The Cleft Collective
Closing the Gap in Cleft Research
A Scar Free Foundation Initiative

ID LABEL

You and Your Child at 18 months

Mother's questionnaire

This questionnaire is for the child's mother.

University of Bristol
University of the West of England Bristol
The Scar Free Foundation
VTCT

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■ 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 cleft teams 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 seven sections:

A. **Your Child's Health** - This section asks you questions related to the health of your child
B. **Feeding Your Child** - This section asks about your experience of feeding your child
C. **Your Child's Teeth** - This section asks questions about your child's teeth and dentist
D. **Additional Questions About Your Child -** This section is additional questions not covered in any other section including childcare, sleep position and hearing
E. **Your Family** - This section asks you questions about where you live, your marital status and your other children (if applicable)
F. **Your Lifestyle** - this section asks questions about your diet, alcohol use, cigarette smoking and exercise
G. **Your Wellbeing** - the last section asks about how you have been feeling recently

<u>Please try to answer all of the questions</u>, 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 was born with a cleft. Please fill out 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 contact your cleft team who can help.

Thank you for completing this questionnaire!

SECTION A - YOUR CHILD'S HEALTH

A1. How many weeks pregnant were you when you gave birth?

Weeks ☐☐

A2. What is your child's gender? ☐ Male ☐ Female

The answers to questions A3 to A7 may be found in your child's red book (if available)

A3. How much did your child weigh **at birth** (if known)?

Lbs ☐☐ Oz ☐☐ OR Kg ☐☐ . ☐☐

A4. How much does your child weigh **now**?

Lbs ☐☐ Oz ☐☐ OR Kg ☐☐ . ☐☐

A5. What was your child's height/length **at birth** (if known)?

Feet ☐ Inches ☐☐ OR Cm ☐☐ . Mm ☐

A6. What is your child's height/length **now**?

Feet ☐ Inches ☐☐ OR Cm ☐☐ . Mm ☐

A7. What was your child's head circumference **at birth** (if known)?

Inches ☐☐ OR Cm ☐☐ . Mm ☐

A8. What is your child's head circumference **now**?

Inches ☐☐ OR Cm ☐☐ . Mm ☐

A9. What type of cleft was your child born with?

☐ Cleft lip ☐ Cleft lip and palate ☐ Don't know
☐ Cleft palate ☐ Submucous cleft palate

A10. If your child has a cleft lip; lip/palate, is it unilateral (on one side of their mouth) or bilateral (on both sides of their mouth)?

☐ Unilateral ☐ Bilateral ☐ Don't know ☐ Not applicable

A11. If your child's cleft is unilateral (on one side of their mouth), which side of your child's mouth is the cleft on **(when looking at your child)**?

☐ Right ☐ Left ☐ Don't know ☐ Not applicable

A12. a) When was your child's cleft lip diagnosed?

☐ At the 20 week scan ☐ During a 3D scan ☐ At birth ☐ Not applicable

b) If your child's cleft lip was diagnosed during a 3D scan, please give the number of weeks

☐☐ Weeks ☐ Not applicable

A13. a) When was your child's cleft palate diagnosed?

☐ At the 20 week scan ☐ At birth ☐ Not applicable
☐ During a 3D scan ☐ After birth (late diagnosis)

b) If your child's cleft palate was diagnosed during a 3D scan, please give the number of weeks

☐☐ Weeks ☐ Not applicable

c) If your child's palate was diagnosed after their birth, please tell us how many years/weeks/days after

Years ☐☐ Weeks ☐☐ Days ☐☐

A14. a) Has your child had their lip repaired?

☐ Yes ☐ No ☐ Not applicable

If yes b) How old was your child when they had their lip repaired?

Months ☐☐ Weeks ☐☐

A15. a) Has your child had their palate repaired?

☐ Yes ☐ No ☐ Not applicable

If yes b) How old was your child when they had their palate repaired?

Months

A16. Has your child had any other surgery relating to their cleft lip / cleft palate (e.g. hearing, grommets?)

a) ☐ Yes ☐ No **If yes** b) Please specify

A17. Has your child had any of the following infections? **(Cross all that apply)**

- ☐ 0) None
- ☐ i) German measles
- ☐ ii) Measles
- ☐ iii) Chickenpox
- ☐ iv) Mumps
- ☐ v) Meningitis
- ☐ vi) Urinary tract infection (E.g. cystitis)
- ☐ vii) Chest infections / pneumonia
- ☐ viii) Recurrent ear infections
- ☐ ix) Other infection (please specify below)

A18. Has your child had / does your child have any of the following conditions or problems? **(Cross all that apply)**

a) Neurological / Sensory Conditions

- ☐ 0) None
- ☐ i) Epilepsy / Fits / Convulsions
- ☐ ii) Cerebral Palsy
- ☐ iii) Development delay
- ☐ iv) Hearing loss or impairment
- ☐ v) Glue Ear, OME (Otitis Media with Effusion)
- ☐ vi) Difficulties with vision / blindness
- ☐ vii) Other neurological condition (specify below)

b) Heart / Lungs / Immune system

- ☐ 0) None
- ☐ i) Heart condition
- ☐ ii) Lung condition
- ☐ iii) Asthma / Difficulties breathing
- ☐ iv) Allergies
- ☐ v) Immune deficiency
- ☐ vi) Other problems with heart / lungs/ immune system (please specify below)

