair amount (between 25% and 50%)
- The majority of your income (50% or more)

SECTION C - FAMILY LIFE

C1. How long have you lived at your current address? years months

C2. In which of these ways does your household occupy your current address? **(Cross one box only)**

- Buying it with the help of a mortgage or loan
- Owns it outright
- Rents it
- Lives here rent free (e.g. in a relative's or friend's property)
- Pays part rent and part mortgage (shared ownership)
- Don't know
- Other (please specify)

C3. If you rent your property, live in your property rent free, or pay part rent and part mortgage, please tell us who your landlord is? **(Cross one box only)**

- Private landlord or letting agency
- Housing Association, Housing Co-Operative, Charitable Trust
- Local Authority/Council
- Relative or friend
- Employer
- Don't know
- Other (please specify)
- Not applicable

C4. a) Please tell us who lives with you in your current household? **(Cross all that apply)**

- i) Your spouse or domestic partner
- ii) Your children/stepchildren
- iii) Your siblings
- iv) Your parents
- v) Other relatives (please specify)
- vi) Unrelated individuals (please specify)





C4 Continued...

- b) Number of children/stepchildren who live with you
- c) Number of siblings who live with you
- d) Number of parents who live with you
- e) Number of other relatives who live with you
- f) Number of unrelated individuals who live with you

C5. How long have you lived in this current household arrangement?

years AND/OR months AND/OR weeks

C6. What is your current marital status?

- Single Domestic partner Married
- Separated Divorced Widowed
- Civil Union

C7. How long have you lived in this current arrangement?

years AND/OR months AND/OR weeks

C8. What is your marital history?

- a) Number of marriages or civil unions
- b) Number of times separated
- c) Number of times divorced
- d) Number of times widowed



C9. How would you describe your relationship with your current partner (if applicable)?

	Agree	Agree Somewhat	Neutral	Disagree Somewhat	Disagree
a) My partner and I have a close relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) My partner and I have problems in our relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I am very happy in my relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) My partner is usually understanding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I often think about ending our relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I am satisfied with my relationship with my partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) We often disagree about important decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) I have been lucky in my choice of a partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) We agree about how children should be raised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) I think my partner is satisfied with our relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C10. a) Is this your first biological child? Yes No

b) Please tell us all of your biological children's date of birth and gender?

	Date of Birth (dd/mm/yyyy)	Gender
i) First child (first born)	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female
ii) Second child	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female
iii) Third child	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female
iv) Fourth child	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female
v) Fifth child	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female



C11. a) Are any of your biological children from a previous relationship(s)? Yes No

b) If yes, please indicate which children (Cross **all** that apply):

i) First ii) Second iii) Third iv) Fourth v) Fifth

C12. a) Do you have any stepchildren? Yes No

b) If yes, please tell us your stepchildren's date of birth and gender:

	Date of Birth (dd/mm/yyyy)			Gender	
i) First stepchild (eldest)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male	<input type="checkbox"/> Female
ii) Second stepchild	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male	<input type="checkbox"/> Female
iii) Third stepchild	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male	<input type="checkbox"/> Female
iv) Fourth stepchild	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male	<input type="checkbox"/> Female
v) Fifth stepchild	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male	<input type="checkbox"/> Female

C13. What is your first language? English Other (please specify below)

C14. If you speak a language other than English, do you often speak this language in your home? Yes No

SECTION D - HEALTH AND ILLNESS

- D1. Please tell us if **YOU** were born: At full term
 Prematurely
 Don't know

D2. What was **YOUR** birth weight (if known)?

Lbs Oz Kg
 OR . Don't know

D3. a) Are **YOU** a twin or multiple? Yes No

- b) If yes, are **YOU**: An identical twin (monozygotic)
 A non-identical twin (dizygotic)
 Multiple
 Don't know

D4. a) When **YOU** were a child, did **YOU** ever go to a speech and language therapist?

Yes No Don't know

b) If yes, please tell us more:



D5. Have **you** or any of your **biological family members** (parents, grandparents, your child born with cleft, siblings, cousins, etc.) been diagnosed by a medical professional with any of the following medical conditions?

Medical Conditions	i) You	ii) Is there a family history?	iii) If yes, who in your family?
a) Epilepsy or seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
b) High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
c) Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
d) Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
e) Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
f) Thyroid condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
g) Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
h) Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
i) Severe acne	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
j) Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
k) Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
l) Severe headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
m) Chronic ear infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
n) Other medical cond. <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
o) Other medical cond. <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>

D6. Have **you** or any of your **biological family members** (parents, grandparents, your child born with cleft, siblings, cousins, etc.) been diagnosed by a medical professional with any of the following types of cancer?

Type of Cancer	i) You	ii) Is there a family history?	iii) If yes, who in your family?
a) Breast	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
b) Cervical	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
c) Colon and/or rectum	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
d) Leukaemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
e) Lung	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
f) Prostate	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
g) Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
h) Testicular	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
i) Thyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
j) Uterus	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
k) Other type of cancer <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>





D7. Have **you** or any of your **biological family members** (parents, grandparents, your child born with cleft, siblings, cousins, etc.) been diagnosed by a medical professional with any of the following specific health conditions?

