Oregon Kids
PEDIATRIC DENTISTRY

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?
_____

7. 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 _____