The Sleepy Tooth GROUP®

Infant Frenectomy Assessment Sheet

Patient's Name _____ 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?

_____

8. 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 _____ Phone number: _____

Lactation Consultant _____ Phone number:_____

Who referred you to us? _____

Doctor's Signature _____