

*1. Patient personal details

Insurance number:..... Name:

.....

Date of birth:.....

Admittance: yes/ no

If yes: Date of interview:.....

If no: reason: death/ not available/ refused to admit

2. Heredity of cleft (includes all known relatives)

New diagnosis fo cleft in family? yes/ no

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)

3. Significant changes in the medical history since the last visit

3.1. Details from the medical history of the patient

Has there been any changes in medical history since your child's last recording? yes/no

If yes:

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

Medications:

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

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) (volt-e változás az előző adatfelvételtől óta?)

- 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:.....

Growth:

Has your child had any recent rapid pubertal growth? yes/ no/ not applicable

If so, how much? (cm/ month)

Females: Has menstruation begun?

If yes, when?

Pregnant? yes/no

Using birth control pills?

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

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

3.2. Dental history of the patient (a kérdéseket átírni, hogy jelenleg van-e...)

*previously filled out? yes/no

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

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

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

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

Will your child be uncooperative? yes/ no/NA

If yes, explan:(yyyy-mm-dd)

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

If yes, explan:(yyyy-mm-dd)

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

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

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

If yes, explan:(yyyy-mm-dd)

Prevention:

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

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

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

Function:

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

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

Dental trauma:(kérdést átírni)

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

Has your child ever injured his/her jaw or face? yes/ no/NA

Habits:

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

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

Does your child have any other dental problems we should know about? yes/ no/NA

If yes, explain:.....

4. Symptoms

Previously recorded? yes/no

Has there been any changes in symptoms since your (child's) last recording? yes/no

If yes:

Muscle: Improvement / worsening / unchanged / ceased

Lip: Improvement / worsening / unchanged / ceased

Bone: Improvement / worsening / unchanged / ceased

Nose:

Nasal tip: Improvement / worsening / unchanged / ceased

Columella: Improvement / worsening / unchanged / ceased

Nasal base Improvement / worsening / unchanged / ceased

Nostril: Improvement / worsening / unchanged / ceased

Septum: Improvement / worsening / unchanged / ceased

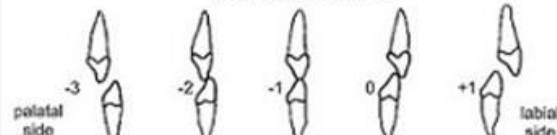
New complaints, symptoms: yes / no

If yes, explain:.....

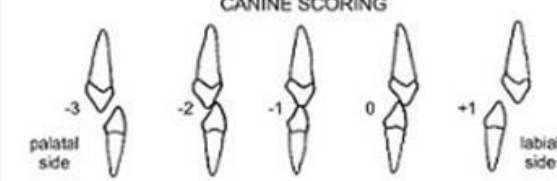
5. Examination

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

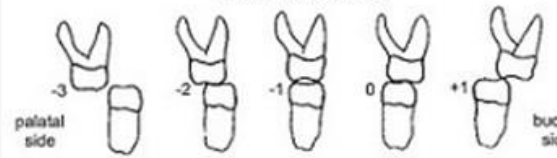
INCISOR SCORING



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

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

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

B form - Follow-up










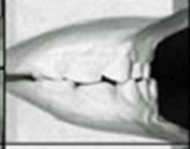


Anterior score/ central incisors:

Posterior score/ right side:

Posterior score/ left side:

