infant frenectomy assessment

Patient's Name: ________________________________ Date of Birth: ____________ Today Date: ___________________
How did you hear about our office? ____
Did your infant receive Vitamin K at birth? ❑ No ❑ Yes Has your infant had any surgeries? ❑ No ❑ Yes
Does your infant have any heart disease? ❑ No ❑ Yes Family history of bleeding disorder? ❑ No ❑ Yes
Was your child premature? ❑ No ❑ Yes, if so # of weeks? _______ Was your pregnancy high risk? ❑ No ❑ Yes
Type of Delivery (select all that apply): ❑ Home ❑ Hospital ❑ Vaginal ❑ C-section
Any other stressors with labor? ❑ Long labor ❑ Trauma from forceps ❑ Breech ❑ Unplanned C-section
Is your child taking any medications (reflux, thrush, etc)? ❑ No ❑ Yes, If so please list: _______________________
Food allergies? ________________________________ Medication allergies? _____________________________________
Does your infant have any other health concerns? ____

Main concerns:
Pediatrician's Name: __________________________________ Birth Weight: __________ Current Weight: ___________
Are you currently working with a lactation consultant? ❑ No ❑ Yes, Who? ________________________________
Is your infant being seen for bodywork (chiropractor, physical therapy, osteopath, myofunctional therapy, occupational therapy, other)? ❑ No ❑ Yes Who? ____
Is this your first child? ❑ No ❑ Yes Family history of lip or tongue ties? ❑ No ❑ Yes
Check all that apply: ❑ Breastfeeding ❑ Pumping ❑ Formula ❑ Nipple Shield ❑ SNS device

Mode of feeding:
Is this your first time breastfeeding? ❑ No ❑ Yes Other breastfed children/how long? __________
Are you supplementing w/ pumped breast milk? ❑ No ❑ Yes If yes, how many bottles/oz per day? __________
Are you supplementing w/ formula? ❑ No ❑ Yes If yes, how many bottles/oz per day? __________
How would you rate your milk supply? ❑ Oversupply ❑ Good ❑ Fair ❑ Poor
Have you done pre/post feeding weight checks? ❑ No ❑ Yes If yes, what is transfer rate (oz/min)? __________

Mother's symptoms	Infant's symptoms
❑ Creased, dry, cracked or bleeding nipples ❑ Painful latch ❑ Poor or incomplete breast drainage ❑ Clogged ducts/mastitis ❑ Thrush ❑ Oversupply of breast milk ❑ Heavy let down ❑ Undersupply of breast milk ❑ Average length of feeding time: ❑ Less than 15 ❑ 15-30 ❑ 30-45 ❑ 45-60 ❑ 60+ ❑ Depression	❑ Difficulty in achieve a good latch ❑ Slow nursing, often falls asleep ❑ Comes unlatched often ❑ Reflux ❑ Poor weight gain ❑ Frequent feeding (every 1-2 hours) ❑ Waking up congested in morning ❑ Only sleeping in upright position ❑ Milk leaking out of mouth during nursing ❑ Gas or frequently swallowing air ❑ Upper lip curls when latched ❑ Colic ❑ Mouth open at rest

Release of Information
❑ I hereby authorize Sprout Pediatric Dentistry to release any personal health information to other providers working with my child.

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479-365-6556 | 101 Monument Ste C Lowell, AR 72745 | hello@sproutpd.com | www.sproutpd.com

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PEDIATRIC DENTISTRY

Parent/Legal Guardian Signature Date