
**Dr Musani MDS**
**Pediatric Dentist**
**Specializing in treating Infants & Children's Tongue Ties**
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## Infant Assessment / Mother Assessment

**Patient's Name** _____Parent's Name _____

Phone Number:_____ Email: _____

Birth date _____ Today's Date:_____

Medical problems: _____ Heart disease _____ Bleeding disorders _____ Other_____

_____Male _____Female Birth Weight _____ Present Weight _____ Birth Hospital_____

_____Vaginal birth _____C-Section Birth Any birth complications? _____

Are you presently breastfeeding _____Yes _____No If no, how long since you stopped breastfeeding _____

**Medical History:**

1. Infants are usually given vitamin K at birth. Did your child receive the vitamin K shot? _____yes _____no
2. Was your infant premature? ____ Yes ____ No If yes, how many weeks? _____
3. Does your infant have any heart disease ____ Yes ____ No
4. Has your infant had any surgery? ____ Yes ____ No
5. **Has your infant experienced any of the following? Please check / circle / 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
____ Clicking or smacking noises when eating
____ Spits up often? Amount / Frequency_____
____ Gagging, choking, coughing when eating
____ Gassy (toots a lot) / Fussy often
____ Poor weight gain
____ Hiccups often
____ Lip curls under 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 mouth when nursing/bottle
_____ Short sleeping requiring feedings every 1-2hrs
_____Snoring, noisy breathing or mouth breathing
_____Feels like a full time job just to feed baby
_____ Nose congested often
_____ Baby is frustrated at the breast or bottle
How long does baby take to eat? _____
How often does baby eat? _____

6. Is your infant taking any medications? ____ Reflux _____Thrush Name of medication: _____
7. Has your infant had a prior surgery to correct the tongue or lip tie? If yes, when, where, and by whom?

_____

**7. Do you have any of the following signs or symptoms? Please check / circle / 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 (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 other _____ (R/L)

Pediatrician _____Phonenumber:_____

Lactation Consultant _____Phone number:_____