INFANT ORAL FEEDING AND ANATOMY QUESTIONNARIE

Please answer the questions as fully and accurately as possible. The information that you provide on this form will help to create a better understanding of your child and the course of evaluation and treatment. If you are unsure of a particular answer, mark with a question mark (?). If a question is not relevant to your child, please write "N/A." All material and information is strictly confidential.

Patient's Name: _____
Date of Birth: _____
Age: _____

Oral Anatomy

□ Lip Tie □ Tongue Tie □ Buccal Tie	Diagnosed By

Surgical History

Previous surgery to correct? □ Yes □ No	Was the surgery successful? □ Yes □ No
Performed By	Were you assigned exercises/ home plan? □ Yes □ No
Date Performed	Complications

Medical History

Medical Problems/Diagnoses:		
Birth Place/Hospital	Birth Weight	Present Weight
□ Vaginal □ C Section	Complications	
Current Medications Taken		

Medical Team

Pediatrician	Contact Number
Lactation Consultant	Contact Number

Sleep

Describe Infant's Sleep Schedule	
How many hours of sleep is considered "bad"	How many hours of sleep is considered "good"

Feeding

□ Breast □ Bottle □ Both	If both, percentage: Breast _____% Bottle _____%
Do you pump? □ Yes □ No	What pumping option
Type of Formula	
Type of Bottle and Nipple Used	
Average Length of Feed	Average Number of Feeds/Day
Does Infant have a Preferred Side □ Yes □ No	Position while feeding
Presently Breastfeeding? □ Yes □ No	If No, When did you stop?
Pain 1-10 when first latching	Pain 1-10 during nursing

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Have you noted any of the following behaviors in your infant?

□ Shallow latch at breast or bottle □ Slides or pops on and off the nipple □ Falls asleep while eating □ Colic symptoms □ Crying during feeding □ Reflux Symptoms □ Gassy □ Hiccups often □ Gagging, choking, coughing while eating □ Lip curls under when nursing/taking bottle □ Clicking or smacking noises while eating	□ Short Sleeping □ Gumming or chewing nipple □ Milk dribbles out of mouth when nursing/taking bottle □ Baby is frustrated at breast/bottle □ Spits up often □ Poor Weight Gain □ Feels like a full time job to feed your baby □ Nose congested often □ Snoring, noisy breathing / mouth breathing □ Upper respiratory infections □ Thrush

Do you have any of the following signs or symptoms?

□ Creased, flattened, or blanched nipples □ Blistered or cut nipples □ Poor or incomplete breast drainage □ Plugged ducts □ Engorgement □ Drainage	□ Lipstick shaped nipples □ Bleeding nipples □ Infected nipples or breasts □ Nipple thrush □ Using nipple shields

Postpartum

□ I am not getting enough sleep and rest □ I have enough support at home but would like more help □ I feel loved and supported by my family □ I do not have enough support at home □ I have many opportunities for self-care □ I have opportunities for self-care, but need more □ I have time to feed myself □ I often forget to eat during the day □ I don't have time to eat during the day □ I find time to pump during the day	□ Breastfeeding is going well, but I have questions □ I am having a hard time breastfeeding □ I have concerns about going back to work/school and maintaining my milk supply □ I have questions about caring for my baby □ Feeding my baby is relaxing □ Feeding my baby is stressful □ I am concerned about my child's feeding □ I am the primary person feeding my child □ My partner and I both feed our child