c) Skin / Musculoskeletal conditions

- ☐ 0) None
- ☐ i) Skin condition
- ☐ ii) Skeletal condition
- ☐ iii) Talipes (Club foot)
- ☐ iv) Spine condition
- ☐ v) Other skin / musculoskeletal condition (specify below)

d) Metabolic conditions

- ☐ 0) None
- ☐ i) Thyroid condition
- ☐ ii) Abnormal calcium levels
- ☐ iii) Blood condition
- ☐ iv) Other metabolic condition (specify below)

e) Abdominal conditions

- ☐ 0) None
- ☐ i) Severe / persistent vomiting
- ☐ ii) Severe / persistent diarrhoea
- ☐ iii) Severe / persistent gut abnormalities
- ☐ iv) Liver problems
- ☐ v) Jaundice
- ☐ vi) Failure to gain weight or grow
- ☐ vii) Other abdominal condition (specify below)

f) Kidney and bladder problems

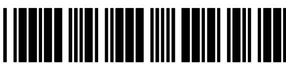
- ☐ 0) None
- ☐ i) Kidney / bladder problems (specify)
- ☐ ii) Hypospadias (males only)

A19. Does your child have problems with the development of any of the following? **(Cross all that apply)**

- ☐ a) Eyes
- ☐ b) Ears
- ☐ c) Cheekbones
- ☐ d) Jaw
- ☐ e) Tongue
- ☐ f) Hands
- ☐ g) Feet
- ☐ h) Spine
- ☐ i) Other development condition (please specify)
- ☐ j) None of the above

A20. Has **<u>your child</u>** been diagnosed with any of the following syndromes / genetic conditions? **(Cross <u>all</u> that apply)**

- ☐ a) Pierre Robin sequence (PRS)
- ☐ b) Van der Woude syndrome
- ☐ c) Treacher Collins syndrome
- ☐ d) Hemifacial Microsomy / Goldenhar syndrome
- ☐ e) Stickler syndrome
- ☐ f) 22q 11.2 deletion syndrome (also known as Velocardiofacial syndrome, Shprintzen syndrome, DiGeorge syndrome)
- ☐ g) Craniosynostosis (including Crouzon syndrome, Apert syndrome, Pfeiffer syndrome, Saethre-Chotzen syndrome)
- ☐ h) Cornelia de Lange syndrome
- ☐ i) Other syndrome / genetic condition (specify) ____________
- ☐ j) We are currently undergoing genetic testing at the hospital
- ☐ k) None of the above



A21. Have **you, the child's biological father, or any of your other children** been diagnosed with any of the following conditions? (For other children, please give their date of birth)

	i) You	ii) Child's father	iii) Other child	iv) Other child's DOB (if applicable) DD / MM / YY
a) Pierre Robin sequence (PRS)	☐	☐	☐	☐☐/☐☐/☐☐
b) Van der Woude syndrome	☐	☐	☐	☐☐/☐☐/☐☐
c) Treacher Collins syndrome	☐	☐	☐	☐☐/☐☐/☐☐
d) Hemifacial Microsomy / Goldenhar syndrome	☐	☐	☐	☐☐/☐☐/☐☐
e) Stickler syndrome	☐	☐	☐	☐☐/☐☐/☐☐
f) 22q 11.2 deletion syndrome (also known as Velocardiofacial syndrome, Shprintzen syndrome, DiGeorge syndrome)	☐	☐	☐	☐☐/☐☐/☐☐
g) Craniosynostosis (including Crouzon syndrome, Apert syndrome, Pfeiffer syndrome, Saethre-Chotzen syndrome)	☐	☐	☐	☐☐/☐☐/☐☐
h) Cornelia de Lange syndrome	☐	☐	☐	☐☐/☐☐/☐☐
i) We are currently undergoing genetic testing at the hospital	☐	☐	☐	☐☐/☐☐/☐☐
j) Other syndrome / genetic condition (specify below)	☐	☐	☐	☐☐/☐☐/☐☐

SECTION B - FEEDING YOUR CHILD

Babies who are born with a cleft often have difficulties feeding. Some parents are able to feed their baby directly from the breast, while other parents need to express breast milk, or use formula milk to help their baby feed

B1. a) Were you able to feed your child directly from the breast?

☐ We tried but were unable to ☐ We didn't try ☐ Yes

If yes b) How long did you breast feed your child?

i) ☐☐ weeks ii) ☐ My child is still being fed on breast milk

c) If no, how did you initially feed your child?

☐ MAM soft bottle (squeezy bottle) ☐ With a normal feeding bottle or teat

☐ Haberman feeder bottle system ☐ Other (please specify below)

B2. Did you feed your child using.....

☐ Breast milk only (including feeding directly from the breast and expressed breast milk)

☐ Formula milk only

☐ A combination of breast milk and formula milk

B3. a) Did you have difficulties feeding your child in the first few months?

☐ Yes, great difficulty ☐ Yes, some difficulty ☐ No difficulties

If yes b) Did you find these difficulties upsetting?

☐ Very upsetting ☐ A little upsetting ☐ No

B4. Did your child initially require any of the following?

☐ Feeding assistance with a feeding tube (Nasogastric Intubation, NGT)
☐ Respiratory assistance due to a blocked airway (Nasopharyngeal Airway, NPA)
☐ No assistance

B5. Has your child had any nasal regurgitation (food coming down their nose)?

