

*1. Patient personal details

Insurance number:.....

Name:

Date of birth:.....

Gender: female / male

Race: Asian-Indian / Caucasian / Black / N/A

Date of interview: (csak dátum)

2. Details from the medical history of mother during the pregnancy

Smoking: yes / no

if yes: amount (cigarettes/day):..... for
how many years?

if not: Did he/she smoke earlier? yes/no/ N/A

if yes: amount (cigarettes/day):..... for
how many years?.....

Number of years since quit:

Did the physician provide smoking cessation guidance to patient? yes/no/ N/A

Does the patient suffer from secondhand smoke? yes/no/ N/A

Drug abuse: yes / no *Prescribed medication should not be included here. if*

yes: type of drug:.....

amount: heavy moderate mild

for how many years:.....

Alcohol consumption: yes / no

Guide for estimation of the amount:

1 dl beer (4.5 vol. %) = ~3.5 g alcohol

1 dl wine (12.5 vol. %) = ~10 g alcohol

1 dl hard drink (50 vol. %) = ~40 g alcohol

If yes: frequency: occasionally/monthly/weekly/daily/N/A

amount (g/occasion):..... for how many years:

.....

If not: Did he/she drink alcohol earlier? yes/no/ N/A

If yes: frequency: occasionally/monthly/weekly/daily/N/A

amount (g/occasion):.....

for how many years?.....

Number of years since quit:.....

Special diet: yes / no if

yes: (többválasztós)

Diet form: vegetarian / vegan / gluten free / lactose free / other, please specify:

3. Risk factors of mother during the pregnancy

The answer is “yes” if the etiological factor is proven, the answer is “no” if the etiological factor can be ruled out, the answer is “N/A” if the etiological factor was not examined. Please answer “yes” to “Idiopathic” if etiological factor was not identified.

Aspirin	yes	no	N/A
Cigarette smoking	yes	no	N/A
Dilantin	yes	no	N/A
6-Mercaptopurin	yes	no	N/A

4. Heredity of cleft (includes all known relatives)

Family history of clefts: yes no N/A

If yes, relationship: father / mother / sibling / child / paternal grandfather / paternal grandmother / maternal grandmother / maternal grandfather / paternal cousin / maternal cousin / father sibling (uncle, aunt) / mother sibling (uncle, aunt) / siblings child (nephew, niece) / grandchild / paternal grandfathers sibling / paternal grandmothers sibling / maternal grandfathers sibling / maternal grandmothers sibling / other blood relation / spouse (husband, wife, other not blood relation)

5. Details from the medical history of the patient

General health:

Is your child in good health? yes/ no/ NA

Has your child ever been hospitalized, had general anesthesia, or emergency room visits? yes/ no/ NA

If yes, explain:.....

Are your child’s immunizations up to date? yes/ no/ NA

Feeding: mother breast / baby bottle / Habermann feeder / Soft cup feeder / SNS device / other:..... breast milk/ tipster/ other, specify:.....

Regurgitation:

yoghurt: yes/ no

chocolate: yes/ no

fluid: yes/ no solid

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food: yes/ no

other:.....

Growth:

Has your child had any recent rapid growth? yes/ no If so, how much?(cm/ month)

Females: Has menstruation begun? yes/ no If yes, when?.....(yyyy/mm)

Pregnant? yes/ no

Using birth control pills? yes/ no

If yes to any above, please explain this or any other problem:.....

Medications:

Does your child have allergies to medications, medical products, or the environment? yes/ no/ N/A

If yes, please list: drug / latex/ dust/ mites/ pollen/ mold / other:.....

Medications taken regularly by child: yes / no

Please specify the name of the active substance (e.g. "acetylsalicylic acid"). Please specify the amount using the International System of Units –SI (e.g. milligram, gram) if yes:

Name of medication:..... active

substance:.....

dose: (number only!)

unit: g / mg / IU if fluid, concentration (e.g. 10%, 1g/2ml, etc.)..... how many times per day (e.g. 3):

.....

method of administration: intravenous / oral / enteral / subcutan

other notes:

Has your child ever had or been treated by a physician for:

Select one for each condition: (többválasztós)

Problem at birth Heart murmur Heart disease

Rheumatic fever Anemia Sickle cell anemia Bleeding/ hemophilia

Blood transfusion Hepatitis AIDS or HIV+ Tuberculosis

Liver disease Kidney disease Diabetes Arthritis Cancer

Cerebral palsy Seizures Asthma Speech or hearing problem

Eye problems/ contact lenses Skin problems Tonsil/ adenoid/ sinus problems Sleep problems Emotional/ behavior problems Radiation therapy Growths problems Attention deficit disorders Osteoporosis (bisphosphonates) Other, specify:.....

