Steve W. Browning, D.D.S

BROWNING
Family Dentistry

Scott Koo, D.D.S.

Tongue & Lip Tie Questionnaire

Date:_____/_____/_________ Referrer:_______________________________________

What is your chief concern for bringing in your child? ____

Does/did your child have any of the following problems? (check all that apply)

- ☐ No effective latch-on
- ☐ Un-sustained latch-on
- ☐ Unable to hold pacifier
- ☐ Slides off nipple
- ☐ Prolonged feeding times
- ☐ Poor weight gain or failure to thrive
- ☐ Unsatisfied hunger after feeding
- ☐ Gumming or chewing on nipple
- ☐ Falling asleep on the breast
- ☐ Gas, Colic and /or reflux, including vomiting (circle)
- ☐ Dental decay
- ☐ Others:

____

Have you, the mother, experienced any of the following when breastfeeding? (check all that apply)

- ☐ Severe pain with latch-on
- ☐ Incomplete breast drainage
- ☐ Mastitis or nipple thrush
- ☐ Continued pain during nursing
- ☐ Infected nipples
- ☐ Reoccurring Plugged ducts
- ☐ Nipple trauma : Cracked , Bruised , Bleeding , Blistered, Creased , Blanched or Flattened nipples (circle)
- ☐ Others:

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☐ Boy ☐ Girl

Child's Information

Patient Name: ____ Nickname: ______________
Last First MI

Birth Date: ____________________ Age: _________ months OR ________ weeks______ days

Birth weight: ____ lbs ____ oz Current Weight : ____lbs ____ oz When last weighed? ______________

Parent's/Guardian Information

Parent Name: ____
Last First

Phone (Cell): ______________________________ Can you receive text messages? YES NO

Email Address: _________________________________

Office Use Only:

Milk supply: Strong letdown Adequate Losing supply Not certain

Dietary changes: ____

Nipple shield: Yes No Left / Right breast only

Previous lip or tongue tie treatment: __________________________________

Prescribed medications: ____________________________________

Vitamin K drops/injection: Drops Injection None

Nursing blister: Present Absent