B form - Follow-up

At 6 years:
Attack

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

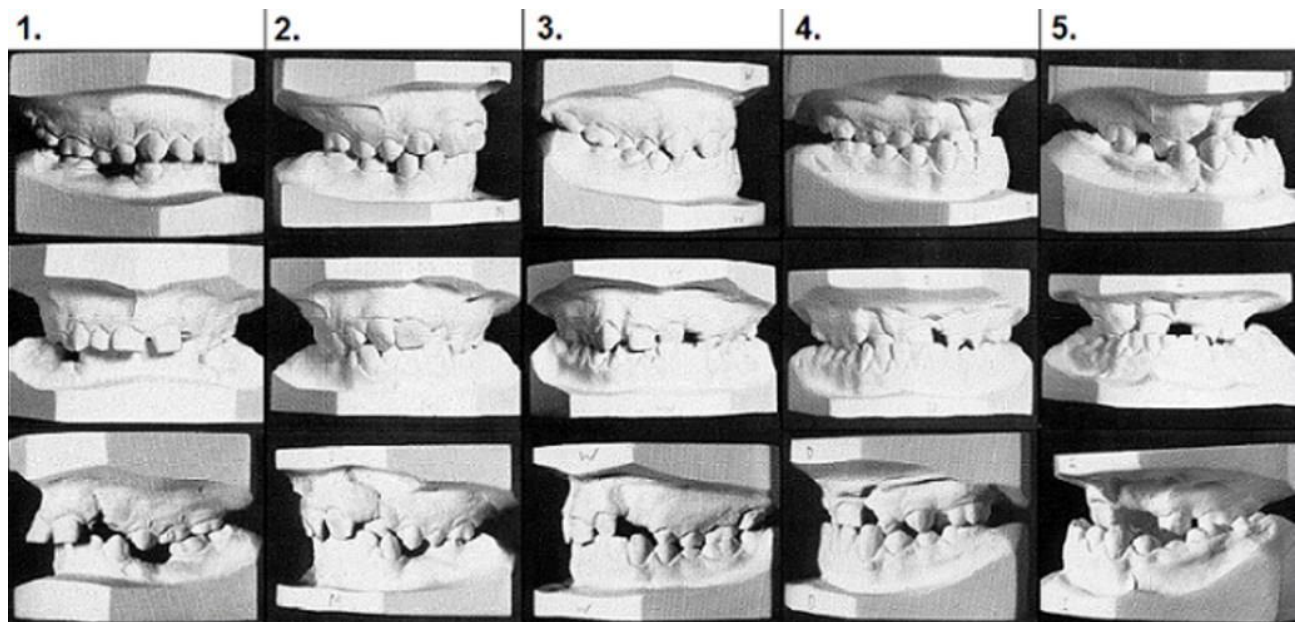
At 10 & 19 years, 1 year after orthognathic surgery:

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.



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 SNA° SNB° ANB° ML- NSL°

Around 10 years (before bone grafting):

Agensis / 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 SNA° SNB° ANB° ML- NSL°

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 SNA° SNB° ANB° ML- NSL°

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 SNA° SNB° ANB° ML- NSL°

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

6. Genetic testing

previously recorded? yes/no

if no, select from the list:

Pierre Robin Sequence yes / no

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

Fetal alcohol syndrome yes / no

Fetal valproate syndrome yes / no

Other yes / no If yes, specify:.....

Date of diagnosis:.....(yyyy-mm-dd)

7. State:

Regurgitation:

yoghurt: yes/ no
chocolate: yes/ no
fluid: yes/ no
solid food: yes/ no
other:.....

Body index:

Body weight on the day of the examination: (kg)
Body height on the day of the examination: (cm)
BMI:

*8. Any changes in imaging examinations

OPG: Yes / No

If yes, select from the list:

supernumerary tooth: yes/no

if yes, select the number of tooth:

1.8; 1.7; 1.6; 1.5; 1.4; 1.3; 1.2; 1.1; 2.1; 2.2; 2.3; 2.4; 2.5; 2.6; 2.7; 2.8; 3.8; 3.7;
3.6; 3.5; 3.4; 3.3; 3.2; 3.1; 4.1. 4.2; 4.3; 4.4; 4.5; 4.6; 4.7; 4.8

aplasie: yes/no

if yes, select the number of tooth:

1.8; 1.7; 1.6; 1.5; 1.4; 1.3; 1.2; 1.1; 2.1; 2.2; 2.3; 2.4; 2.5; 2.6; 2.7; 2.8; 3.8; 3.7;
3.6; 3.5; 3.4; 3.3; 3.2; 3.1; 4.1. 4.2; 4.3; 4.4; 4.5; 4.6; 4.7; 4.8

other:

