STONEBRIDGE RANCH DENTISTRY

TEXAS PEDIATRIC DENTISTRY

TPD Smiles

Infant Questionnaire
Tongue/Lip Tie

Patient Name _____ DOB _____ Age _____

Birth Weight _____ Present Weight _____ Full Term Birth? _____

Pediatrician _____ Lactation Consultant _____

Medical History

1. Have you had a nursing/feeding evaluation by a doctor or lactation consultant? YES NO
2. Has your infant been evaluated by a speech pathologist or other professional? YES NO
3. Has your infant been diagnosed with an upper lip tie ___ or tongue tie ___?
4. Please rate any of the following problems your infant has experienced, from 1-10.

_____ Latch Efficiency

_____ Sleepiness while nursing

_____ Slides off nipple when attempting to latch

_____ Colic symptoms

_____ Reflux symptoms

_____ Poor weight gain

_____ Gumming or chewing nipple

_____ Ability to use a bottle or hold a pacifier

_____ Short sleep episodes around the clock

5. Have you experienced cracked, bleeding, or blistered nipples? YES NO
6. Do you have any other family members who were diagnosed with lip/tongue tie? YES NO
7. Any history of bleeding disorders in the patient or other family members? YES NO
8. Has your infant received a Vitamin K shot? YES NO
9. Does your infant have heart disease? YES NO
10. Previous surgeries _____
11. Current medications _____
12. Allergies _____