QUESTIONNAIRE for LIP/TONGUE-TIE or TETHERED ORAL TISSUE SYNDROME (TOTS)

Patient's Name

DOB

Today's Date

☐ Male

☐ Female

Allergies (If nothing, answer "none")

Medications (If nothing, answer "none")

Medical Conditions (If nothing, answer "none")

History of anyone in your family with a lip or tongue tie? ☐ / ☐

Who and which areas were tied?

What is your goal of having the revisions done?

Who would be best to contact for post op calls?

☐ Mom ☐ Dad

Whom can we thank for referring you to our office?

Mother's Information

First Name

Middle Initial

Last Name

Phone Number

Email

To your knowledge, was Mom breastfed? ☐ / ☐

Were there any difficulties with nursing?

Father's Information

First Name

Middle Initial

Last Name

Phone Number

Email

To your knowledge, was Dad breastfed? ☐ / ☐

Were there any difficulties with nursing?

Information about Patient:

Please select all that apply.

- [ ] Food Aversion
- [ ] Attention Deficit/ ADD / ADHD
- [ ] GERD symptoms, presently or previously as an infant
- [ ] Sleep Irregularitires (Sleep Apnea, Snoring/Mouth Breathing, head tilted upwards while sleeping)
- [ ] Angry in the morning
- [ ] Headaches (Migraines)
- [ ] Temporomandibular Joint (TMJ) Disorder
- [ ] Speech Difficulties
- [ ] Constipation
  Please Explain _____
- [ ] Pocketing food (pushing into cheek while eating rather than swallowing)

PAST EATING HABITS

As a child, was the patient nursed or bottle fed?

- [ ] Nursed
  At what age was it stopped? _____
- [ ] Bottle Fed
- [ ] Both
  At what age was nursing stopped? _____

Was nursing discontinued sooner than planned because of issues with the nursing process [ ] / [ ]

What issues caused this to happen? _____

Pediatrician Information

Pediatrician Name _____

Speech Therapist Information

Speech Therapist Name _____

Address 1

Address 2

City

State / Province

Zip Code / Postal Code

Phone Number

Address 1

Address 2

City

State / Province

Zip Code / Postal Code

Phone Number

Other Specialist Information

Specialist Name

Speciality

Address

Address 1

Address 2

City

State / Province

Zip Code / Postal Code

Phone Number

Other Specialist Information

Specialist Name

Speciality

Address

Address 1

Address 2

City

State / Province

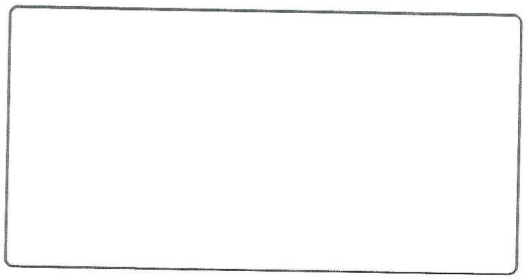
Zip Code / Postal Code

Phone Number

Signature By Patient

Date signed:

Patient's Signature



By drawing in the box above I understand and agree that this is a legal representation of my signature

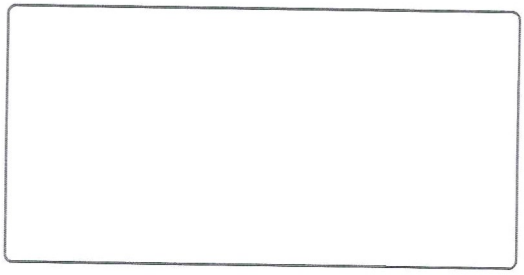
Signature By Guardian

Name*

Relationship*

Date signed:

Legal Guardian's Signature



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