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
_____ Falls asleep while eating
_____ Slides or pops on and off the nipple
_____ Colic symptoms/cries a lot
_____ Reflux symptoms
_____ Spits up often? Amount/Frequency _____
_____ Gagging, choking, coughing when eating
_____ Gassy/Fussy often
_____ Poor weight gain
_____ Hiccups often
_____ Lip curls in 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 the mouth when nursing/bottle
_____ Baby acts frustrated at the breast or bottle
_____ Snoring, noisy breathing or mouth breathing
_____ Feels like a full time job just to feed the baby
_____ Nose congested often

How long does it take baby to eat? _____
How long does baby go between feeds? _____
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
_____ Lipstick shaped nipples
_____ Blistered or cut nipples
_____ Bleeding nipples
Pain on a scale of 1-10 when first latching _____
Pain on a scale of 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 another _____R/L

Pediatrician _____ Phone number _____

Lactation Consultant _____ Phone number _____

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