Stony Brook Medicine

NAME:_______________
Date of Birth:____________

Cleft Palate/Craniofacial Case History Attachment

Pediatrician:__________________ **Plastic Surgeon : ____________________**
ENT:________________________ **Orthodontist:________________________**
Other Specialists:____

Type of Cleft
Lip: ☐Both sides ☐Left ☐Right
☐Complete ☐Incomplete Date of repair:________
Palate: ☐Hard and Soft Palate ☐ Soft Palate ☐Submucous
Date(s) of repair:____

Feeding ☐Breastfed ☐ Bottlefed age discontinued _______________
List age your child: Drank from a cup_________ Ate solids______________
Current diet and management:____
____

Status of physical management of palate: ☐Un-operated ☐Surgically Repaired
☐Pharyngoplasty ☐Pharyngeal Flap ☐Prosthesis / Pharyngeal Bulb

Please list below all surgical procedures along with the date and surgeon's name:

Surgery	Date	Surgeon

Please describe the child's speech and how the surgeries or appliances have changed his/her speech or eating:____
____
____

Please check all that describe the child's voice: ☐Nasal ☐Harsh ☐Hoarse
☐Hyponasal (sounds like they have a cold) ☐High/low pitch ☐High/low volume
Does the child: ☐Mouth breath ☐Snore
Please write down any information that you feel may be helpful:
____
____

Speech Pathologist's Notes:
____
____