☐ Often ☐ Sometimes ☐ No

B6. Has your child had any difficulties swallowing?

☐ Often ☐ Sometimes ☐ No

B7. Approximately how old was your child when they first had something other than milk to drink (e.g. tap water, mineral water, fruit juice)?

☐☐ months

B8. Approximately how old was your child when they were first given savoury solids to eat (e.g. savoury baby food in a jar, packet or tin, or homemade e.g. baby rice, pureed vegetables)?

☐☐ months

B9. Approximately how old was your child when they were first given sweet solids to eat (e.g. sweet baby food in a jar, packet or tin, or homemade e.g. rice pudding, pureed fruits)?

☐☐ months

B10. Since your child was 6 months old, have they at any time:

	i) Yes and worried me greatly	ii) Yes and worried me a bit	iii) Sometimes	iv) Almost never
a) Not eaten a sufficient amount of food	☐	☐	☐	☐
b) Refused to eat the right food	☐	☐	☐	☐
c) Been choosy with food	☐	☐	☐	☐
d) Overeaten	☐	☐	☐	☐
e) Been difficult to get into an eating routine	☐	☐	☐	☐

B11. Does your child have difficulties with particular tastes or textures?

a) ☐ Yes ☐ No

If yes b) Please specify ☐

B12. a) Does your child want to feed themselves?

☐ Yes ☐ No

If yes b) How do they feed themselves?

☐ Spoon or fork ☐ Fingers ☐ Both

B13. What does your child normally drink? **(Cross all that apply)**

☐ a) Water ☐ d) Squash

☐ b) Milk ☐ e) Other (please specify)

☐ c) Fruit juice ☐

B14. What does your child usually drink from?

☐ A bottle ☐ A cup or beaker ☐ Both

B15. If applicable, when did your child first begin drinking from a cup or a beaker?

i) ☐☐ months   ii) ☐ Not applicable

B16. a) Where does your child normally eat their meals? **(Cross <u>all</u> that apply)**

☐ i) At the table   ☐ iii) Walking around

☐ ii) In a highchair   ☐ iv) Other (please specify) ____________

b) Is this in front of the television? ☐Yes ☐No

B17. Does your child normally eat... **(Cross <u>all</u> that apply)**

☐ i) Alone   ☐ iii) With the whole of the family

☐ ii) With siblings   ☐ iv) Other (please specify) ____________

B18. Does your child eat the same foods as the rest of the family?

☐ Usually ☐ Sometimes ☐ No

B19. Does your child have snacks in the day, between meals?

☐ No ☐ Once ☐ Twice ☐ More than twice

B20. Now that your child is 18 months of age, do you have any concerns about their eating habits?

a) ☐ Yes ☐ No

If yes
b) please specify ____________

■ SECTION C - YOUR CHILD'S TEETH

C1. How old was your child when they developed their first tooth?

☐☐ months

C2. How many teeth does your child have now? ☐☐

C3. a) Do you brush your child's teeth? ☐ Yes ☐ No

If yes b) When?

☐ Morning ☐ Evening

☐ Morning and evening ☐ Other (please specify) ☐

C4. What toothpaste is your child using?

☐ None ☐ Children's paste (over 3 years)

☐ Children's paste (0-3 years) ☐ Adult toothpaste

C5. a) Does your child have a drink in the last hour before bed?

☐ Yes ☐ No

If yes b) What does your child drink? **(Cross <u>all</u> that apply)**

☐ i) Water ☐ iii) Juice

☐ ii) Milk ☐ iv) Other (please specify) ☐

If yes c) Do you brush your child's teeth afterwards? ☐ Yes ☐ No

C6. a) Does your child drink in the night? ☐ Yes ☐ No

If yes b) What does your child drink? **(Cross <u>all</u> that apply)**

☐ i) Water ☐ iii) Juice

☐ ii) Milk ☐ iv) Other (please specify) ☐

C7. Do you have a family dentist? ☐ Yes ☐ No

C8. Has your child come with you to the dentist? ☐ Yes ☐ No ☐ Not applicable

C9. Did the dentist look in your child's mouth? ☐ Yes ☐ No ☐ Not applicable

C10. Did the dentist talk to you about caring for your child's teeth?

☐ Yes ☐ No ☐ Not applicable

C11. Did the dentist place fluoride varnish on your child's teeth?

☐ Yes ☐ No ☐ Don't know ☐ Not applicable

C12. a) Has your child seen another dental specialist besides your family dentist?

☐ Yes ☐ No

If yes b) Where?

☐ In the cleft team ☐ At the hospital

☐ Somewhere else (please specify) [ ]

C13. Has your child been told they have dental caries / decay?

☐ Yes ☐ No ☐ Don't know

C14. Do you have any concerns about your child's teeth? **(Cross all that apply)**

☐ a) Number of teeth ☐ d) Colour of teeth

☐ b) Shape of teeth ☐ e) No concerns

☐ c) Position of teeth ☐ f) Other (specify below)

[ ]

SECTION D - ADDITIONAL QUESTIONS ABOUT YOUR CHILD

D1. In the first few months after your baby was born, what position was your baby in?

a) When they went down for the night?

☐ i. Lying on their back ☐ ii. Lying on their side ☐ iii. Lying on their front

b) When they woke up?