Specific Health Condition	i) You	ii) Is there a family history?	iii) If yes, who in your family?
a) Heart defect	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 100%; height: 20px;" type="text"/>
b) Short-sightedness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 100%; height: 20px;" type="text"/>
c) Learning disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 100%; height: 20px;" type="text"/>
d) Other congenital defect (other than cleft)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 100%; height: 20px;" type="text"/>
e) Genetic disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 100%; height: 20px;" type="text"/>
f) Hearing loss or impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 100%; height: 20px;" type="text"/>

g) **If yes to f), please tell us about the type of hearing loss:**

- Temporary (conductive)
- Permanent (sensorineural)
- Don't know

h) **If this hearing loss is permanent, do you/they use hearing aids?**

- Yes No Don't know



D8. Have **you** or any of your **biological family members** (parents, grandparents, your child born with cleft, siblings, cousins, etc.) been diagnosed by a medical professional with any of the following mental health conditions?

Mental Health Condition	i) You	ii) Is there a family history?	iii) If yes, who in your family?
a) Behavioural problem iv) Please specify below <input data-bbox="113 440 463 504" type="text"/>	<input data-bbox="482 408 549 435" type="checkbox"/> Yes <input data-bbox="482 448 549 475" type="checkbox"/> No	<input data-bbox="598 408 665 435" type="checkbox"/> Yes <input data-bbox="598 448 665 475" type="checkbox"/> No	<input data-bbox="698 408 1009 475" type="text"/>
b) Anxiety	<input data-bbox="482 528 549 555" type="checkbox"/> Yes <input data-bbox="482 576 549 603" type="checkbox"/> No	<input data-bbox="598 528 665 555" type="checkbox"/> Yes <input data-bbox="598 576 665 603" type="checkbox"/> No	<input data-bbox="698 536 1009 603" type="text"/>
c) Phobia	<input data-bbox="482 663 549 691" type="checkbox"/> Yes <input data-bbox="482 703 549 730" type="checkbox"/> No	<input data-bbox="598 663 665 691" type="checkbox"/> Yes <input data-bbox="598 703 665 730" type="checkbox"/> No	<input data-bbox="698 663 1009 730" type="text"/>
d) Depression	<input data-bbox="482 791 549 818" type="checkbox"/> Yes <input data-bbox="482 831 549 858" type="checkbox"/> No	<input data-bbox="598 791 665 818" type="checkbox"/> Yes <input data-bbox="598 831 665 858" type="checkbox"/> No	<input data-bbox="698 791 1009 858" type="text"/>
e) Manic depressive illness (Bipolar)	<input data-bbox="482 919 549 946" type="checkbox"/> Yes <input data-bbox="482 959 549 986" type="checkbox"/> No	<input data-bbox="598 919 665 946" type="checkbox"/> Yes <input data-bbox="598 959 665 986" type="checkbox"/> No	<input data-bbox="698 919 1009 986" type="text"/>
f) Schizophrenia	<input data-bbox="482 1046 549 1074" type="checkbox"/> Yes <input data-bbox="482 1086 549 1114" type="checkbox"/> No	<input data-bbox="598 1046 665 1074" type="checkbox"/> Yes <input data-bbox="598 1086 665 1114" type="checkbox"/> No	<input data-bbox="698 1046 1009 1114" type="text"/>
g) Other iv) Please specify below <input data-bbox="113 1214 463 1278" type="text"/>	<input data-bbox="482 1174 549 1201" type="checkbox"/> Yes <input data-bbox="482 1214 549 1241" type="checkbox"/> No	<input data-bbox="598 1174 665 1201" type="checkbox"/> Yes <input data-bbox="598 1214 665 1241" type="checkbox"/> No	<input data-bbox="698 1174 1009 1241" type="text"/>



D9. a) Have **YOU** been diagnosed with a cleft lip or palate?

- No Cleft palate Submucous cleft palate
- Cleft lip Cleft lip and palate Don't know

b) If yes, is your cleft unilateral (on one side of your mouth) or bilateral (on both sides of your mouth)?

- Unilateral Bilateral Don't know

D10. Has any relative in **your family including your other children and your child's biological father and his family**, been diagnosed with a cleft lip or palate? (If this includes any of your children, please also give their date of birth)

a) i) Please tell us who in your family? ii) What was their cleft type? iii) Was their cleft:

- Cleft lip Unilateral
- Cleft palate Bilateral
- Cleft lip and palate Not known
- Submucous cleft palate
- Not known

b) i) Please tell us who in your family? ii) What was their cleft type? iii) Was their cleft:

- Cleft lip Unilateral
- Cleft palate Bilateral
- Cleft lip and palate Not known
- Submucous cleft palate
- Not known

c) i) Please tell us who in your family? ii) What was their cleft type? iii) Was their cleft:

