Infant Lip & Tongue Tie Assessment

Patient Name: _____Childs DOB: _____Todays Date: _____

Male ☐ Female ☐ Current Age: _____weeks _____days Birth Weight: _____Current Weight: _____

What is your main area of concern: ☐ Lip Tie ☐ Tongue Tie ☐ Both

Are you breastfeeding? ☐ Yes ☐ No If no, how long since you stopped breastfeeding?_____

Is your infant taking any medication?_____Reflux _____Thrush Name of Medication:_____

Did any specialist refer you to our office? _____

1. Additional medical history

a. Was baby born premature? Yes ☐ No ☐
b. Was baby born via c-section or delivered via vacuum extraction? Yes ☐ No ☐
c. Was Vitamin K injection (normally given immediately after birth) declined? Yes ☐ No ☐
d. Is there a family history of sickle cell? Yes ☐ No ☐
e. Was mother on any anticoagulants during pregnancy? Yes ☐ No ☐
f. Does baby have Torticollis or any facial/cervical asymmetry? Yes ☐ No ☐
g. Does baby have Pierre-Robin Sequence or micrognathic jaw? Yes ☐ No ☐
h. Does baby have a known heart condition or pant/breathe rapidly while nursing? Yes ☐ No ☐
i. Have you consulted with a Lactation Consultant or Speech Language Pathologist? Yes ☐ No ☐
If yes, please indicate name: _____

2. Has your baby experienced any of the following? Please check and 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/chewing on your nipple when nursing
___Pacifier fall out easily, 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 the baby
___Nose congested often
___Baby is frustrated at the breast or bottle
___Lip curls in when nursing or taking a bottle
How often does baby eat?_____
How long does baby take to eat?_____

3. Do you have any of the following signs or symptoms? Please check and 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 the other ☐ R ☐L