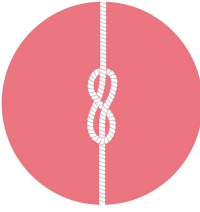


London Tongue & Lip Tie Network: Infant Questionnaire



Parent/Guardian Name _____

Patient's Name _____

Birth Date _____ Today's Date _____

Male _____ Female _____ Birth Weight _____ Current Weight _____

Vaginal Birth _____ C-Section Birth _____ Any birth complications? (ie vacuum, forceps, breach, nuchal cord) _____

Medical Problems _____

Currently Breastfeeding? _____ If No, how long since you stopped breastfeeding and why? _____

Medical History

1. Did your child receive the vitamin K shot at birth? _____
2. Was your infant premature? If yes, at how many weeks was your infant born? _____
3. Does your infant have any heart disease? _____
4. Has your infant had any surgery? _____
5. Is your infant taking any medication? _____
6. Has your infant taken medication for thrush (name: _____) Reflux (name: _____)
7. Has your infant had a prior surgery to correct the tongue or lip tie? _____ If yes, when/where/by whom/instrument used: _____

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

- | | |
|--|--|
| _____ Shallow latch at breast or bottle | _____ Gumming or chewing your nipple when nursing |
| _____ Falls asleep while eating | _____ Pacifier falls out easily, doesn't like, won't stay in |
| _____ Slides or pops on and off the nipple | _____ Milk dribbles out of the mouth when nursing/bottle |
| _____ Colic symptoms/cries a lot | _____ Baby acts frustrated at the breast or bottle |
| _____ Reflux symptoms | _____ Snoring, noisy breathing or mouth breathing |
| _____ Spits up often? Amount/Frequency _____ | _____ Feels like a full time job just to feed the baby |
| _____ Gagging, choking, coughing when eating | _____ Nose congested often |
| _____ Gassy/Fussy often | |
| _____ Poor weight gain | How long does it take baby to eat? _____ |
| _____ Hiccups often | How long does baby go between feeds? _____ |
| _____ Lip curls in when nursing or taking bottle | How long does baby sleep: Day: _____ Night: _____ |

Do you have any of the following signs or symptoms? Please check all that apply and elaborate as needed.

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

Pediatrician _____ Phone number _____

Lactation Consultant _____ Phone number _____

Additional Supportive Care (ie: Chiro, osteo, massage) _____