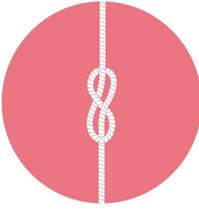


# London Tongue & Lip Tie Network: Infant Questionnaire



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) \_\_\_\_\_