

TEXAS CLEFT AND CRANIOFACIAL TEAM

Child's Name _____ Date of Birth: _____ Sex: M F Race: _____

Mother's Name: _____ Father's Name: _____

Cleft/Craniofacial Diagnosis:	Height ____ / ____ feet/inches
Other Diagnoses/Health Problems:	Weight ____ / ____ pounds/ounces

Allergies circle: (Latex, Drug, Food, Seasonal/Environmental)	Current Medications (name and dose)
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PAST HOSPITALIZATIONS/SURGERIES/PROCEDURES (with dates)

REVIEW OF SYSTEMS

<i>Please check any PROBLEM area</i>	Yes	No	History of	Describe
FEEDING/NUTRITION (Feeding problem, tube feeding, reflux, weight loss, other)				
EYES (vision problem, "crossed" eyes, other)				
EAR, NOSE, THROAT (frequent ear infections? ear tubes? Snoring? Hoarseness? mouth breathing? Other?)				
CARDIO-RESPIRATORY (Any problem?)				
GASTRO-INTESTINAL (Any reflux, spitting up, frequent diarrhea/nausea, bowel abnormality, other)				
GENITO-URINARY (Any bedwetting, urinary or kidney infections, other?)				
MUSCULOSKELETAL: (Any muscle, joint or bone problem? limb abnormality? Craniosynostosis? Torticollis? Other?)				
SKIN (rashes, lumps, moles, other)				
NEUROLOGICAL (Any seizures, weakness, trouble walking, other?)				
BLOOD/LYMPHATIC/ENDOCRINE (Any disorders such as diabetes or gland)				
SPEECH/HEARING (difficulty hearing, hoarseness, speech problems)				
BEHAVIOR/DEVELOPMENTAL (Delays, hyperactivity, sadness, anxiety, stress)				
DENTAL (bleeding gums, missing teeth or teeth in wrong place, tooth decay)				

Pregnancy and Birth History

Weight at birth ____ pounds / ____ ounces	Place of Birth (Hospital, City, State)
Mother's residence during first 12 weeks of pregnancy (city, county, state/country)	
Indicate any medical problems during pregnancy and birth:	

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Child's Name _____ DOB: _____

SOCIAL HISTORY

Is the child yours by: Birth; Adoption; Marriage (stepchild); Other _____

Are the child's parents/guardians: Married; Unmarried; Separated; Divorced

Household Members including patient:

Name	Relation	Age	Name	Relation	Age

Agency/service you are currently working with:

Agency	Type of Services	Agency name/phone/contact person
ECI/School		
Home Health Care		
Child Protective Services		
Counseling		
Parent Support Group		

Is there any other information/concern that you would like to share with the Team?

Would you like the social worker to contact you about anything? Yes No

RELEASE OF INFORMATION

I understand that all the members of the Texas Cleft and Craniofacial Team will receive a copy of the Team notes from today's visit.

I also want to send a summary of today's Team Evaluation to the following physician(s):

Physician Name _____ Phone _____

Address _____

City,State _____ Zip _____

Signature of Parent

Date

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