☐ i. Lying on their back ☐ ii. Lying on their side ☐ iii. Lying on their front

D2. The following questions ask you about who looks after your child (apart from yourself and your partner). **(Cross <u>all</u> that apply)**

Who looks after your child?	ii) How old was your child when this person / organisation regularly started looking after them?			iii) How often does this person / organisation look after your child each week?			
	Less than 6 months	Between 6 & 12 months	Between 12 & 18 months	Less than 1 day per week	1 to 2 days per week	3 to 4 days per week	More than 4 days per week
a) Baby's grandparent	☐	☐	☐	☐	☐	☐	☐
b) Other relative	☐	☐	☐	☐	☐	☐	☐
c) Friend or neighbour	☐	☐	☐	☐	☐	☐	☐
d) Paid person outside the home (e.g.child -minder)	☐	☐	☐	☐	☐	☐	☐
e) Paid person inside the home (e.g. nanny /babysitter)	☐	☐	☐	☐	☐	☐	☐
f) Private day nursery or creche	☐	☐	☐	☐	☐	☐	☐
g) Local authority day nursery	☐	☐	☐	☐	☐	☐	☐
h) Other (please specify below)	☐	☐	☐	☐	☐	☐	☐

D3. Generally, does your child listen to people or things that happen nearby?

- ☐ Usually
- ☐ Often
- ☐ Sometimes
- ☐ Usually not
- ☐ Don't know

D4. Does your child turn their head towards sounds?

- ☐ Usually
- ☐ Sometimes
- ☐ Only to very loud sounds
- ☐ Never
- ☐ Don't know

D5. During or after a cold, is your child's hearing worse than usual?

- ☐ Much worse
- ☐ A little worse
- ☐ About the same
- ☐ Don't know

D6. Does your child pull, scratch or poke at their ears?

- ☐ Quite often
- ☐ Sometimes
- ☐ Only when ill, restless or in pain
- ☐ Hardly ever
- ☐ Don't know

D7. Has pus or sticky mucus (not ear wax) ever leaked out of your child's ears?

- ☐ Never
- ☐ Once
- ☐ More than once
- ☐ Don't know

D8. Does your child breathe through their mouth rather than through their nose?

- ☐ All the time
- ☐ Much of the time
- ☐ Sometimes
- ☐ Hardly ever
- ☐ Don't know

D9. When children are first learning to communicate, they often use gestures to make their wishes known. Which of the following gestures does your child use?

	i) Not yet	ii) Some times	iii) Often
a) Extends arm to show you something they are holding	☐	☐	☐
b) Reaches out and gives you an object they are holding	☐	☐	☐
c) Points (with arm and index finger extended) at some interesting object or event	☐	☐	☐
d) Waves goodbye on their own when someone leaves	☐	☐	☐
e) Extends their arms upwards to signal a wish to be picked up	☐	☐	☐
f) Shakes head 'no'	☐	☐	☐
g) Nods head 'yes'	☐	☐	☐
h) Gestures 'hush' by placing finger to lips	☐	☐	☐
i) Asks for something by opening and closing hand	☐	☐	☐
j) Blows kisses from a distance	☐	☐	☐

D10. Has your child been involved in any other research studies?

☐ Yes ☐ No ☐ Don't know

If you answered 'no' or 'don't know' to D10, please go to section E.

D11. a) Was/is your child involved in the study, 'Timing Of Palatal Surgery (TOPS)?

☐Yes ☐No

If yes b) When did your child have their palate repair?

☐ 6 months ☐ 9 months ☐ 12 months

c) Was/is your child involved in the study, 'Supporting Parents Of Children with a Cleft Lip (SPOCCL)' study?

☐Yes ☐No

D11 continued...

If yes d) Which group was/is your child in?

☐ 'Watch and Discover' group (children were videoed at regular intervals and met with researchers for feedback)

☐ The 'Supported Information and Advice' group

e) Was/is your child involved in another research study? (Please specify below)

SECTION E - YOUR FAMILY

E1. a) Have you had any more children in the last 18 months? ☐ Yes ☐ No

If yes b) What is their date of birth? DD / MM / YY

If yes c) What is their gender? ☐ Male ☐ Female

If twins d) What is the gender of the other twin? ☐ Male ☐ Female

E2. a) Have any of your other children been born with a cleft (apart from the child in this study)?
☐ Yes ☐ No ☐ I have no other children

If yes, please give us the following information
If no, please go to question E3

b) Child 1

i) Date of birth DD / MM / YY

ii) Gender?

☐ Male
☐ Female

iii) What is their cleft type?

☐ Cleft lip
☐ Cleft palate
☐ Cleft lip and palate
☐ Submucous cleft palate
☐ Not known

iv) Is their cleft:

☐ Unilateral
☐ Bilateral
☐ Not known

c) Child 2

i) Date of birth DD / MM / YY

ii) Gender?

☐ Male
☐ Female

iii) What is their cleft type?

