

**Ectrodactyly-Ectodermal Dysplasia-Clefting (EEC) Syndrome and Related Issues**

*All information will be kept strictly confidential.*

Patient Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Male: \_\_\_\_\_ Female: \_\_\_\_\_ Email address: \_\_\_\_\_

Age at diagnosis of EEC syndrome: \_\_\_\_\_

Other diagnoses considered: \_\_\_\_\_

How was your diagnosis confirmed? (Blood tests, Family History, Physician exam or Other \_\_\_\_\_

Affected family members and relationship to you: \_\_\_\_\_

*Please use additional paper if necessary. You are welcome to submit photocopies of hospitalization and doctor visit records that you may have on file.*

Medications: \_\_\_\_\_

Hospitalizations (Please list timeframe and reason for hospitalization): \_\_\_\_\_

Surgeries (Please list type of surgery and age at time of surgery): \_\_\_\_\_

Newborn events (what happened right after the birth): \_\_\_\_\_

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(Please see reverse side)

**Please provide a brief synopsis on a separate sheet of paper of any significant issues in these areas:**

Audiology (Hearing)  
Otolaryngology (Ears, nose and speech issues)  
Ophthalmology (Eyes)  
Cardiovascular (Heart)  
Dental and Tooth Development  
Dermatology (Skin)  
Sweat Glands  
Development  
Growth and Nutrition  
Learning  
Mental Health  
Social Skills  
Gastrointestinal (Stomach or Bowel)  
Genitourinary (kidneys, bladder, urination)  
Women's Health issues  
Men's Health issues  
Neurological (nervous system, sensory)  
Orthopedic Surgery  
Plastic Surgery  
Other surgeries  
Skeletal (bones, muscles)  
Other

**Please feel free to include copies of any genetic testing and abnormal Laboratory, Radiology or Pathology test results.**

*Thank you for completing this survey.  
All information will be kept strictly confidential.*