- Cleft lip Unilateral
- Cleft palate Bilateral
- Cleft lip and palate Not known
- Submucous cleft palate
- Not known

d) i) Please tell us who in your family? ii) What was their cleft type? iii) Was their cleft:

- Cleft lip Unilateral
- Cleft palate Bilateral
- Cleft lip and palate Not known
- Submucous cleft palate
- Not known

■ D10. Continued...

e) i) Please tell us who in your family? ii) What was their cleft type? iii) Was their cleft:

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Cleft lip | <input type="checkbox"/> Unilateral |
| <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Bilateral |
| <input type="checkbox"/> Cleft lip and palate | <input type="checkbox"/> Not known |
| <input type="checkbox"/> Submucous cleft palate | |
| <input type="checkbox"/> Not known | |

f) i) Please tell us who in your family? ii) What was their cleft type? iii) Was their cleft:

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Cleft lip | <input type="checkbox"/> Unilateral |
| <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Bilateral |
| <input type="checkbox"/> Cleft lip and palate | <input type="checkbox"/> Not known |
| <input type="checkbox"/> Submucous cleft palate | |
| <input type="checkbox"/> Not known | |

D11. a) Around the time your child was conceived did you have any infectious diseases? Yes No

b) If yes, please specify below:

D12. Have you ever been diagnosed with fertility problems? Yes No

D13. a) Was your child conceived using assisted methods? Yes No

b) If yes, please tell us more:



SECTION E - YOUR LIFESTYLE

- E1. What is your height? feet inches m cm
 OR .
- E2. What was your weight before you / your partner became pregnant? stone lbs kg
 OR .
- E3. What is the heaviest you have weighed since you were 16 years old (Excluding pregnancy)? stone lbs kg
 OR .
- E4. What is the lightest you have weighed since you were 16 years old? stone lbs kg
 OR .
- E5. Have you ever dieted or limited your food intake? Yes No
- E6. If yes, how old were you the first time you dieted or limited your food intake? years
- E7. Have you ever used any of the following methods to control your weight? (**Cross all that apply**) i) Vomiting iv) Hard physical exercise
 ii) Laxatives v) Medication
 iii) Fasting vi) None
- E8. How would you describe your general diet? I have a varied diet I eat a vegan diet
 I eat a vegetarian diet Other (please specify below)
(Cross one box only)
- E9. Before you/your partner became pregnant, on average, how often did you eat fruit and vegetables (including fruit juice)?
- Never or rarely Four to seven times a week
 Twice a month More than once a day
 One to three times a week



E10. Before you/your partner became pregnant, on average, how often did you eat milk and dairy products (such as cheese and yoghurt)?

- Never or rarely
- Twice a month
- One to three times a week
- Four to seven times a week
- More than once a day

E11. Before you/your partner became pregnant, on average, how often did you eat protein-rich products (such as meat, fish, eggs and beans)?

- Never or rarely
- Twice a month
- One to three times a week
- Four to seven times a week
- More than once a day

E12. Before you/your partner became pregnant, on average, how often did you eat products containing fat and sugar (such as chocolate, biscuits, cakes and ice cream)?

- Never or rarely
- Twice a month
- One to three times a week
- Four to seven times a week
- More than once a day

E13. Before you/your partner became pregnant, on average, how often did you eat starchy products (such as bread, rice, potatoes and pasta)?

- Never or rarely
- Twice a month
- One to three times a week
- Four to seven times a week
- More than once a day



E14. Before you/your partner became pregnant, on average, how often did you eat wholegrain food varieties (such as wholegrain cereal and bread)?

Never or rarely

Four to seven times a week

Twice a month

More than once a day

One to three times a week

E15. Before you/your partner became pregnant, on average, how often did you eat meals and sandwiches bought from canteens/petrol stations/corner shops?

Never or rarely

Four to seven times a week

Twice a month

More than once a day

One to three times a week

E16. Before you/your partner became pregnant, on average, how often did you eat foods or meals from a takeaway outlet or fast-food restaurant?

Never or rarely

Four to seven times a week

Twice a month

More than once a day

One to three times a week

E17. Before you/your partner became pregnant, on average, how often did you eat 'ready meals' (such as microwavable or oven-ready meals)?

Never or rarely

Four to seven times a week

Twice a month

More than once a day

One to three times a week



E18. Before you/your partner became pregnant, on average, how often did you drink caffeinated tea or coffee?

- Never or rarely
- One or two cups a week
- One or two cups a day
- Three to five cups a day
- More than five cups a day

E19. Before you/your partner became pregnant, on average, how often did you drink herbal tea or decaffeinated tea or coffee?

- Never or rarely
- One or two cups a week
- One or two cups a day
- Three to five cups a day
- More than five cups a day

E20. Before you/your partner became pregnant, on average, how often did you drink fizzy drinks (such as coke or lemonade)?

- Never or rarely
- One or two times a week
- One to two times a day
- Three to five times a day
- More than five times a day

E21. Before you/your partner became pregnant, on average, how often did you drink energy drinks?

