MOUNTAIN KIDS
PEDIATRIC DENTISTRY

Infant/Mother Follow-Up Assessment

Infant's Name: _____ Birth Date: _____ Today's Date:_____

Date of Procedure: _____ Procedure: ___ TONGUE ___ LIP ___ BUCCAL CHEEK TIES

Birth Weight: _____ Weight at initial visit: _____ Weight today: _____ Change: _____

Infant Assessment

Have you noticed any changes since the procedure for your baby?

Please check if improved.

____ Deeper latch at breast or bottle
____ Less falling asleep while eating
____ Slides or pops on and off the nipple less
____ Less colic symptoms/crying
____ Less reflux
____ Less clicking or smacking noises
____ Less spit up ____ More spit up
____ Less gagging, choking, coughing when eating
____ Less gassy / Less fussy
____ Less constipation / regular stools now
____ Better weight gain
____ Happier baby than before
____ Less hiccups
_____ Lips flip out better / not curling under as much
_____ Less gumming or chewing the nipple
_____ Pacifier stays in better
_____ Milk dribbles/leaks out of mouth less
_____ Sleeping longer
_____ Less snoring or mouth breathing
_____ Less moving around in sleep
_____ Nose congested less often
_____ Baby babbles more or ___ makes new sounds
_____ Baby is less frustrated at the breast or bottle
_____ Eats solid foods better (if applicable)

How long does baby take to eat? _____
_____

How often does baby eat? _____
_____

Has anything worsened? If so, explain: _____
_____

Additional Comments: _____
_____
_____
_____

Mother Assessment

Have you noticed any changes in your symptoms since the procedure?

____ Check here if bottle-feeding (N/A).

____ Less creased, flattened or blanched nipples
____ Less lipstick shaped nipples
____ Less blistered or cut nipples
____ Less bleeding nipples
____ Somewhat less pain
____ Significantly less pain
____ Better emotional state/more confident
____ Better milk supply
____ Improved breast drainage (baby gets more)
____ Less infected nipples or breasts
____ Less plugged ducts, engorgement and/or mastitis
____ Less nipple thrush
____ Less using a nipple shield
____ Baby doesn't prefer one side over other

On a scale of 1-10: Pain before procedure: _____ Pain now: _____

How are you doing mentally/emotionally? _____

_____

_____

Were you able to stretch the sites four (4) times a day? _____ Any issues? _____

_____

_____

How was your experience at our office? _____

_____

_____

Any other comments? _____

_____

_____

_____

_____

If you have any questions or concerns, please give us a call any time at 970.224.3600
We're here to support you 100% of the way through your child's recovery.