

## Infant Tongue & Lip Tie Questionnaire

Today's Date \_\_\_\_\_ Guardian's Name \_\_\_\_\_

Patient's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ M F

Type of Delivery: (please circle) Home Hospital Vaginal C-Section

Delivered at How Many Weeks? \_\_\_\_\_ Baby's Birth Weight: \_\_\_\_\_ Present Weight: \_\_\_\_\_

Are you presently breastfeeding? Yes No  
If no, how long since you stopped breastfeeding? \_\_\_\_\_  
Are you using a nipple shield? Yes No  
Are you choosing not to breastfeed? Yes No  
Are you pumping breastmilk? Yes No  
Are you supplementing using formula? Yes No  
Are you using a SNS device? Yes No

### **MEDICAL HISTORY**

Infants are usually given Vitamin K at birth to prevent bleeding in the first 8 weeks of life. Did you sign a waiver to refuse the administration of vitamin K? Yes No

Was your child premature? Yes No

Does your child have any heart disease? Yes No

Has your child had any surgery? Yes No

Is your child taking any medications? Yes No

\_\_\_\_\_ Reflux meds \_\_\_\_\_ Thrush meds \_\_\_\_\_ Other

Name of meds: \_\_\_\_\_

### **Mother's Symptoms**

\_\_\_\_\_ Creased, cracked or blanching of nipples  
\_\_\_\_\_ Painful latching of infant onto the breast  
\_\_\_\_\_ Gumming or chewing of the nipples  
\_\_\_\_\_ Bleeding, cracked or cut nipples  
\_\_\_\_\_ Infant unable to achieve a successful, tight latch  
\_\_\_\_\_ Poor or incomplete breast drainage (engorged)  
\_\_\_\_\_ Infected nipples or breasts  
\_\_\_\_\_ Plugged ducts  
\_\_\_\_\_ Abraded nipples  
\_\_\_\_\_ Mastitis  
\_\_\_\_\_ Nipple thrush  
\_\_\_\_\_ Feelings of depression (lack of infant-mother bonding)  
\_\_\_\_\_ Over-supply (Infant doesn't require a good latch)  
\_\_\_\_\_ Have you had surgery for a breast abscess

### **Child's Symptoms**

\_\_\_\_\_ Difficulty in achieving a good, firm latch  
\_\_\_\_\_ Falls asleep while attempting to nurse  
\_\_\_\_\_ Slides off breast when attempting to latch  
\_\_\_\_\_ Reflux (clicking, swallowing air during nursing)  
\_\_\_\_\_ Slow or poor weight gain  
\_\_\_\_\_ Short sleep episodes (feeding every 1-2 hours)  
\_\_\_\_\_ Apnea-snoring, heavy noisy breathing  
\_\_\_\_\_ Unable to keep pacifier in mouth  
\_\_\_\_\_ Waking congested in the morning or nap time  
\_\_\_\_\_ Only sleeping when held upright or in car seat  
\_\_\_\_\_ Gagging when attempting to introduce solid foods  
\_\_\_\_\_ Milk leaking out sides of mouth during feedings  
\_\_\_\_\_ Sleep in the tee-pee position (bottom up in the air)  
\_\_\_\_\_ Notch in the upper gum or if teeth present, a gap exists

Pediatrician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Has your physician evaluated your child's lip and tongue ties? Yes No

Lactation Consultant's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

How were you referred to our office?

\_\_\_\_\_ internet search \_\_\_\_\_ mommy blogs \_\_\_\_\_ Facebook \_\_\_\_\_ lactation consultant

\_\_\_\_\_ physician \_\_\_\_\_ friend \_\_\_\_\_ relative \_\_\_\_\_ another child was treated here

Name of referring person \_\_\_\_\_



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