MOUNTAIN KIDS
TONGUE & LIP TIE CENTER

INFANT

Today's Date: _____

Patient's Name: _____ Patient's Birthdate: _____/_____/_____

Birth Information

____ Male ____ Female Current Weight _____
Birth Weight _____ Birth: VAGINAL C-SECTION
Birth Hospital _____

Any birth complications? YES NO
If yes, please explain _____
_____

Are you currently breastfeeding?____If no, how long since you stopped breastfeeding? _____

Medical Problems

Heart Disease _____ Bleeding Disorders _____ Other _____

Medical History

Please check/circle & elaborate as needed.

1. Infants are usually given vitamin K at birth to prevent bleeding in the first 8 weeks of life. Did your child receive a vitamin K shot? YES NO
2. Does your infant have heart disease? YES NO
3. Was your infant premature? YES NO
   If yes, how many weeks? _____
4. Has your infant had any surgery? YES NO

5. Has your infant experienced any of the following?
Please check all that apply & elaborate as needed.

__ Shallow latch at breast or bottle
__ Falls asleep while eating
__ Slides or pops on and off the nipple
__ Colic symptoms / Cries a lot
__ Reflux symptoms
__ Clicking or smacking noises when eating
__ Spits up often? Amount / Frequency _____
__ Gagging, choking, coughing when eating
__ Gassy (toots a lot) / Fussy often
__ Poor weight gain
__ Hiccups often
__ Lip curls under when nursing or taking bottle
__ Gumming or chewing your nipple when nursing
__ Pacifier falls out easily/doesn't like/won't stay in
__ Milk dribbles out of mouth when nursing/bottle
__ Short sleeping requiring feedings every 1-2hrs
__ Snoring, noisy breathing or mouth breathing
__ Feels like a full time job just to feed baby
__ Nose congested often
__ Baby is frustrated at the breast or bottle
__ How long does baby take to eat? _____
__ How often does baby eat? _____

6. Is your infant taking any medications? __ Reflux __ Thrush Name of medication: _____
7. Has your infant had a prior surgery to correct the tongue or lip tie?
   If yes, when, where, by whom? _____

Mother Assessment

Do you have any of the following signs or symptoms? Please check/circle & elaborate as needed.

__ Creased, flattened or blanched nipples
__ Lipstick shaped nipples
__ Blistered or cut nipples
__ Bleeding nipples
__ Pain on a scale of 1-10 when first latching ____
__ Pain (1-10) during nursing _____
__ Poor or incomplete breast drainage
__ Infected nipples or breasts
__ Plugged ducts / engorgement / mastitis
__ Nipple thrush
__ Using a nipple shield
__ Baby prefers one side over other _____ (R/L)

Pediatrician: _____ Phone Number: _____
Lactation Consultant: _____ Phone Number: _____
Who referred you to us? _____ Doctor's Signature: _____

If you have any questions or concerns,
please give us a call any time at:
970.224.3600