Cephalometric Radiograph: Yes / No

If yes:

SNA: no change/ decrease/ increase

SNB: no change/ decrease/ increase

ANB: no change/ decrease/ increase

ML- NSL: no change/ decrease/ increase

Cone Beam Computed Tomography: yes / no

If yes, select from the list:

supernumerary tooth: yes/no

if yes, select the number of tooth:

1.8; 1.7; 1.6; 1.5; 1.4; 1.3; 1.2; 1.1; 2.1; 2.2; 2.3; 2.4; 2.5; 2.6; 2.7; 2.8; 3.8; 3.7;
3.6; 3.5; 3.4; 3.3; 3.2; 3.1; 4.1. 4.2; 4.3; 4.4; 4.5; 4.6; 4.7; 4.8

aplasie: yes/no

if yes, select the number of tooth:

1.8; 1.7; 1.6; 1.5; 1.4; 1.3; 1.2; 1.1; 2.1; 2.2; 2.3; 2.4; 2.5; 2.6; 2.7; 2.8; 3.8; 3.7;
3.6; 3.5; 3.4; 3.3; 3.2; 3.1; 4.1. 4.2; 4.3; 4.4; 4.5; 4.6; 4.7; 4.8

fistula: yes/no

other:

9. Any new operation since the last visit

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"/>
58981	Closing of incomplete lateral cleft lip (Lipadhesion)	<input type="checkbox"/>	<input type="checkbox"/>
58983	Lip and outer mouth plastic surgery, according to Millard (Liplasty)	<input type="checkbox"/>	<input type="checkbox"/>
	Other procedures	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>
52752	Hard and soft palate plastic surgery in one session	<input type="checkbox"/>	<input type="checkbox"/>
52751	Hard palate plastic surgery	<input type="checkbox"/>	<input type="checkbox"/>

Operation code	(State primary and, if applicable, secondary code)	Major code (tick only one)	Minor code (tick only one)
52750	Soft palate plastic surgery	<input type="checkbox"/>	<input type="checkbox"/>
	Pharyngeal flap	<input type="checkbox"/>	<input type="checkbox"/>
	Plastic operation of pharynx	<input type="checkbox"/>	<input type="checkbox"/>

Nose 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"/>
	Conchotomy	<input type="checkbox"/>	<input type="checkbox"/>
	Plastic repair of septum	<input type="checkbox"/>	<input type="checkbox"/>
	Reconstruction of cartilage of nose	<input type="checkbox"/>	<input type="checkbox"/>
	Reconstruction of bone of nose	<input type="checkbox"/>	<input type="checkbox"/>
	Rhinoplasty, bone and cartilage	<input type="checkbox"/>	<input type="checkbox"/>
	V to Y plasty	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>
	Mucogingival repair	<input type="checkbox"/>	<input type="checkbox"/>
	Oronasal fistula repair	<input type="checkbox"/>	<input type="checkbox"/>

Operation code	(State primary and, if applicable, secondary code)	Major code (tick only one)	Minor code (tick only one)
	Lefort I osteotomi	<input type="checkbox"/>	<input type="checkbox"/>
	Distraction of maxilla	<input type="checkbox"/>	<input type="checkbox"/>
	Vomer osteotomi	<input type="checkbox"/>	<input type="checkbox"/>
57750	Jaw plastic surgery with bone resection without implant	<input type="checkbox"/>	<input type="checkbox"/>
57861	Bone block transplantation (autologous)	<input type="checkbox"/>	<input type="checkbox"/>
57862	Bone block transplantation (homologous)	<input type="checkbox"/>	<input type="checkbox"/>
57865	Spongiosa plastica, autologous	<input type="checkbox"/>	<input type="checkbox"/>
57866	Spongiosa plastica, homologous	<input type="checkbox"/>	<input type="checkbox"/>

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

***10. Any changes in the orthodontic therapy: yes / no**

If yes: (select from the list)

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

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

11. Complications

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

12. 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

13. Comments, notes

B form - Follow-up



(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

.....
.....
.....

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