FOSTER & FOSTER FAMILY DENTAL

Phone #:_____ E-mail:_____

Tongue / Lip Tie: Patient Information

NOTE: For children beyond breastfeeding age, you can skip those questions labeled with an *

Today's date: _____Patient's DOB: _____

Patient's name: _____Parent's Name(s):_____

Home address: _____

Reason for today's visit: _____

Pediatrician's name: _____

Are you currently working with a lactation consultant? *_____If so, who? *_____

Do you work with them at home or a hospital setting? *_____

Is your child currently being seen by anyone such as chiropractors, craniosacral therapists, PT, OT, etc.?

If yes, what type & with whom? _____

MEDICAL HISTORY

Birth weight: _____ Most current weight and date: _____

Allergies of any type whether food product or medicine? _____

Please list all medications baby is taking: _____

Was your child premature? _____If yes, what was the gestational age at birth? _____

Does your child have any medical conditions of any kind? _____If yes, please list: _____

_____

Has your child had any surgeries including previous lip or tongue revisions? ____If yes, please list _____

_____

PREGNANCY/LABOR/BREASTFEEDING QUESTIONS

Any stressors during labor? *_____ If yes, please explain: *_____

Was there difficulty with your baby properly latching at birth?* _____If yes, please explain: *_____

_____

Are you exclusively breastfeeding or supplementing (pumped breast milk or formula)? *_____

Are you using a nipple shield?* _____ How would you rate your milk supply? *_____

NOTE: For children *beyond* breastfeeding age, you can skip this entire page.

BABY'S SYMPTOMS

How would you rate your baby's latch? (circle one)

5-no issues 4-minor issues 3-major issues 2-breast damage 1-mostly using bottle 0-no latch

Does your little one fall asleep nursing? _____ How long do feedings last? _____

Does your little one frequently fall off the breast/lose his latch while nursing? _____

Does your little one's top lip flange *up* or does it curl *under* during breastfeeding? _____

Does milk or formula leak out of your little one's mouth while feeding? _____

Does your little one exhibit reflux? _____ Is your little one frequently gassy? _____

Has your little one's weight gain been ON the curve or BELOW it? _____

If working with a lactation consultant, have they done pre and post feeding weight checks? _____

If they have, what has been the transfer rate? _____

Does your little one require feedings sooner than every 2-3 hours? _____

Do you notice a clicking noise while your little one is feeding whether breast or bottle? _____

MOM'S SYMPTOMS

How much discomfort do you experience while breastfeeding?

N/A 0-none 1-very low 2-not much 3-moderately painful 4-OMG 5-unbearable

Are your nipples lipstick-shaped following feedings? _____

Have you experienced any cracking, bleeding or bruising to your nipples after nursing? _____

Is there severe pain when your little one attempts latching? _____ If so, which side or both? _____

Are you experiencing incomplete breast drainage? _____

Have you had or do you currently have mastitis? _____ Have you or your little one had thrush? _____

Please briefly describe your goals with feeding or breastfeeding: _____

_____

Who referred you to our office today? _____

Office use only:	Type	Recommend treatment?	
Lip	1, 2, 3, 4	Yes / No	
Tongue	1, 2, 3, 4	Yes / No	Doctor's Initials_____