School:

Patient's school: Nem vett részt oktatásban / Óvoda / 1 osztály / 2 osztály / 3 osztály / 4 osztály / 5 osztály / 6 osztály / 7 osztály / 8 osztály / 9 osztály / 10 osztály / 11 osztály / 12 osztály, érettségi nélkül / Érettségi // Megkezdett egyetem vagy főiskola diploma nélkül / Szakképesítés/ Főiskolai diploma/Alapszint (Bachelor fokozat) (pl.: Ba, Ab, Bs, Bba) / Egyetemi diploma/Mesterszint (Master fokozat) (pl.: Ma, Ms, Meng, Med, Mba) / Doktori címet adó egyetemi végzettség (például: orvos, fogorvos, állatorvos, jogász) / Doktori fokozat (pl.: Phd,) / Nem kíván válaszolni / Nem tudja

Do you consider your child to be (check one):

- Advanced in learning Progressing normally Slow learner

6. Dental history of the patient

What is your main concern about your child's dental condition?.....

Has your child been to a dentist before? no yes If yes, date of last visit:...(yyyy/mm)

Has your child ever had dental x-rays? yes no N/A

If yes, date of the last x-rays:..... (yyyy/mm/dd)

Will your child be uncooperative? yes no N/A

If yes, explan:.....

Has your child experienced any complications following dental treatment? yes no N/A

If yes, explan: bleeding/ pain/ swelling/ fever

Has your child had cavities and/ or toothaches? yes no N/A

Are your child's teeth sensitive to temperature or food? yes no N/A

Has your child inherited any family facial or dental characteristics? yes no N/A

If yes, explan:.....

Prevention:

Did you or child ever get instructions in brushing? yes no N/A

Do your child's gums bleed when brushed? yes no N/A

Does your child use fluoride products: rinses, drops, tabs? yes no N/A

Function:

Does or has your child had any clicking or pain in the jaw joint? yes no N/A

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Does or has your child had any problems opening or closing their mouth? yes no N/A

Dental trauma:

Has your child ever injured his/her teeth? yes no N/A Has

your child ever injured his/her jaw or face? yes no N/A

Habits:

Does or did your child use a pacifier? yes no N/A Does

or did your child suck his/her fingers or thumb? yes no N/A Does your

child have any other dental problems we should know about?

Please, explain:

7. Diagnosis (State primary and, if applicable, secondary diagnoses)

7.1. ICD 10

ICD10 code		Primary (tick only one)	Secondary (tick only one)
			No sec. code <input type="checkbox"/>
Q3500	Cleft hard palate		
Q3530	Cleft soft palate		
Q3550	Cleft hard palate with cleft soft palate		
Q3570	Uvula bifida		
Q3600	Cleft lip, bilateral		
Q3610	Cleft lip, median		
Q3690	Cleft lip, unilateral		
Q3700	Cleft hard palate with bilateral cleft lip		
Q3710	Cleft hard palate with unilateral cleft lip		

Q3720	Cleft soft palate with bilateral cleft lip		
Q3730	Cleft soft palate with unilateral cleft lip		
Q3740	Cleft hard and soft palate with bilateral cleft lip		
Q3750	Cleft hard and soft palate with unilateral cleft lip		
Q3850	Congenital malformations of palate, not elsewhere classified		

7.2. Genetic testing

Refer to situation at baseline. Updates due to later identified conditions can be performed at any time in the web-application form.