☐ Cleft lip
☐ Cleft palate
☐ Cleft lip and palate
☐ Submucous cleft palate
☐ Not known

iv) Is their cleft:

☐ Unilateral
☐ Bilateral
☐ Not known

E3. a) Are any of your other children enrolled in this study? ☐ Yes ☐ Not applicable ☐ No

If yes b) What is their date of birth? DD [ ][ ] / MM [ ][ ] / YY [ ][ ]

If yes c) What is their gender? ☐ Male ☐ Female

E4. a) Please tell us who lives in your current household? (Cross **all** that apply)

- ☐ i) Your spouse or domestic partner
- ☐ ii) Your children or stepchildren
- ☐ iii) Your siblings
- ☐ iv) Your parents
- ☐ v) Other relatives (please specify) [ ]
- ☐ vi) Unrelated individuals (please specify) [ ]
- ☐ vii) Live alone

b) Please tell us the following

i) Number of children/stepchildren who live with you [ ][ ]

ii) Number of siblings who live with you [ ][ ]

iii) Number of parents who live with you [ ][ ]

iv) Number of other relatives who live with you [ ][ ]

v) Number of unrelated individuals who live with you [ ][ ]

E5. How long have you lived in this current household arrangement?

[ ][ ] years AND/OR [ ][ ] months AND/OR [ ][ ] weeks

E6. What is your current marital status?

☐ Single ☐ Domestic partner ☐ Married

☐ Separated ☐ Divorced ☐ Widowed

☐ Civil Partnership

E7. How long have you lived in this current marital arrangement?

☐☐ years AND/OR ☐☐ months AND/OR ☐☐ weeks

E8. How would you describe your relationship with your current partner (if applicable)?

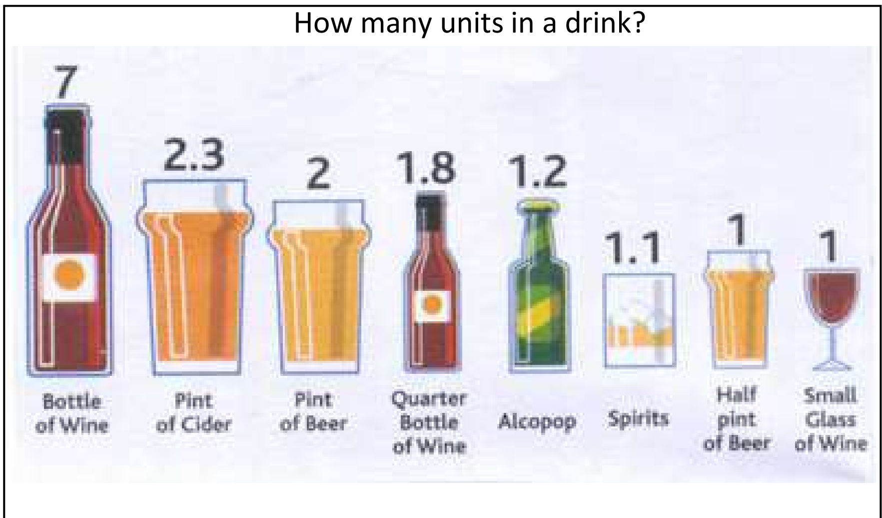
	Agree	**Agree Somewhat**	**Neutral**	**Disagree Somewhat**	**Disagree**
a) My partner and I have a close relationship	☐	☐	☐	☐	☐
b) My partner and I have problems in our relationship	☐	☐	☐	☐	☐
c) I am very happy in my relationship	☐	☐	☐	☐	☐
d) My partner is usually understanding	☐	☐	☐	☐	☐
e) I often think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

SECTION F - YOUR LIFESTYLE

F1. Do you currently drink alcohol? ☐ Yes ☐ No

If yes, go to question F2, if no go to question F5.

Please use the image below to help you answer question F2



F2. On average, how many units of alcohol do you drink **per week?**

☐ 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

F3. On average, how often do you drink alcohol?

- ☐ 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

F4. What type(s) of alcohol do you usually drink? **(Cross <u>all</u> 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) ______

F5. Do you currently smoke?

- ☐ Yes **(Go to question F6)**
- ☐ No **(Go to question F8)**

F6. On average, how many cigarettes do you currently smoke **<u>per day?</u>**

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

F7. Where do you usually smoke?

☐ Only outside ☐ Only inside ☐ Both inside and outside

F8. a) Are you ever exposed to passive smoke (breathing in other people's smoke e.g. at home, work or during leisure time)? ☐ Yes ☐ No

If yes b) How many hours a day are you exposed to passive smoke?

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

F9. a) Is your child (born with a cleft) ever exposed to passive smoke? ☐ Yes ☐ No

If yes b) How many hours is your child exposed to passive smoke?

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

F10. Do you currently use any other types of nicotine? **(Cross <u>all</u> that apply)**

☐ a) Nicotine gum
☐ b) Adhesive patch
☐ c) Nicotine sprays
☐ d) Nicotine inhalers
☐ e) Lozenges or tablets
☐ f) 'Snus' or nasal snuff
☐ g) Chewing tobacco
☐ h) Electronic cigarette
☐ i) None
☐ j) Other (please specify)

[ ]

F11. a) Do you currently use any drugs? ☐ Yes ☐ No

If yes b) How often do you use these substances? **(Cross <u>all</u> 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	☐	☐	☐	☐	☐	☐	☐
ii) Cocaine	☐	☐	☐	☐	☐	☐	☐
iii) Ecstasy	☐	☐	☐	☐	☐	☐	☐
iv) Amphetamine	☐	☐	☐	☐	☐	☐	☐
v) Heroin	☐	☐	☐	☐	☐	☐	☐
vi) Other (specify below)	☐	☐	☐	☐	☐	☐	☐

[ ]

Question F12 has been intentionally removed

F13. During a typical week, how many minutes / times per week on average do you do the following types of exercise?

a) 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

b) Moderate exercise (heart rate increases slightly, but is not exhausting).
For example: fast walking or gentle cycling

☐☐☐ minutes per week

c**) Muscle strengthening activities**
For example: lifting weights, push-ups and sit-ups, heavy gardening or yoga

☐☐ times per week

F14. On average, how much time do you spend outdoors?