- Never or rarely
- One to two times a week
- One to two times a day
- Three to five times a day
- More than five times a day

E22. Before you/your partner became pregnant, on average, how often did you drink water?

- Never or rarely
- One to two times a week
- One to two times a day
- Three to five times a day
- More than five times a day



E23. Please tell us which supplements you have taken/currently take?

	i) Around the time your child was conceived	ii) During the first three months of pregnancy
a) Multivitamins	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
b) Vitamin A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
c) Vitamin B	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
d) Vitamin C	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
e) Vitamin D	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
f) Vitamin E	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
g) Calcium	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
h) Folic Acid	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
i) Iron	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
j) Zinc	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
k) Any other nutritional supplement?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

l) If yes to k), please specify:

E24. a) Did/do you take any herbal remedies?

i) **Around the time your child was conceived**

- Yes
- No
- Don't know

ii) **During the first three months of pregnancy**

- Yes
- No
- Don't know

b) If yes, please specify:

E25. Did you drink alcohol around the time your child was conceived? Yes No

E26. Did you drink alcohol during the first three months of pregnancy?

- Yes No

If you answered yes to E25 or E26 go to question E27, if no go to question E30.

Please use the image below to help you answer question E27



E27. On average, how many units of alcohol did you drink **per week?**

i) Around the time your child was conceived

- None
- One to two units
- Three to five units
- Five to ten units
- Ten to twenty units
- Twenty to thirty units
- More than thirty units

ii) During the first three months of pregnancy?

- None
- One to two units
- Three to five units
- Five to ten units
- Ten to twenty units
- Twenty to thirty units
- More than thirty units

E28. On average, how often did you drink alcohol?

i) Around the time your child was conceived

- Less than once per month
- One to three times per month
- One to two times per week
- Three to four times per week
- Every day or most days

ii) During the first three months of pregnancy

- Less than once per month
- One to three times per month
- One to two times per week
- Three to four times per week
- Every day or most days

E29. What type(s) of alcohol do you usually drink? (**Cross all that apply**)

- a) Beer
- b) Wine
- c) Spirits (such as vodka, gin, whisky)
- d) Fortified wines (such as sherry, port, Madeira)
- e) Mixed drink
- f) Other (please specify)



E30. a) Have you ever smoked cigarettes regularly? Yes
If no, go to question E36 No

b) If yes, when did you first start smoking? Year

E31. Did you smoke during the first three months of pregnancy? Yes **(Go to question E32)**
 No **(Go to question E33)**

E32. On average, how many cigarettes did you smoke **per day** during the first three months of pregnancy?

- Less than one per day One pack (15-24 per day)
 One per day One ½ packs (25-34 per day)
 Two to four per day Two packs (35-44 per day)
 ½ a pack (five to 14 per day) More than two packs per day

E33. a) If you used to smoke but have since stopped, please tell us when you quit? Year

b) If you used to smoke, on average, how many cigarettes did you used to smoke **per day**?

- Less than one per day One pack (15-24 per day)
 One per day One ½ packs (25-34 per day)
 Two to four per day Two packs (35-44 per day)
 ½ a pack (five to 14 per day) More than two packs per day

E34. a) Did you smoke at the time your child was conceived? Yes No

If you answered no to question E34 a), go straight to question E35



b) If yes, on average, how many cigarettes did you used to smoke **per day** at the time your child was conceived?

- | | |
|--|--|
| <input type="checkbox"/> Less than one per day | <input type="checkbox"/> One pack (15-24 per day) |
| <input type="checkbox"/> One per day | <input type="checkbox"/> One ½ packs (25-34 per day) |
| <input type="checkbox"/> Two to four per day | <input type="checkbox"/> Two packs (35-44 per day) |
| <input type="checkbox"/> ½ a pack (five to 14 per day) | <input type="checkbox"/> More than two packs per day |

E35. Where did you usually smoke?

- Only outside Only inside Both inside and outside

E36. Were you ever exposed to passive smoke e.g. at home, work or during leisure time)?

i) Around the time your child was conceived

- Yes
 No

If no, go to question E38

ii) During the first three months of pregnancy

- Yes
 No

If no, go to question E38

E37. How many hours a day were you exposed to passive smoke?

i) Around the time your child was conceived

- Less than one hour per day
 One to two hours per day
 Three to four hours per day
 More than four hours per day

ii) During the first three months of pregnancy

- Less than one hour per day
 One to two hours per day
 Three to four hours per day
 More than four hours per day

E38. Did you use any other types of nicotine? (Cross **all** that apply)

a) Around the time your child was conceived

- i) Nicotine gum
- ii) Adhesive patch
- iii) Nicotine sprays
- iv) Nicotine inhalers
- v) Lozenges or tablets
- vi) 'Sinus' or nasal snuff
- vii) Chewing tobacco
- viii) None
- ix) Other (specify below)

b) During the first three months of pregnancy

- i) Nicotine gum
- ii) Adhesive patch
- iii) Nicotine sprays
- iv) Nicotine inhalers
- v) Lozenges or tablets
- vi) 'Sinus' or nasal snuff
- vii) Chewing tobacco
- viii) None
- ix) Other (specify below)