Pierre Robin Sequence

No / Unknown / Yes*), specify when diagnosed

Age of diagnosis: Age ≤ 3months / Age >3months, give date (yyyy-mm-dd)

*) Yes must only be ticked if all the three conditions Glossoptosis, Micrognathia and Cleft palate are present

Syndrome

Trisomy 13 yes / no

Trisomy 18 yes / no

Velocardiofacial syndrome (22q11 delation) yes / no

Pierre Robin sequence yes / no CHARGE

association yes / no

Goldenhar syndrome yes / no

Ectrodactyly-ectodermal dysplasia-clefting syndrome yes / no

Gorlin syndrome yes / no

Oto-palato-digital syndrome yes / no

Smith -Lemli-Opitz syndrome yes / no

Stickler syndrome yes / no

Treacher Collins syndrome yes / no

Van der Woude syndrome yes / no

de Lange syndrome yes / no Kabuki syndrome yes / no

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Fetal alcohol syndrome yes / no Fetal
valproate syndrome yes / no
Other yes / no If yes, specify:.....

Age of diagnosis

Age \leq 3months / Age $>$ 3months, give date (yyyy-mm-dd)

Other deformity

No / Yes, Specify (Please, use block letters):

Other deformity diagnosed

Age \leq 3months / Age $>$ 3months, give date (yyyy-mm-dd)

8. State 8.1.Cleft morphology

Nasal floor: Right Yes/ No; Left Yes/ No

Lip: Right Yes/ No; Left Yes/ No

Alveolus: Right Yes/ No; Left Yes/ No

Primary palate: Right Yes/ No; Left Yes/ No

Hard palate: Right Yes/ No; Left Yes/ No

Soft palate: Right Yes/ No; Left Yes/ No

8.2. Body index

Body weight on the day of the examination: (kg) Body

height on the day of the examination: (cm) BMI:

9. Symptoms

Skin:

Deficient across partial (incomplete) vertical height of upper lip yes/ no

Deficient across full (complete) vertical height of upper lip yes/ no

Muscle (m. orbicularis oris) :

Deficient and/or disoriented across cleft yes/ no

Absent in prolabium yes/ no **Lip:**

Cupid's bow is less conspicuous and upwardly rotated toward the cleft side. Philtral column is shorter on the cleft side yes/ no

Bilateral loss of Cupid's bow and philtral structures yes/ no

Bone:

Mild alveolar cleft yes/ no

Moderate alveolar cleft yes/ no

Wide alveolar cleft yes/ no

Premaxilla may be significantly protruded yes/ no **Nose:**

Nasal tip: normal (symmetric)/ flat and deflected to non-cleft side/ flat and broad

Columella: normal (symmetric)/ short

Nasal base: normal (symmetric)/ Lateral crus of alar cartilage is displaced laterally, posteriorly, and inferiorly on cleft side/ Bilateral lateral crura of alar cartilages are displaced laterally, posteriorly, and inferiorly

Nostril: oriented vertically/ oriented horizontally on cleft side / oriented horizontally on both sides

Septum: normal (caudal)/ displaced to non-cleft side

10. Examination

10.1. Cephalometric analysis (after first lateral x-ray and the others)

	Mean	Date N. 1	Date N. 2	Date N. 3	Date N. 4	Date N. 5
SNA	82					
SNB	80					
ANB	2					
SNPg	81					
NSBa	130					
Gn-tgo-Ar	126					
angle N	58					
angle H	8					
ML-NSL	32					
NL- NSL	8,5					
ML-NL	23,5					
N-Sp' (mm)						
Sp'-Gn (mm)						
N-Sp' / Sp'-Gn x100	79%					
T-⊥	131					
⊥- NA	22					

T-NB	25				
L- NA (mm)	4				
T-NB (mm)	4				
Pg-NB					
T-NPg					
NasoLab	110				
Tweed					


10.2. Classification of occlusion Modified Huddart Bodenham index (at 6, 10, 19 years and at 1 year after orthognathic surgery)

Anterior score/ central incisors:

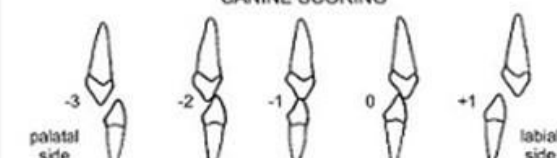
Posterior score/ right side:

Posterior score/ left side:

