Texas Pediatric Dentistry

Infant Questionnaire

Patient name: _________________________________ Date of birth: _________ Age: ________

Birth weight: __________ Present weight: ________ Full term birth? _________

Pediatrician: __________________________________ Lactation consultant____________________

Medical History

1. Does your infant have heart disease? Yes No
2. Any history of surgeries? ____
3. Taking any medications? ____
4. Any allergies? ____
5. Has your infant experienced any of the following problems:

______ Poor latch
______ Falls asleep while nursing
______ Slides off nipple when attempting to latch
______ Colic symptoms
______ Reflux symptoms
______ Poor weight gain
______ Gumming or chewing nipple
______ Unable to use bottle or hold pacifier
______ Short sleep episodes around the clock

6. Have you experienced cracked, bleeding, or blistered nipples? Yes No
7. Have you had a nursing/feeding evaluation by a doctor or lactation consultant? Yes No
8. Has your infant been diagnosed with an upper lip tie ______or tongue tie? ________
9. Do you have any other family members who were diagnosed with this issue? Yes No
10. Any history of bleeding disorders in the patient or family members? Yes No
11. Has your infant received a vitamin K shot while in the hospital? Yes No
12. Has your infant been evaluated by a lactation consultant, speech pathologist or body worker?

    Yes No

    Please explain: ____