E39. a) Have you **previously** used any of the following substances? (Cross **all** that apply)

	Never	Once a year	Twice a year	Once every two months	Once a month	Twice a month	Once a week or more
i) Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii) Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii) Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv) Amphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v) Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi) Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b) Did you use any of the following substances **around the time your child was conceived?**

(Cross **all** that apply)

	Never	Once a year	Twice a year	Once every two months	Once a month	Twice a month	Once a week or more
i) Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii) Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii) Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv) Amphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v) Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi) Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



c) Did you use any of the following substances **during the first three months of pregnancy?** (Cross **all** that apply)

	Never	Once a year	Twice a year	Once every two months	Once a month	Twice a month	Once a week or more
i) Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii) Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii) Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv) Amphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v) Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi) Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E40. Before you/your partner became pregnant, during a typical week, how many minutes on average did you do the following types of exercise?

i) Vigorous exercise (breathing hard, heart beats rapidly).

For example: running, aerobics, martial arts, fast swimming, or a team sport such as football or hockey

minutes per week

ii) Moderate exercise (heart rate increases slightly, but is not exhausting).

For example: fast walking or gentle cycling

minutes per week

iii) Muscle strengthening activities

For example: lifting weights, push-ups and sit-ups, heavy gardening or yoga

times per week

E41. On average, how much time did you spend outdoors?

i) Around the time your child was conceived

- Less than one hour per day
- One to two hours per day
- Three to four hours per day
- Five or more hours per day

ii) During the first three months of pregnancy

- Less than one hour per day
- One to two hours per day
- Three to four hours per day
- Five or more hours per day

SECTION F - YOUR WELLBEING

F1. How many close friends do you have (other than your partner)?

- 0 1 2 3 4 or more

F2. Overall, how would you rate your relationships with your close friends?

- Poor Fair Good Excellent

F3. During the last year, did you experience a period of acute stress or an emotional event which had an influence on your state of mind? (**Please cross all boxes that apply to you**)

- i) Death of a partner
- ii) Divorce
- iii) Marital separation
- iv) Prison sentence
- v) Death of a parent or close family member
- vi) Personal injury or illness
- vii) Marriage
- viii) Being sacked or laid off from work
- ix) Marital reconciliation
- x) Retirement
- xi) Change in health of family member
- xii) Pregnancy
- xiii) Sex difficulties
- xiv) Gaining a new family member
- xv) Business readjustment
- xvi) Change in financial state
- xvii) Death of a close friend
- xviii) Change to a different line of work



F3 continued...

- xix) Change in number of arguments with spouse
- xx) Setting up a mortgage
- xxi) Foreclosure of mortgage or loan
- xxii) Change in responsibilities at work
- xxiii) Son or daughter leaving home
- xxiv) Trouble with in-laws
- xxv) Outstanding personal achievement
- xxvi) Partner begins or stops work
- xxvii) Begin or end school/higher education
- xxviii) Change in living conditions
- xxix) Change in personal habits
- xxx) Trouble with your boss at work
- xxxi) Change in work hours or conditions
- xxxii) Moving house
- xxxiii) Change in schools/higher education
- xxxiv) Change in hobbies
- xxxv) Change in church activities
- xxxvi) Change in social activities
- xxxvii) Getting a small loan
- xxxviii) Change in sleeping habits
- xxxix) Change in the number of family get-togethers
- xl) Change in eating habits
- xli) Holiday
- xlii) Christmas
- xliii) Minor breaches of the law

F4. These questions ask you about your view of the world. Please cross the box for each statement that applies to you.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
a) In uncertain times, I usually expect the best	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) It's easy for me to relax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) If something can go wrong for me, it will	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I'm always optimistic about my future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I enjoy my friends a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) It's important for me to keep busy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I hardly ever expect things to go my way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) I don't get upset too easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) I rarely count on good things happening to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Overall, I expect more good things to happen to me than bad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



F5. Families sometimes have special concerns or difficulties because of their child's health. Below there is a list of things that might be a problem for you.

In the past **one month, as a result of your child's diagnosis**, how much of a problem **have you** had with...

	Never	Almost never	Sometimes	Often	Almost always
a) I feel tired during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I feel tired when I wake up in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I feel too tired to do the things I like to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I get headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I feel physically weak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I feel sick to my stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I feel anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) I feel sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) I feel angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) I feel frustrated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) I feel helpless or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) I feel isolated from others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) I have trouble getting support from others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) It is hard to find time for social activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) I do not have enough energy for social activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F5 continued...

