QUESTIONNAIRE for INFANTS LIP/TONGUE-TIE

or

TETHERED ORAL TISSUE SYNDROME (TOTS)

Baby's Name _____

DOB _____

Today's Date _____

Current Weight _____

Birth Weight _____

☐ Male

☐ Female

Medications (If nothing, answer "none") _____

Allergies (if nothing, answer "none") _____

Are you nursing or bottle feeding? _____

☐ Nursing

☐ Bottle Feeding

☐ Both

What is your goal of having the revisions done? _____

Who would be best to contact for post op calls? _____

☐ Mom ☐ Dad

Mother's Information

First Name _____

Middle Initial _____

Last Name

Father's Information

First Name _____

Middle Initial _____

Last Name

TOTS

Symptoms Overview

BABY SYMPTOMS

- [ ] A. Prolonged Nursing
- [ ] B. Incomplete Nursing
- [ ] C. Baby falls off the breast and sleeps, tires, easily when eating
- [ ] D. Lip or tongue feels weak
- [ ] E. Baby slides off the nipple
- [ ] F. Chronic burping and/or gas
- [ ] G. Distended or bloated belly
- [ ] H. Signs of reflux such as chronic spitting up or vomiting
- [ ] I. Signs of discomfort such as arching of back or clenching of the hands
- [ ] J. Baby makes clicking noises while eating
- [ ] K. Lip or tongue cycles through sucking and movement for a short time, then stops and repeats
- [ ] L. Lip callus present (all of the time or just sometimes)
- [ ] M. Milk leaks from corners or mouth when eating
- [ ] N. Fussiness (more than usual)
- [ ] O. Gasping for air when eating
- [ ] P. Gagging when eating
- [ ] Q. Weight loss
- [ ] R. Supplementing with bottle to assist with proper feeding
- [ ] S. Baby unable to hold pacifier
- [ ] T. Constipation
- [ ] U. Sleeps with mouth open

HISTORY OF TONGUE TIE IN THE FAMILY?

☐ YES ☐ NO

FAMILY HISTORY OF CLOTTING PROBLEMS?

☐ YES ☐ NO

ARE YOU CURRENTLY NURSING, BOTTLE FEEDING, OR BOTH?

☐ Nursing ☐ Bottle Feeding

☐ Both

VITAMIN - K INJECTION

☐ GIVEN (ADMINISTERED) ☐ DECLINED (NOT ADMINISTERED)

MOM SYMPTOMS

- [ ] A. Painful nursing
- [ ] B. Bruised, cracked, blistered, flattened, or bleeding nipples
- [ ] C. Breast swelling
- [ ] D. Mastitis
- [ ] E. Thrush of the nipples
- [ ] F. Using nipple shield to breastfeed

IS THIS YOUR FIRST CHILD?

☐ / ☐

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☐ Nursing

☐ Bottle Feeding

☐ Both

What is your goal of having the revisions done? _____

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☐ Mom ☐ Dad

Mother's Information

First Name _____

Middle Initial _____

Last Name

Father's Information

First Name _____

Middle Initial _____

Last Name

Email _____

To your knowledge, was Mom breastfed as a child? ☐ / ☐

Were there any difficulties with nursing? _____

Email _____

To your knowledge, was Dad breastfed as a child? ☐ / ☐

Were there any difficulties with nursing? _____

Information about BABY:

Please Select ALL that apply/applied for Baby:

- ☐ Prolonged Nursing
- ☐ Incomplete Nursing
- ☐ Baby Falls off the breast and sleeps, tires easily when eating
- ☐ Baby sleeps with mouth open
- ☐ Lip or tongue feels weak
- ☐ Baby slides off the nipple
- ☐ Chronic burping and/or gas
- ☐ Distended or Bloated Belly
- ☐ Signs of Reflux such as chronic spitting up or vomiting
- ☐ Signs of discomfort such as arching of back or clenching of the hands
- ☐ Baby makes clicking noises while eating
- ☐ Lip or tongue cycles through sucking and movement for a short time, then stops and repeats
- ☐ Lip callus present (all of the time or just sometimes)
- ☐ Milk leaks from the corners of mouth when eating
- ☐ Fussiness (more than usual)
- ☐ Gasping for air when eating
- ☐ Gagging when eating
- ☐ Supplementing with bottle to assist with proper feeding
- ☐ Baby unable to hold pacifier
- ☐ Constipation
- ☐ None of the Above

Does baby have good sleeping patterns? ☐/☐

How long does baby sleep at a time? (Minutes)

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

Who and which area?

Family history of clotting problems? ☐/☐

Was Vitamin K injection at birth DECLINED? ☐/☐

Additional information regarding your chlid's health that should be considered?

Pediatrician Information

First Name

Last Name

Phone Number

Office Address

Address 1

Address 2

City

State / Province

Zip Code / Postal Code

Last Visit

Lactation Consultant Information (if applicable)

First Name

Last Name

Phone Number

Office Address

Address 1

Address 2

City

State / Province

Zip Code / Postal Code

Last Visit

Has any healthcare provider ever stated that he/she thinks your baby has a lip or tongue tie? ☐/☐

Whom can we thank for referring you to our practice?

Information about Mom

Please select all that apply for MOM (if nursing or when nursed)

- [ ] Painful nursing
- [ ] Bruised, cracked, blistered, flattened, or bleeding nipples
- [ ] Breast swelling
- [ ] Mastitis
- [ ] Thrush of the nipples
- [ ] Using nipple shield to breastfeed

How many times a day do you breastfeed?

Is this your first child? ☐ / ☐

Did you breastfeed your other children? ☐ / ☐

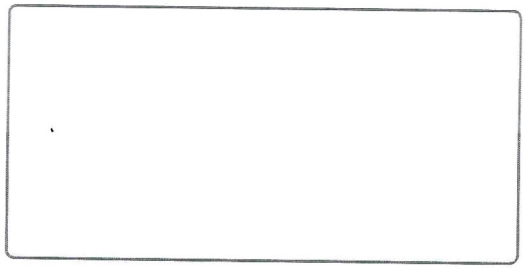
How many months did you breastfeed your other child/children?

Additional information regarding your health that should be considered:

Signature By Patient

Date signed:

Patient's Signature



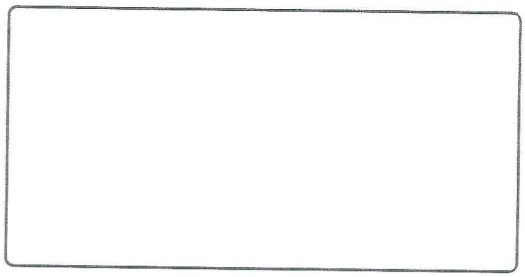
By drawing in the box above I understand and agree that this is a legal representation of my signature

Name*

Relationship*

Date signed:

Legal Guardian's Signature



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