- ☐ 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 G - YOUR WELLBEING

G1. How many close friends do you have (other than your partner if applicable)?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

G2. Overall, how would you rate your relationships with your close friends?

☐ Poor ☐ Fair ☐ Good ☐ Excellent

G3. In 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

G3 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

G4. 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 health**, how much of a problem have **you** had with the following...

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

G4 continued...

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

G5. 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 health**, 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	☐	☐	☐	☐	☐
b) Difficulty finding time to finish household tasks	☐	☐	☐	☐	☐
c) Feeling too tired to finish household tasks	☐	☐	☐	☐	☐
d) Lack of communication between family members	☐	☐	☐	☐	☐
e) Conflicts between family members	☐	☐	☐	☐	☐
f) Difficulty making decisions together as a family	☐	☐	☐	☐	☐
g) Difficulty solving family problems together	☐	☐	☐	☐	☐
h) Stress or tension between family members	☐	☐	☐	☐	☐

G6. Please answer the following questions telling us how happy you are with the care **you, your child, 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?	☐	☐	☐	☐	☐	☐
b) How much information was provided to you about the treatment and course of your child's health condition?	☐	☐	☐	☐	☐	☐
c) How much information was provided to you about the side effects of your child's treatment?	☐	☐	☐	☐	☐	☐

G6 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?	☐	☐	☐	☐	☐	☐
j) How well the staff explain your child's health condition and treatment to **your child** in a way that she/he can understand?	☐	☐	☐	☐	☐	☐
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?	☐	☐	☐	☐	☐	☐

G6 continued...

How happy are you with...	Never	Some-times	Often	Almost always	Always	N/A
n) The preparation provided for **your child** about what to expect during tests and procedures?	☐	☐	☐	☐	☐	☐
o) How well the staff respond to your child's needs?	☐	☐	☐	☐	☐	☐
p) Efforts to keep your child comfortable and as pain-free as possible?	☐	☐	☐	☐	☐	☐
q) How much time the staff take to help you with your child coming back home after hospitalisation?	☐	☐	☐	☐	☐	☐
r) The amount of time given to your child to play, talk about her/his feelings, and any questions she/he may have?	☐	☐	☐	☐	☐	☐
s) The amount of time spent helping your child with going back to school after hospitalisation?	☐	☐	☐	☐	☐	☐
t) The amount of time spent attending to **your child's** emotional needs?	☐	☐	☐	☐	☐	☐
u) The amount of time spent attending to **your** emotional needs?	☐	☐	☐	☐	☐	☐
v) The overall care your child is receiving?	☐	☐	☐	☐	☐	☐
w) How friendly and helpful the staff are?	☐	☐	☐	☐	☐	☐
x) The way your child is treated at the hospital?	☐	☐	☐	☐	☐	☐

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?**

G7. a) Are you happy with the outcome of your child's surgery so far?

☐ Very happy ☐ Neutral ☐ Very unhappy
☐ Quite happy ☐ Quite unhappy

b) How noticeable do you think your child's cleft is to other people?

☐ Not at all noticeable ☐ Makes no difference ☐ Very noticeable
☐ A little noticeable ☐ Quite noticeable

	Never	Almost never	Some-times	Often	Almost always
c) I feel that the cleft is dominating my experience of bringing up my child	☐	☐	☐	☐	☐
d) I feel that it is my fault that my child was born with a cleft	☐	☐	☐	☐	☐
e) I struggle to come to terms with my child's cleft	☐	☐	☐	☐	☐
f) I worry that I am unable to care for my child because of the cleft	☐	☐	☐	☐	☐
g) I worry about other health problems my child may have	☐	☐	☐	☐	☐
h) I worry that the cleft is affecting my relationship with my child	☐	☐	☐	☐	☐
i) I worry about my child's future cleft treatment	☐	☐	☐	☐	☐
j) I feel optimistic about my child's future	☐	☐	☐	☐	☐
k) I feel that there are positives to having a child with a cleft **(please specify below)**	☐	☐	☐	☐	☐

The Cleft Lip and Palate Association (CLAPA) is a UK charity which provides support to families affected by cleft lip/palate. CLAPA are separate from your cleft team.

G8. Since your child's cleft was diagnosed, have you received any support from CLAPA?

☐ Yes ☐ No

If no, go to question G11.

For more information about CLAPA please go to the website; www.clapa.com, or contact them by telephone on 020 7833 4883

G9. What type of support have you received from CLAPA? **(Cross all that apply)**

☐ a) Information about cleft lip and palate
☐ b) Information about treatment
☐ c) Feeding bottles
☐ d) Emotional support
☐ e) Other (specify below)

G10. How often have you been satisfied with the support you have received from CLAPA?

☐ Never ☐ Almost never ☐ Sometimes ☐ Often ☐ Almost always

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.

