Lip and Tongue Tie Evaluation Form in Children

Patient name ____________________ DOB______________ Today's Date _________

1. Can your child extend his/her tongue beyond his lower teeth and lips and lick all the way around their mouth? Y / N
2. Does your child have any issues with certain textures of food. Y /N
3. Can your child lick and ice cream cone without trouble or without knocking the scoop off the cone? Y / N
4. Does your child dribble a lot or is a messy eater? Y / N
5. Does your child have delayed speech? Y / N
6. Does your child have frequent upset stomach or gas? Y / N
7. Does your child snore regularly? Y / N
8. Does your child have any difficulty pronouncing any letters? Y / N If so which ones? __________
9. Is your child receiving speech therapy? Y / N
10. Does your child have any areas in his mouth they don't like to be brushed or pull away when you brush the area? Y / N
11. Does your child grind his teeth at night? Y/N
12. Inability to chew certain solid foods or choke or gag when eating? Y / N
13. If your child did nurse or is still nursing did you experience any of the following symptoms: Please circle any that apply.
    - Painful latch
    - Mastitis or clogged ducts
    - Sleep deprivation (baby not nursing efficiently so compensating by nursing more frequently)
    - Poor or incomplete breast drainage
    - Under or over supply of breast milk
    - Cracking or bleeding nipples

Did your infant have any of the following when nursing: Circle all that apply.

- Reflux or colic
- Difficulty latching or shallow latch
- Gassy
- Poor weight gain
- Makes clicking noise while suckling
- Falls asleep while attempting to nurse
- Unable to keep pacifier in mouth
- Excessive drooling
- Choking on milk or popping off the breast to gasp for air

Hudson Valley Pediatric Dentistry
Infant Questionnaire

Patient's Name ___________________________ DOB ________________ Today's Date _________
Male / Female Birth weight __________ Current weight _________ Vaginal Birth___ C-section_____
Pediatrician Name ___________________ Pediatrician Phone __________________
Address________________________City______________________State___________Zip________
Lactation Consultant Name _________________ Phone______________ email_________________
Address________________________City_____________________State_________Zip__________
Who referred you to our office _______________________________________

Medical History

1. Was your infant premature? Y / N
2. Does your infant have any heart disease? Y / N If yes explain____
3. Has your infant had any surgery? Y / N ________________________________
4. Is your child taking any medications? Y / N If yes please list __________________
   ____
5. Infants usually receive a vitamin K shot at birth to prevent bleeding in the first 8 weeks of life. Did you sign a waiver refusing administration of vitamin K? Y / N
6. Do you, your baby or any immediate family have any bleeding disorders? Y / N
7. Are you currently breastfeeding? Y / N Supplementing with bottle? Y / N
8. Have you chosen not to breastfeed? Y / N
9. Are you using a nipple shield? Y / N Are you using an SNS device? Y / N
10. Has your child ever been evaluated for a tongue/lip tie? Y / N
11. Did your infant have any prior surgery for tongue or lip ties? Y/N

Infant's Symptoms (Check all that Apply)

__ Difficulty achieving a good latch
__ Colic and/or irritability
__ Gassy
__ Makes clicking noises while sucking
__Choking, couching or gulping during feeds
__ Poor weight gain or weight loss
__Gumming, chewing or clamping on nipple
__ Slides of breast when trying to latch

____Pacifier falls out of mouth easily
____Shallow latch
____Reflux symptoms
____Milk dribbles out of mouth when nursing
____ Baby frustrated when feeding
____Falls asleep while nursing
____Upper lip curls in when nursing/bottle fed
____ Apnea (snoring, mouth breathing)

How long does it take your baby to nurse or bottle feed? _______________

Mother's Symptoms (check all that apply)

___Cracked /bleeding nipples
___Low milk supply
___Over supply
___Poor or incomplete drainage

___Mastitis/Thrush
___Infant unable to latch
___Plugged ducts/engorgement
Pain (scale 1-10) when first latch ____ Pain during nursing ____

(Adapted from Larry Kotlow, DDS)