	Never	Almost never	Some- times	Often	Almost always
p) It is hard for me to keep my attention on things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) It is hard for me to remember what people tell me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r) It is hard for me to remember what I just heard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s) It is hard for me to think quickly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) I have trouble remembering what I was just thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u) I feel that others do not understand my family's situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v) It is hard for me to talk about my child's health with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w) It is hard for me to tell doctors and nurses how I feel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
y) I worry about the side effects of my child's medications/medical treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
z) I worry about how others will react to my child's condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
aa) I worry about how my child's illness is affecting other family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bb) I worry about my child's future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Question F5. x) has been intentionally removed.





F6. Below is a list of things that might be a problem for your **family**.

In the past **one month, as a result of your child's diagnosis**, how much of a problem has **your family** had with...

	Never	Almost never	Some-times	Often	Almost Always
a) Family activities taking more time and effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Difficulty finding time to finish household tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Feeling too tired to finish household tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Lack of communication between family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Conflicts between family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Difficulty making decisions together as a family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Difficulty solving family problems together	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Stress or tension between family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F7. Please answer the following questions telling us how happy you are with the care **you and your family** have received at the hospital from the staff.

Please cross N/A (not applicable) if the item does not apply to you.

How happy are you with...

(For example, 'Never happy', 'Often happy' etc)

	Never	Some-times	Often	Almost always	Always	N/A
a) How much information was provided to you about your child's diagnosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) How much information was provided to you about the treatment and course of your child's health condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) How much information was provided to you about the side effects of your child's treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



F7 continued...

How happy are you with...

Never | Some-
times | Often | Almost
always | Always | N/A

d) How soon information was given to you about your child's test results?

e) How often you are updated about your child's health?

f) The sensitivity shown to you and your family during your child's treatment?

g) The willingness to answer questions that you and your family may have?

h) The effort to include your family in discussion of your child's care and other information about your child's health condition?

i) How much time the staff give you to ask any questions you may have had about your child's health condition and treatment?

k) The time taken to explain your child's health condition and treatment to you in a way that you could understand?

l) How well the staff listen to you and your concerns?

m) The preparation provided for you about what to expect during tests and procedures?





F7 continued...

How happy are you with:

	Never	Some- times	Often	Almost always	Always	N/A
u) The amount of time spent attending to your emotional needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w) How friendly and helpful the staff are?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Questions j, n, o, p, q, r, s, t, v and x have been intentionally removed.



We are asking these questions to help us understand the challenges families may experience. This will allow us to make recommendations about support that could be made available.

F8. These questions ask you about your feelings and thoughts **during the last month.**

	Never	Almost never	Some-times	Fairly often	Very often
a) How often have you been upset because of something that happened unexpectedly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) How often have you felt that you were unable to control the important things in your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) How often have you felt nervous and "stressed"?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) How often have you felt confident about your ability to handle your personal problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) How often have you felt that things were going your way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) How often have you found that you could not cope with all the things that you had to do?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) How often have you been able to control irritations in your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) How often have you felt that you were on top of things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) How often have you been angered because of things that were outside of your control?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) How often have you felt difficulties were piling up so high that you could not overcome them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



We are asking these questions to help us understand the challenges families may experience. This will allow us to make recommendations about support that could be made available.

F9. These questions ask you about your feelings and thoughts **during the last month.**

a) I feel tense or 'wound up'

- Most of the time
- A lot of the time
- From time to time, occasionally
- Not at all

c) I get a sort of frightened feeling as if something awful is about to happen

- Very definitely and quite badly
- Yes, but not too badly
- A little, but it doesn't worry me
- Not at all

e) Worrying thoughts go through my mind

- A great deal of the time
- A lot of the time
- From time to time, but not too often
- Only occasionally

g) I can sit at ease and feel relaxed

- Definitely
- Usually
- Not often
- Not at all

b) I still enjoy the things I used to enjoy

- Definitely as much
- Not quite so much
- Only a little
- Hardly at all

d) I can laugh and see the funny side of things

- As much as I always could
- Not quite so much now
- Definitely not so much now
- Not at all

f) I feel cheerful

- Not at all
- Not often
- Sometimes
- Most of the time

h) I feel as if I am slowed down

- Nearly all the time
- Very often
- Sometimes
- Not at all

■ F9 continued...

i) I get a sort of frightened feeling like 'butterflies' in the stomach

- Not at all
- Occasionally
- Quite often
- Very often

k) I feel restless as I have to be on the move

- Very much indeed
- Quite a lot
- Not very much
- Not at all

m) I get sudden feelings of panic

- Very often indeed
- Quite often
- Not very often
- Not at all

j) I have lost interest in my appearance

- Definitely
- I don't take as much care as I should
- I may not take quite as much care
- I take just as much care as ever

l) I look forward with enjoyment to things

- As much as I ever did
- Rather less than I used to
- Definitely less than I used to
- Hardly at all

n) I can enjoy a good book or radio or TV Programme

- Often
- Sometimes
- Not often
- Very seldom

Questions F10, F11 and F12 have been intentionally removed.

F13. These questions ask you about **your** feelings about your child's cleft. To what extent are each of these statements true of your feelings over the last **six months?**

	Never	Almost never	Some-times	Often	Almost always
a) I feel that the cleft has dominated my experience of having a baby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I feel that it is my fault that my baby has a cleft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I struggle to come to terms with my baby's cleft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





F13 continued...