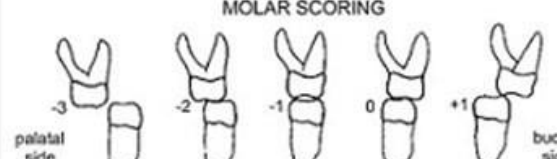
INCISOR SCORING



CANINE SCORING



MOLAR SCORING



Calculation of MHB

1. Missing central incisor - equal score as other central
2. Missing canine - score determined by alveolar ridge
3. Missing primary molar/premolar - equal score as adjacent tooth/alveolar ridge if both are missing

All ages: both centrals=sum of scores for 2 pairs of teeth




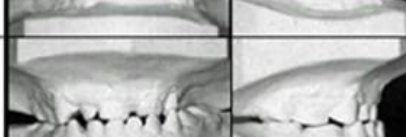

5 yrs: canine+2 primary molars=sum of scores for 3 pairs of teeth.

10, 19 yrs and 1y post-surgery: canine+premolars+1st molar=sum of scores for 4 pairs of teeth

At 6 years:

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<input type="checkbox"/>	1. Positive overjet with average inclined or retroclined incisors. No crossbite/open bites.	
<input type="checkbox"/>	2. Positive overjet with average inclined or proclined incisors. Unilateral crossbite/cross bite tendency. Open bite tendency around cleft site.	
<input type="checkbox"/>	3. Edge-to-edge bite with average inclined/proclined incisors or reverse overjet with retroclined incisors. Unilateral crossbite. ±Open bite tendency around cleft site.	
<input type="checkbox"/>	4. Reverse overjet with average inclined or proclined incisors. Unilateral crossbite ± bilateral crossbite tendency. ±Open bite tendency around cleft site.	
<input type="checkbox"/>	5. Reverse overjet with proclined incisors. Bilateral crossbite. Poor maxillary arch form and palatal vault anatomy.	

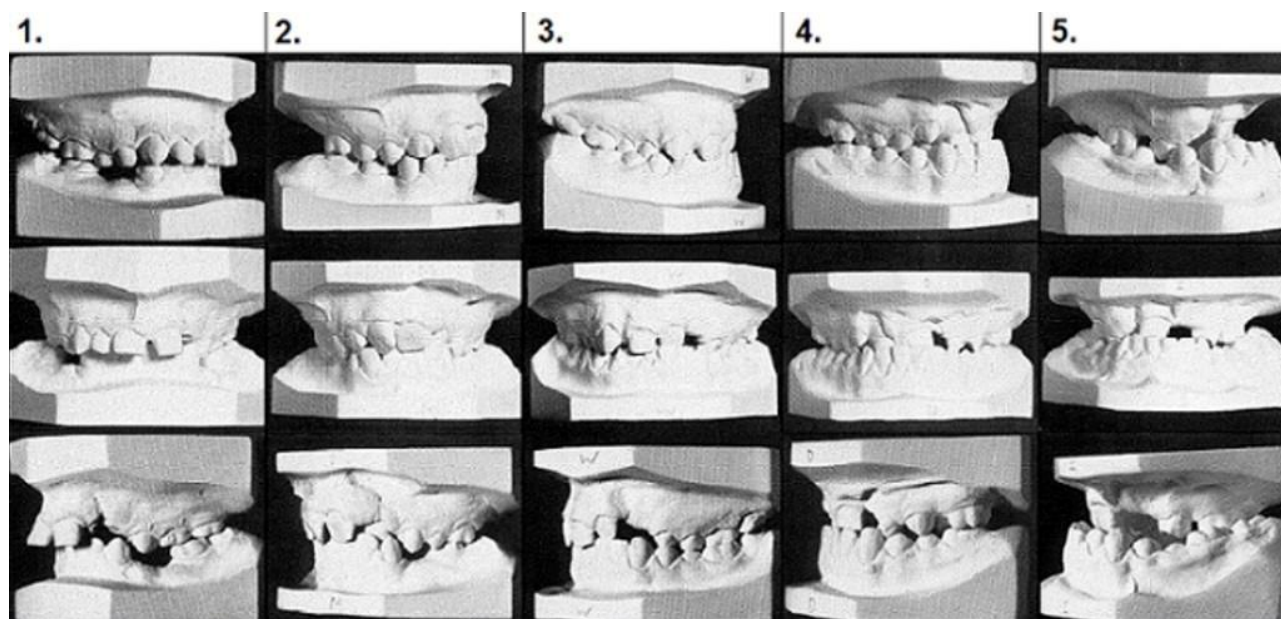
At 10 & 19 years, 1 year after orthognathic surgery:

GOSLON

Anteroposterior assessment: Dentoalveolar compensation with marked proclination of upper incisors and retroclination of lower - a higher category should be considered. If incisor inclination or mandibular overclosure exaggerates the severity - a lower score should be considered

Vertical assessment: Favorable vertical features (i.e. deep overbite) do not indicate modification of category except in borderline cases. A reduced overbite or anterior open bite suggests higher score.