G11. 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?	☐	☐	☐	☐	☐
b) How often have you felt that you were unable to control the important things in your life?	☐	☐	☐	☐	☐
c) How often have you felt nervous and "stressed"?	☐	☐	☐	☐	☐
d) How often have you felt confident about your ability to handle your personal problems?	☐	☐	☐	☐	☐
e) How often have you felt that things were going your way?	☐	☐	☐	☐	☐
f) How often have you found that you could not cope with all the things that you had to do?	☐	☐	☐	☐	☐
g) How often have you been able to control irritations in your life?	☐	☐	☐	☐	☐
h) How often have you felt that you were on top of things?	☐	☐	☐	☐	☐
i) How often have you been angered because of things that were outside of your control?	☐	☐	☐	☐	☐
j) How often have you felt difficulties were piling up so high that you could not overcome them?	☐	☐	☐	☐	☐

G12. 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

b) I still enjoy the things I used to enjoy

- ☐ Definitely as much
- ☐ Not quite so much
- ☐ Only a little
- ☐ Hardly 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

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

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

f) I feel cheerful

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

g) I can sit at ease and feel relaxed

- ☐ Definitely
- ☐ Usually
- ☐ Not often
- ☐ Not at all

h) I feel as if I am slowed down

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

G12 continued...

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

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

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

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

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

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

m) I get sudden feelings of panic

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

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

- ☐ Often
- ☐ Sometimes
- ☐ Not often
- ☐ Very seldom

The following questions ask about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not yet begun doing. For each item, please cross the box that indicates whether your child is doing the activity regularly, or not yet.

G13.	Yes	Some-times	Not yet
a) When your child wants something, does he/she tell you by pointing to it?	☐	☐	☐
b) When you ask your child to, does he/she go into another room to find a familiar object?	☐	☐	☐
c) Does your child say eight or more words in addition to 'mama' and 'dada'?	☐	☐	☐
d) Does your child imitate a two-word sentence? For example, when you say a two-word phrase such as 'mama eat', does your child say both words back to you?	☐	☐	☐
e) Without showing him/her, does your child point to the correct picture when you say, 'Show me the cat', or ask, 'Where is the dog?'	☐	☐	☐
f) Does your child say two or three words that represent different ideas together, such as 'See dog', or 'mummy come home'?	☐	☐	☐

G14.	Yes	Some-times	Not yet
a) Does your child bend over or squat to pick up an object from the floor and then stand up again without any support?	☐	☐	☐
b) Does your child move around by walking, rather than crawling on his/her hands and knees?	☐	☐	☐
c) Does your child walk well and seldom fall?	☐	☐	☐
d) Does your child climb on an object such as a chair to reach something he wants (for example, to get a toy on to a counter or to 'help' you in the kitchen?)	☐	☐	☐
e) Does your child walk down the stairs if you hold onto one of his/her hands? He/she may also hold onto the railing or wall	☐	☐	☐
f) When you show your child how to kick a ball, does he/she try to kick the ball by moving his/her leg forward or by walking into it?	☐	☐	☐

G15.	Yes	Some-times	Not yet
a) Does your child throw a small ball with a forward arm motion ?	☐	☐	☐
b) Does your child stack a small block or toy on top of another one?	☐	☐	☐
c) Does your child make a mark on the paper with the tip of a crayon (or pencil or pen) when trying to draw?	☐	☐	☐
d) Does your child stack three small blocks or toys on top of each other by him/herself?	☐	☐	☐
e) Does your child turn the pages of a book by him/herself? (He/she may turn more than one page at a time)	☐	☐	☐
f) Does your child get a spoon into his/her mouth right side up so that the food usually doesn't spill?	☐	☐	☐

G16.	Yes	Some-times	Not yet
a) Does your child drop several small toys, one after another, into a container like a bowl or a box?	☐	☐	☐
b) After you have shown your child how, does he/she try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool?	☐	☐	☐
c) After a crumb of food is dropped into a small, clear bottle, does your child turn the bottle over to dump it out? **(You may show him/her how)**	☐	☐	☐
d) Without showing him/her how, does your child scribble back and forth when you give him/her a crayon (or pencil or pen)?	☐	☐	☐
e) After watching you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in any direction?	☐	☐	☐
f) After a crumb of food is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb of food? **(Do not show him/her how)**	☐	☐	☐

G17.	Yes	Some-times	Not yet
a) While looking at him/herself in the mirror, does your child offer a toy to his/her own image?	☐	☐	☐
b) Does your child play with a doll or stuffed animal by hugging it?	☐	☐	☐
c) Does your child get your attention or try to show you something by pulling on your hand or clothes?	☐	☐	☐
d) Does your child come to you when he/she needs help, such as with winding up a toy or unscrewing a lid from a jar?	☐	☐	☐
e) Does your child drink from a cup or glass, putting it down again with little spilling?	☐	☐	☐
f) Does your child copy the activities you do, such as wipe up a spill, sweep, shave or comb hair?	☐	☐	☐

G18. Do you think your child hears well? ☐Yes ☐No

G19. Do you think your child talks like other toddlers his / her age? ☐Yes ☐No

G20. Can you understand most of what your child says? ☐Yes ☐No

G21. Do you think your child walks, runs and climbs like other toddlers his / her age?

