

Patient Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Referring Physician \_\_\_\_\_  
Date of Visit \_\_\_\_\_

## Frenotomy & Frenectomy

Which pharmacy do you use (phone # or address): \_\_\_\_\_

Lactation Consultant: \_\_\_\_\_

Medication Allergies

Current Medications (including over-the-counter, herbal, vitamins)

### Past Medical History

Birth weight (lb/oz): \_\_\_\_\_

Present weight: \_\_\_\_\_

Received Vitamin K injections? ☐ Yes ☐ No

Was your infant premature? ☐ Yes ☐ No

if yes, Gestation age (wks): \_\_\_\_\_

Does your infant have any heart disease? ☐ Yes ☐ No

if yes, \_\_\_\_\_

Has your infant had any surgery? ☐ Yes ☐ No

if yes, \_\_\_\_\_

Has patient had prior surgery to correct the tongue or lip tie? ☐ Yes ☐ No if yes, when/by whom? \_\_\_\_\_

### Baby's Symptoms

- ☐ Poor latch
- ☐ Falls asleep while attempting to nurse
- ☐ Slides off the nipple when attempting to latch
- ☐ Colic symptoms
- ☐ Reflux symptoms
- ☐ Poor weight gain
- ☐ Gumming or chewing of your nipple when nursing
- ☐ Unable to hold a pacifier in his or her mouth
- ☐ Short sleep episodes requiring feeding every 2-3 hours

### Mother's Symptoms

- ☐ Creased, flattened or blanched nipples after nursing
- ☐ Cracked, bruised or blistered nipples
- ☐ Bleeding nipples
- ☐ Severe pain when your infant attempts to latch
- ☐ Poor or incomplete breast drainage
- ☐ Infected nipples or breasts
- ☐ Plugged ducts
- ☐ Mastitis or nipple thrush

Family history of Tongue Tie ☐ Lip Tie ☐

### Has your baby had any of the following?

- ☐ Weight loss/gain
- ☐ Nasal obstruction
- ☐ Swallowing issues
- ☐ Cyanosis (turning blue)
- ☐ Breathing issues
- ☐ Reflux/vomiting/spitting up
- ☐ Bleeding problems

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_