Cortez Dental Infant Frenectomy Assessment Form

Patient's name _________________________________Sex: M/F DOB__________Today's date_________

Medical problems: Heart Disease Y/N   Bleeding disorders   Y/N   Did baby get the vitamin K shot? Y/N

Birth weight ________________present weight____________Birth hospital________________________

Delivery: Vaginal/C-section   Any birth complications?____

Was baby premature? Y/N if yes how many weeks?_________________________

Did baby get any surgery? Y/N explain____

Feeding (circle all that apply): Breastfeeding/pumped milk in syringe or bottle/formula in bottle

Has baby experienced any of the following:

___shallow latch at breast or bottle

___falls asleep while eating

___slides or pops on and off nipple

___colic symptoms/cries a lot

___reflux symptoms

___clicking or smacking noises while eating

___spits up often, amount and frequency________

___gagging, choking, coughing while eating

___gassy/fussy often

___poor weight gain

___hiccups often

___lip curls under when nursing

___gumming or chewing your nipple

___pacifier falls out easily or doesn't like it

___milk dribbles out of mouth while feeding

___short sleeping requiring feeding every 1-2 hr

___snoring, noisy breathing or mouthbreathing

___feels like a full time job just to feed baby

___nose congested often

___baby is frustrated at breast or bottle

How long does it take for baby to eat?________________

How often does baby eat?__________________________

Is baby taking medication for reflux/thrush/other?   name______________________________________

Has baby had prior surgery for lip/tongue tie? Y/N Where, when, who?___________________________

Do you have any of the following:

___creased, flattened, or blanched nipples

___lipstick shaped nipples

___blistered or cut nipples

___bleeding nipples

Pain on a scale 1-10 with breast feeding

___poor or incomplete breast drainage

___infected nipples or breasts

___plugged ducts/engorement/mastitis

___nipple thrush

___using a nipple shield

Pediatrician____phone #________________________

Lactation consultant______________________________________phone #________________________

Who referred you to us?____