	Never	Almost never	Some- times	Often	Almost always
d) I worry that I am unable to care for my baby because of the cleft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I worry about other health problems my baby may have	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I worry that the cleft will affect my relationship with my baby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I feel optimistic about my baby's future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



SECTION G - FURTHER INFORMATION

- G1. How old were you when you had your first menstrual period? years
- G2. Have you regularly experienced any of the following problems with your menstrual period? (**Cross all that apply**)
- | | |
|--|---|
| <input type="checkbox"/> a) Feeling depressed or irritable | <input type="checkbox"/> d) Menstrual pains |
| <input type="checkbox"/> b) Irregular periods | <input type="checkbox"/> e) Heavy bleeding |
| <input type="checkbox"/> c) Periods lasting longer than one week | <input type="checkbox"/> f) Anaemia |
- G3. Which of these types of contraceptives have you used in the past? (**Cross all that apply**)
- | | |
|--|--|
| <input type="checkbox"/> a) Condom | <input type="checkbox"/> g) Mini pill |
| <input type="checkbox"/> b) Diaphragm | <input type="checkbox"/> h) Spermicide |
| <input type="checkbox"/> c) Intrauterine Device (IUD) / coil | <input type="checkbox"/> i) Withdrawal |
| <input type="checkbox"/> d) Hormone Intrauterine Device (IUD) / coil | <input type="checkbox"/> j) None |
| <input type="checkbox"/> e) Hormone injection | <input type="checkbox"/> k) Other |
| <input type="checkbox"/> f) Pill | |
- If other, please specify:
-
- G4. If you have ever used the Hormone Intrauterine Device/Hormone injection/pill/mini pill, how long altogether have you used them?
- | | | |
|---|------------------------------------|---|
| <input type="checkbox"/> Less than one year | <input type="checkbox"/> 4-6 years | <input type="checkbox"/> 10 years or more |
| <input type="checkbox"/> 1-3 years | <input type="checkbox"/> 7-9 years | <input type="checkbox"/> Not applicable |
- G5. If applicable, how old were you when you first used hormonal contraception? years

In the following questions, we ask you about your pregnancies. When we ask about 'this pregnancy', please answer in relation to your current pregnancy. Some of these questions may sound repetitive, but we need to ask you about your pregnancy in more detail.

Please remember that we are asking a broad range of questions. If you experienced any problems during this pregnancy it does not necessarily mean that this is what caused your child's cleft.

- G6. How many times have you been pregnant in your life? times



G11. Continued...

i) During the first three months of pregnancy

ii) Rest of the pregnancy so far

d) An infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>
e) A fever with a temperature above 38 degrees Celsius	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>
f) Extreme nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>
g) Extreme nausea with vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>
h) High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>
i) Low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>
j) Gestational diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>
k) Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>
l) Pelvic problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>
m) Anaemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>
n) Vaginal bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>
o) Sleeping problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>
p) Rubella	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication used (if known) <input type="text"/>





G11. Continued...	i) During the first three months of pregnancy	ii) Rest of the pregnancy so far
q) Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No Medication used (if known) <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No Medication used (if known) <input type="text"/>
r) Syphilis	<input type="checkbox"/> Yes <input type="checkbox"/> No Medication used (if known) <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No Medication used (if known) <input type="text"/>
s) Pre-eclampsia	<input type="checkbox"/> Yes <input type="checkbox"/> No Medication used (if known) <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No Medication used (if known) <input type="text"/>
t) Toxoplasmosis	<input type="checkbox"/> Yes <input type="checkbox"/> No Medication used (if known) <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No Medication used (if known) <input type="text"/>

G12. Did you take any other medication during this pregnancy (including over the counter medication)?

i) During the first three months of pregnancy	ii) Rest of the pregnancy so far
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: <input type="text"/>

G13. Were you admitted to hospital unexpectedly during the pregnancy due to an illness or other complication?

a) During the first three months of pregnancy	b) Rest of the pregnancy so far
i) <input type="checkbox"/> Yes <input type="checkbox"/> No	i) Yes <input type="checkbox"/> No <input type="checkbox"/>
ii) If yes, length of stay (days) <input type="text"/> <input type="text"/>	ii) If yes, length of stay (days) <input type="text"/> <input type="text"/>
c) What was the cause of your hospital admission? <input type="text"/>	





G14. Did you receive any treatment involving anaesthetics during this pregnancy?

i) During the first three months of pregnancy

Yes No Don't know

ii) Rest of the pregnancy so far

Yes No Don't know

G15. Did you have an x-ray during this pregnancy?

i) During the first three months of pregnancy

Yes No Don't know

ii) Rest of the pregnancy so far

Yes No Don't know

G16. a) Do you **currently** smoke? Yes No

b) If yes, how many do you smoke per day?

