TONGUE / LIP TIE PATIENT

Today's Date / / Patient's Name Patient's DOB / / Patient's Age

Parent's Name Address

Phone Number Email

Medical History

BIRTH WEIGHT (LB / OZ)

MOST CURRENT WEIGHT (LB / OZ)

Y N
FOOD ALLERGIES?

IF YES, PLEASE LIST FOODS

Y N
MEDICATION ALLERGIES?

IF YES, PLEASE LIST MEDICATIONS

PLEASE LIST ALL CURRENT MATERNAL AND INFANT MEDICATIONS / SUPPLEMENTS

Y N
WAS YOUR INFANT PREMATURE?

IF YES, GESTATIONAL AGE AT BIRTH

Y N
DID YOUR INFANT RECEIVE VITAMIN K INJECTIONS?

Y N
DOES YOUR INFANT HAVE ANY HEART DISEASES?

Y N
HAS YOUR INFANT HAD ANY SURGERIES?

IF YES, WHAT TYPE(S) AND WHEN?

Y N
DOES YOUR FAMILY HAVE ANY HISTORY OF TETHERED ORAL TISSUES? (TONGUE / LIP TIE)

Y N
HAS YOUR INFANT HAD PRIOR SURGERY TO CORRECT THE TONGUE OR LIP TIE

IF YES, WHAT TYPE(S) AND WHERE?

Y N
DOES YOUR CHILD HAVE ANY OTHER MEDICAL CONDITIONS OR HEALTH CONCERNS?

IF YES, WHAT TYPE(S)?

Pregnancy / Labor History

NORMAL HIGH-RISK
NORMAL OR HIGH-RISK PREGNANCY? (PLEASE CIRCLE ONE)

Y N
WERE THERE ANY ADDITIONAL STRESSORS WITH LABOR?

LONG LABOR EXCESSIVE PUSHING BREECH BIRTH UNPLANNED C-SECTION
PLEASE CIRCLE ALL STRESSORS THAT APPLY

TRAUMA FROM VACUUM, FORCEPS, OTHER? (PLEASE EXPLAIN)

Y N
WAS THERE DIFFICULTY WITH LATCH AFTER BIRTH?

IF YES, PLEASE EXPLAIN

FORM CONTINUES

Mode of Feeding

Y N
IS THIS YOUR FIRST TIME BREAST FEEDING?

IF NO, HOW LONG WERE OTHER CHILDREN BREASTFED?

Y N
ARE YOU SUPPLEMENTING WITH PUMPED BREAST MILK?

IF YES, HOW MANY BOTTLES / OUNCES PER DAY?

Y N
ARE YOU SUPPLEMENTING WITH FORMULA?

IF YES, HOW MANY BOTTLES / OUNCES PER DAY?

Y N
ARE YOU CURRENTLY USING SNS OR ANY OTHER SUPPLEMENTER?

Y N
ARE YOU CURRENTLY USING A NIPPLE SHIELD?

Baby's Symptoms

5 – NO ISSUES | 4 – MINOR ISSUES | 3 – MAJOR ISSUES

2 – BREAST DAMAGE | 1 – USE MOSTLY BOTTLE | 0 – NO LATCH

HOW WOULD YOU DESCRIBE YOUR BABY'S LATCH? (PLEASE CIRCLE ONE)

Y N
DOES YOUR INFANT FALL ASLEEP ATTEMPTING TO NURSE?

Y N
DOES YOUR INFANT SLIDE OFF BREAST WHEN LATCHING / FEEDING?

Y N
DOES HIS / HER UPPER LIP CURL INWARD (DOES NOT FLIP OUTWARD) WHEN LATCHING?

Y N
DOES MILK OR FORMULA LEAK / SPILL OUT OF MOUTH WHILE FEEDING AT BREAST / BOTTLE?

Y N
IS YOUR INFANT EXPERIENCING COLIC SYMPTOMS?

Y N
DOES YOUR INFANT EXHIBIT REFLUX SYMPTOMS?

Y N
HAS YOUR INFANT BEEN DIAGNOSED WITH REFLUX BY A PEDIATRICIAN?

Y N
IS YOUR INFANT EXTREMELY GASSY?

Y N
HAS YOUR DOCTOR NOTICED SLOW OR POOR WEIGHT GAIN?

Y N
HAVE YOU DONE ANY PRE- AND POST-FEEDING WEIGHT CHECKS?

IF YES, WHAT WAS THE TRANSFER RATE? (OUNCES PER MINUTES)

Y N
DOES YOUR INFANT DISPLAY GUMMING OR CHEWING OF YOUR NIPPLE WHILE NURSING?

Y N
DOES YOUR INFANT CURRENTLY USE A PACIFIER?

Y N
IF YES TO THE PREVIOUS QUESTION, DOES THE PACIFIER STAY IN MOUTH WELL?

Y N
DOES YOUR INFANT EXPERIENCE SHORT SLEEP EPISODES REQUIRING FEEDS SOONER THAN EVERY 2-3 HOURS?

Y N
IS THERE A NOTICEABLE "CLICKING" NOISE WHILE FEEDING?

FORM CONTINUES

Mother's Symptoms

OVERSUPPLY | GOOD | FAIR | POOR

HOW WOULD YOU RATE YOUR MILK SUPPLY? (PLEASE CIRCLE ONE)

LESS THAN 15 MIN | 15–30 MIN | 30–45 MIN | 45–60 MIN | 60+ MIN

WHAT IS THE AVERAGE LENGTH OF FEEDING TIME AT BREAST IN MINUTES? (PLEASE CIRCLE ONE)

N/A | 0 – NONE | 1 – VERY LOW | 2 – LOW

3 – MEDIUM | 4 – HIGH | 5 – VERY HIGH

PLEASE RATE YOUR LEVEL OF DISCOMFORT WHILE FEEDING OR WHEN YOU DID IN THE PAST (CIRCLE ONE)

Y N

ARE YOU NOTICING YOUR NIPPLES BECOMING CREASED / FLATTENED / LIPSTICK SHAPED / BLANCHED WHITE AFTER NURSING?

LEFT SIDE | RIGHT SIDE | BOTH

IF YES, PLEASE CIRCLE ONE OF THE ABOVE OPTIONS

Y N

ARE YOUR NIPPLES BECOMING CRACKED, BRUISED, OR BLISTERED AFTER NURSING?

LEFT SIDE | RIGHT SIDE | BOTH

IF YES, PLEASE CIRCLE ONE OF THE ABOVE OPTIONS

Y N

ARE YOUR NIPPLES BLEEDING?

LEFT SIDE | RIGHT SIDE | BOTH

IF YES, PLEASE CIRCLE ONE OF THE ABOVE OPTIONS

Y N

IS THERE ANY SEVERE PAIN WHEN YOUR INFANT ATTEMPTS TO LATCH?

LEFT SIDE | RIGHT SIDE | BOTH

IF YES, PLEASE CIRCLE ONE OF THE ABOVE OPTIONS

Y N

ARE YOU EXPERIENCING POOR OR INCOMPLETE BREAST DRAINAGE?

Y N

DO YOU HAVE A HISTORY OF, OR CURRENTLY, HAVE MASTITIS?

Y N

DO YOU HAVE A HISTORY OF, OR CURRENTLY HAVE, NIPPLE / INFANT ORAL THRUSH?

IN A SENTENCE OR TWO, PLEASE SHARE YOUR BREASTFEEDING GOALS OR OTHER CONCERNS:

FOR OFFICE / DOCTOR USE ONLY

Lip Type 1 2 3 4 Rec Tx Y N Doctor Initials

Tongue Type 1 2 3 4 Rec Tx Y N