Infant Questionnaire

Patient Name:__________________________________Birth date:________________Today's Date:_____________
Birth Type: □ Vaginal □ C-Section
Any pregnancy/birth complications? □ Yes □ No If yes, explain:______________________________________
Birth Weight:________________ Present Weight: ________________ Birth Hospital: ____________________
Are you presently breastfeeding? □ Yes □ No If no, how long since you stopped?_______________________

1. Did your child receive a Vit K shot at birth? □ Yes □ No
2. Was your infant premature? □ Yes □ No If yes, how many weeks?___________________________
3. Does your infant have any:
   a. heart diseases? □ Yes □ No If yes, explain:____
   b. bleeding disorders? □ Yes □ No If yes, please explain:_______________________________
   c. connective tissue disorders? □ Yes □ No If yes, please explain:_______________________
4. Has your child had any surgery? □ Yes □ No
5. Has your child experienced any of the following:

□ Shallow latch at breast or bottle
□ Falls asleep when eating
□ Slides or pops on/off the nipple
□ Colic symptoms/cries a lot
□ Reflux symptoms
□ Clicking or smacking noises when eating
□ Spits up often? Amount/frequency__________
□ Gagging, choking, coughing when eating
□ Gassy (toots a lot)/Fussy often
□ Hiccups often
How long does it take baby to eat?____________

□ Gumming or chewing your nipple when nursing
□ Pacifier falls out easily, doesn't like, won't stay in
□ Milk dribbles out of mouth when feeding
□ Short sleeping requiring feedings every 1-2 hours
□ Snoring, noisy breathing or mouth breathing
□ Feels like a full time job just to feed baby
□ Nose congested often
□ Baby is frustrated at the breast or bottle
□ Poor weight gain
□ Lip curls under when nursing or taking bottle
How often does baby eat?_____________________

6. Is your infant taking any medication? □ Yes □ No If yes, name of medication:_________________
7. Has your infant had a prior surgery to correct the tongue or lip tie? □ Yes □ No
   If yes, how was it done? □ Laser □ Scissors □ Scalpel □ I don't know
   If yes, when, where, and by whom?
   ____
   ____
8. Do you have or have you had any of the following signs/symptoms:

□ Creased, flattened or blanched nipples
□ Lipstick-shaped nipples
□ Blistered or cut nipples
□ Bleeding nipples
□ Using a nipple shield

□ Poor or incomplete breast drainage
□ Infected nipples or breasts
□ Plugged ducts/engorgement/mastitis
□ Nipple thrush
□ Baby prefers one side over the other
If yes, circle one: Right / Left

Pain on a scale of 1-10 (1: no pain; 10: intolerable pain) when first latching:_____
Pain on a scale of 1-10 (1: no pain; 10: intolerable pain) when nursing:_____

Pediatrician:____________________________________ Phone Number:______________________________

Lactation Consultant:______________________________ Phone Number:______________________________

Who referred you to us?____

Doctor's Signature:________________________________