Transversal assessment: A normal transverse relationship or a crossbite that can be treated orthodontically does not indicate a change of group. Marked maxillary arch narrowing with bilateral crossbite could indicate a more severe category.



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At 6 years:

Photos :Yes / No / Not possible

Casts: Yes / No / Not possible

OPG: Yes / No / Not possible

Cephalometric Radiograph: Yes / No /Not possible

Cephalometrics SNAo SNBo ANBo ML- NSLo

Around 10 years (before bone grafting):

Agenesis / permanent teeth, tooth name:.....

Photos :Yes / No / Not possible

Casts: Yes / No / Not possible

OPG: Yes / No / Not possible

Cephalometric Radiograph: Yes / No /Not possible

Cephalometrics SNAo SNBo ANBo ML- NSLo

CBCT: Yes / No / Not possible

3 months after bone grafting: Photos

:Yes / No / Not possible

Casts: Yes / No / Not possible

OPG: Yes / No / Not possible

Cephalometric Radiograph: Yes / No /Not possible

Cephalometrics SNAo SNBo ANBo ML- NSLo

CBCT: Yes / No / Not possible

At 16 years:

Photos :Yes / No / Not possible

Casts: Yes / No / Not possible

OPG: Yes / No / Not possible

Cephalometric Radiograph: Yes / No /Not possible

Cephalometrics SNAo SNBo ANBo ML- NSLo

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Retrospective

Bone grafting : Yes / No

Orthodontics before bone grafting: Yes / No

Score; bone level in the cleft area estimated in relation to the root length of the tooth mesial of the cleft

Right side: Not applicable / **0:** Bone missing / **1:** <3/4 / **2:** >=3/4

Left side: Not applicable / **0:** Bone missing / **1:** <3/4 / **2:** >=3/4

At 19 years (before orthognathic surgery):

Photos :Yes / No / Not possible

Casts: Yes / No / Not possible

OPG: Yes / No / Not possible

Cephalometric Radiograph: Yes / No /Not possible

Cephalometrics SNA° SNB° ANB° ML- NSL°

CBCT: Yes / No / Not possible

At 1 year after ortognathic surgery:

Photos :Yes / No / Not possible

Casts: Yes / No / Not possible

OPG: Yes / No / Not possible

Cephalometric Radiograph: Yes / No /Not possible

Cephalometrics SNA° SNB° ANB° ML- NSL°

CBCT: Yes / No / Not possible

11. Pre-operative treatment

None/ Unknown / Yes, specify below (Tick one or more alternatives)

Tape: yes/ no

Plate: yes/no

Nasal alar elevator: yes/no

Nasoalveolar molding: yes/ no

Other, Specify

(Please, use block letters)

How long was she/he taping?weeks

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How long had she/he plate?weeks

How long had she/ he nasal alar elevator?weeks

How long had she / he nasolabial molding?weeks

12. Operation

Lip operation

Not performed / Primary surgery / Secondary surgery

Operation code	(State primary and, if applicable, secondary code)	Major code (tick only one)	Minor code (tick only one)
			No minor code <input type="checkbox"/>
	Lipadhesion		
	Lipplasty		
	Other procedures		

Cleft soft and hard palate operation

Not performed / Primary surgery / Secondary surgery

(több válasz is)

Operation code	(State primary and, if applicable, secondary code)	Major code (tick only one)	Minor code (tick only one)
			No minor code <input type="checkbox"/>
	Repair of fistula		
	Hard and soft palate closure		
	Hard palate closure		
	Soft palate closure		
	Re-repair of palate		
	Pharyngeal flap		
	Plastic operation of pharynx		

Nose operation

Not performed / Primary surgery / Secondary surgery

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Retrospective

(több válasz is)