☐Yes ☐No

G22. Does either parent have a family history of childhood deafness or hearing impairment? ☐Yes ☐No

G23. a) Do you have concerns about your child's vision? ☐Yes ☐No

b) If **yes**, please explain

G24. a) Do you have concerns about your child's behaviour? ☐Yes ☐No

b) If **yes**, please explain

Question G25 has been intentionally removed.

G26. These questions ask about your child's development. Please cross the box which best describes your child's behaviour. In addition, please cross the final box if this behaviour is a concern to you.

	Most of the time	Some-times	Rarely or never	Cross if this is a concern
a) Does your child look at you when you talk to him/her?	☐	☐	☐	☐
b) When you leave, does your child remain upset and cry for more than an hour?	☐	☐	☐	☐
c) Does your child laugh or smile when you play with him/her?	☐	☐	☐	☐
d) Does your child look for you when a stranger approaches?	☐	☐	☐	☐
e) Is your child's body relaxed?	☐	☐	☐	☐
f) Does your child like to be hugged or cuddled?	☐	☐	☐	☐
g) When upset, can your child calm down within 15 minutes?	☐	☐	☐	☐
h) Does your child stiffen and arch his/her back when picked up?	☐	☐	☐	☐
i) Does your child cry, scream, or have tantrums for long periods of time?	☐	☐	☐	☐
j) Is your child interested in things around him/her, such as people, toys and foods?	☐	☐	☐	☐
k) Does your child do things over and over and can't seem to stop? Examples include rocking or hand flapping.	☐	☐	☐	☐
l) Does your child have eating problems, such as stuffing foods, vomiting or eating non-food items?	☐	☐	☐	☐
m) Does your child have trouble falling asleep at naptime or at night?	☐	☐	☐	☐
n) Do you and your child enjoy mealtimes together?	☐	☐	☐	☐

G26. Continued	Most of the time	Some-times	Rarely or never	Cross if this is a concern
o) Does your child sleep at least 10 hours in a 24-hour period?	☐	☐	☐	☐
p) When you point at something, does your child look in the direction you are pointing?	☐	☐	☐	☐
q) Does your child get constipated or have diarrhoea?	☐	☐	☐	☐
r) Does your child let you know how he/she is feeling with gestures or words? For example, does he/she let you know when he/she is hungry, hurt or tired?	☐	☐	☐	☐
s) Does your child follow simple directions? For example, does he/she sit down when asked?	☐	☐	☐	☐
t) Does your child like to play near or be with family members and friends?	☐	☐	☐	☐
u) Does your child check to make sure you are near when exploring new places, such as a park or a friend's home?	☐	☐	☐	☐
v) Does your child like to hear stories or sing songs?	☐	☐	☐	☐
w) Does your child hurt themself on purpose?	☐	☐	☐	☐
x) Does your child like to be around other children?	☐	☐	☐	☐
y) Does your child try to hurt other children, adults, or animals, for example, by kicking or biting?	☐	☐	☐	☐
z) Has anyone expressed concerns about your child's behaviours? If you cross "sometimes" or "most of the time", please specify in the box below	☐	☐	☐	☐

G27. a) Do you have concerns about your child's eating or sleeping behaviours?

☐ Yes ☐ No

If yes b) Please explain

G28. a) Is there anything that worries you about your child? ☐ Yes ☐ No

If yes b) Please explain

G29. What things do you enjoy most about your child?

SECTION H - ADDITIONAL QUESTIONS FOR THE MOTHER

H1. a) Does the child's biological father currently live with you? ☐Yes ☐No

If no b) How old was the child when the biological father left the home?

Months ☐☐ Weeks ☐☐

H2. a) Does the child's biological father have a cleft lip or cleft palate? ☐Yes ☐No

If yes b) What type of cleft?

- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Cleft lip and palate
- ☐ Submucous cleft palate
- ☐ Don't know

c) Was their cleft:

- ☐ Unilateral
- ☐ Bilateral
- ☐ Not known

H3. a) To the best of your knowledge, have any of the biological father's relatives been diagnosed with a cleft lip or cleft palate? ☐Yes ☐No

If yes

b) i) Please tell us who?

☐

ii) What is their cleft type?

- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Cleft lip and palate
- ☐ Submucous cleft palate
- ☐ Not known

iii) Is their cleft:

- ☐ Unilateral
- ☐ Bilateral
- ☐ Not known

c) i) Please tell us who?

ii) What is their cleft type?

- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Cleft lip and palate
- ☐ Submucous cleft palate
- ☐ Not known

iii) Is their cleft:

- ☐ Unilateral
- ☐ Bilateral
- ☐ Not known

d) i) Please tell us who?

ii) What is their cleft type?

- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Cleft lip and palate
- ☐ Submucous cleft palate
- ☐ Not known

iii) Is their cleft:

- ☐ Unilateral
- ☐ Bilateral
- ☐ Not known

Please go to section Z on the back page

SECTION Z

Z1. This questionnaire was completed by:

a) Child's biological mother ☐

b) Someone else (please cross box and describe) ☐ [ ]

Z2. Do you live in the same house as the child? ☐ Yes ☐ No

Z3. On what date did you complete this questionnaire? DD / MM / YYYY

Z4. Please give **your** date of birth DD / MM / YYYY

Z5. Please give **your child's** date of birth DD / MM / YYYY

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
Oakfield Grove
Bristol, BS8 2BN

Office use only ☐

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