FRENOTOMY & FRENECTOMY

Name ______________________ Nickname ______________ Date of Visit ________

Pharmacy ______________________ Referring Physician ______________________

Lactation Consultant ____

Please answer the following:

	Yes	No
Medication		
Medication Allergies – please list:		
Current Medications – please list:		
Past Medical History		
Birth weight (lb/oz):		
Present weight (lb/oz):		
Received Vitamin K injections?		
Was your infant premature? If yes, provide gestation age (wks):		
Does your infant have any heart disease? If yes, provide details:		
Has your infant had any surgery? If yes: provide details:		
Has your infant had prior surgery to correct the tongue or lip tie? 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?		

	Yes	No
Baby's Symptoms		
Reflux symptoms?		
Poor weight gain?		
Gumming or chewing of your nipple when nursing?		
Unable to hold a pacifier in his/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?		
Has your baby had any of the following?		
Nasal obstruction?		
Swallowing issues?		
Cyanosis (turning blue)?		
Breathing issues?		
Reflux/vomiting/spitting up?		
Bleeding problems?		

Thank you for taking time to fill out this form to help us get acquainted and provide you with quality dental care.

Patient's Signature: ______________________ Date: ____________

Doctor's Signature: ______________________ Date: ____________