Operation code	(State primary and, if applicable, secondary code)	Major code (tick only one)	Minor code (tick only one)
			No minor code <input type="checkbox"/>
	Conchotomy		
	Plastic repair of septum		
	Reconstruction of cartilage of nose		
	Reconstruction of bone of nose		
	Rhinoplasty, bone and cartilage		
	V to Y plasty		

Jaw operation

Not performed / Primary surgery / Secondary surgery

(több válasz is)

Operation code	(State primary and, if applicable, secondary code)	Major code (tick only one)	Minor code (tick only one)
			No minor code <input type="checkbox"/>
	Tooth extraction		
	Mucogingival repair		
	Oronasal fistula repair		
	Lefort I osteotomi		
	Distraction of maxilla		
	Reconstruction of maxilla with bone graft		
	Bone transplant to the alveolar ridge		

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	Vomer osteotomi		
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Operator Skill of operator: in training / certified / senior

Hospital Stay

Sign in date(yyyy-mm-dd)

Discharge date(yyyy-mm-dd)

Bleeding: Yes/ No/ NA

Infection: Yes/ No/NA

Rupture: Yes/ No/ NA

Antibiotics (tick only one alternative): No /Profylax /Postoperative / Profylax and postoperative

13. Orthodontic treatment

Removable appliance:

Class I Trainer: yes/no

Class II Trainer: yes/no

Class III Trainer: yes/no

Pitvarlemez: yes/no

Pitvarlemez nyelvráccsal: yes/no

Fränkel I: yes/no

Fränkel II: yes/no

Fränkel III: yes/no Fränkel

IV: yes/no

Bionator: yes/no

Activator appliance: yes/no

Twin-Block appliance: yes/no

Schwarz Double Plate: yes/no

Hansa II appliance: yes/no

Hansa III appliance: yes/no

Other:.....

Fixed appliance:

Multiband appliance: yes/no

Palatal arch: yes/no

Transpalatal arch (Goshgarian): yes/no

Lingual arch: yes/no

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Retrospective

Lip-bumper: yes/no

Labial arch: yes/no

Nance appliance: yes/no

Eva plate: yes/no

"New" Distalizer: yes/no

Beneslider: yes/no

Carriere Distalizer: yes/no

Distal Jet: yes/no

Mandibular Anterior Repositioning Appliance (MARA): yes/no

Molar Distalization Bow: yes/no

Multi-Distalizing Arch: yes/no

Pendulum appliance: yes/no

Simplified Molar Distalizer (FROG): yes/no

Herbst Appliance: yes/no

MARA Appliance: yes/no

Jasper Jumper: yes/no

Twin Force Bite Corrector: yes/no

PowerScope 2: yes/no

Forsus Appliance: yes/no

Quick Fix: yes/no

Modified Tandem Appliances (MTA): yes/no

Class III Tandem Bow: yes/no

Carriere® Motion™ Appliance for Class III Correction: yes/no

Face Mask: yes/no Mesial

Jet: yes/no

TAD:

Miniscrew: yes/no

Miniplate: yes/no

14. Complications (többválasztós)

Minor category: no; partial wound separation; vermilion notching; stitch marks formation; hypertrophic or keloid scar formation following cleft lip surgery; fistula formation following cleft palate surgery

Major category: no; excessive postoperative bleeding; airway obstruction

General complications: no; diarrhea; malaria; upper respiratory tract infection; lower respiratory tract infection

15. Epicrisis (többválasztós)

Control examination: not necessary/ suggested: date:.....(yyyy-mm-dd)

Dental treatment recommended: primary tooth filling: yes/ no primary tooth pulpotomy: yes/ no primary tooth extraction: yes/ no permanent tooth filling: yes/ no permanent tooth root canal treatment: yes/ no permanent tooth extraction due to caries: yes/ no permanent tooth extraction due to orthodontics: yes/ no periodontal treatment: yes/ no surgery treatment: yes/ no other treatment:.....

Cleft team care: in progress/ completed

16. Comments, notes

(E.g. a short summary, if necessary of how the patient got to medical care, diagnosis, most important facts and events of the hospitalization, what happened with the patient after the hospitalization, any recommended control examinations, surgery etc.).

Description

.....
.....

File upload