Less than one per day

One pack (15-24 per day)

One per day

One ½ packs (25-34 per day)

Two to four per day

Two packs (35-44 per day)

½ a pack (five to 14 per day)

More than two packs per day

G17. a) Do you **currently** drink alcohol? Yes No

b) If yes, how much alcohol do you drink **per week?** (See image on page 30 to help answer the question)

None

Ten to twenty units

One to two units

Twenty to thirty units

Three to five units

More than thirty units

Five to ten units



G18. a) Did you drink caffeinated drinks (such as tea, coffee and fizzy drinks) during the **first three months** of this pregnancy?

Yes No

b) If yes, how often did you drink caffeinated drinks during the **first three months** of this pregnancy?

- Less than once a month
- One or two cups a week
- One or two cups a day
- Three to five cups a day
- More than five cups a day

G19. a) Do you **currently** use drugs? Yes No

b) If yes, how often do you use them? (Cross **all** that apply)

	Never	Once a year	Twice a year	Once every two months	Once a month	Twice a month	Once a week or more
i) Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii) Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii) Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv) Amphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v) Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi) Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



These questions ask you about **your partner**. Please fill in what you can.

G20. What is the highest educational qualification **your partner** has obtained? **(Cross one box only)**

- One or more O Levels/CSEs/GCEs (any grades)
- Five or more O Levels/CSEs (grade 1)/GCSEs (grades A*-C)/School Certificate
- One or more A Levels/AS Levels
- Two or more A Levels/Four or more AS Levels/Higher School Certificate
- NVQ Level 1/Foundation GNVQ
- NVQ Level 2/Intermediate GNVQ
- NVQ Level 3/Advanced GNVQ
- NVQ Levels 4-5/HNC/HND
- First degree (e.g. BA/BSc)
- Higher degree (e.g. MA, PhD, postgraduate PGCE)
- Other qualifications (e.g. City and Guilds, RSA/OCR, BTEC/Edexcel)
- Overseas qualifications (please specify)
- No qualifications
- Don't know
- Other (please specify)

G21. What is **your partner's** current employment status? **(Cross one box only)**

- Student
- At home
- Intern/apprentice
- Military Service
- Unemployed/laid off
- Rehabilitation/disabled
- Employed in public sector
- Employed in private sector
- Self-employed
- Other (please specify below)



G22. **This table shows income in weekly, monthly and annual amounts.** Which of the amounts on this list represents **YOUR PARTNER'S** individual total income from all jobs, tax credits, benefits and other sources **after tax** when added together? (**Cross one box only**)

Weekly Income after Tax	Monthly Income after Tax	Annual Income after Tax	
Less than £25	Less than £108	Less than £1,299	<input type="checkbox"/>
£25 - £39	£109 - £175	£1,300 - £2,099	<input type="checkbox"/>
£40 - £59	£176 - £259	£2,100 - £3,099	<input type="checkbox"/>
£60 - £79	£260 - £350	£3,100 - £4,199	<input type="checkbox"/>
£80 - £99	£351 - £433	£4,200 - £5,199	<input type="checkbox"/>
£100 - £124	£434 - £542	£5,200 - £6,499	<input type="checkbox"/>
£125 - £149	£543 - £650	£6,500 - £7,799	<input type="checkbox"/>
£150 - £179	£651 - £775	£7,800 - £9,299	<input type="checkbox"/>
£180 - £209	£776 - £917	£9,300 - £10,999	<input type="checkbox"/>
£210 - £259	£918 - £1,125	£11,000 - £13,499	<input type="checkbox"/>
£260 - £299	£1,126 - £1,333	£13,500 - £15,999	<input type="checkbox"/>
£300 - £379	£1,334 - £1,667	£16,000 - £19,999	<input type="checkbox"/>
£380 - £479	£1,668 - £2,083	£20,000 - £24,999	<input type="checkbox"/>
£480 - £577	£2,084 - £2,500	£25,000 - £29,999	<input type="checkbox"/>
£578 - £769	£2,501 - £3,333	£30,000 - £39,999	<input type="checkbox"/>
£770 - £962	£3,334 - £4,167	£40,000 - £49,999	<input type="checkbox"/>
£963 - £1,154	£4,168 - £5,000	£50,000 - £59,999	<input type="checkbox"/>
£1,155 - £1,346	£5,001 - £5,833	£60,000 - £69,999	<input type="checkbox"/>
£1,347 - £1,538	£5,834 - £6,667	£70,000 - £79,999	<input type="checkbox"/>
£1,539 or more	£6,668 or more	£80,000 or more	<input type="checkbox"/>

Please go to section Z on the back page.

SECTION Z

Z1. This questionnaire was completed by:

a) Baby's biological mother

b) Someone else (please cross box and describe)

Z2. Will you live in the same house as the baby? Yes No

Z3. On what date did you complete this questionnaire?

DD	MM	YYYY
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Z4. Please give **your** date of birth

DD	MM	YYYY
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

Please use this space for any additional comments you would like to make:

When completed please send this back in the freepost brown envelope to:

**The Cleft Collective
University of Bristol
Oakfield House
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