MOUNTAIN KIDS
PEDIATRIC DENTISTRY

INFANT

Patients Name .... **Birth date** .... **Todays 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 ....

If no, how long since you stopped breastfeeding ....

Medical History

1. Infants are usually given vitamin K at birth to prevent bleeding in the first 8 weeks of life. 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, by whom?

....

1. 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 ....