



Dickson Pediatric Dentistry, PLLC.

Infant Frenectomy Sheet

PATIENT INFORMATION

First Name				Last Name				Birth Date		
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Birth Weight		Present Weight		Birth Location			
<input type="checkbox"/> Vaginal Birth			<input type="checkbox"/> C-Section Birth		Any birth complications?					
Are you presently breastfeeding?			<input type="checkbox"/> Yes		<input type="checkbox"/> No		If no, how long since you stopped breastfeeding?			
Infants are usually given vitamin K at birth. Did your child receive the vitamin K shot?								<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was your infant premature?			<input type="checkbox"/> Yes		<input type="checkbox"/> No		If yes, how many weeks?			
Does your infant have any heart disease?			<input type="checkbox"/> Yes		<input type="checkbox"/> No		Known bleeding disease?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your infant had any surgery?								<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Has your infant experienced any of the following? Please check or elaborate as needed.

<input type="checkbox"/> Shallow latch at breast or bottle	<input type="checkbox"/> Baby seems always hungry and not full
<input type="checkbox"/> Falls asleep in the middle of a feed	<input type="checkbox"/> Lip curls under when nursing or taking bottle
<input type="checkbox"/> Slides or pops on and off the nipple	<input type="checkbox"/> Clicking or smacking noises when eating
<input type="checkbox"/> Gagging, choking, or coughing when eating	<input type="checkbox"/> Sucking blisters or callouses on lips
<input type="checkbox"/> Poor or slow weight gain	<input type="checkbox"/> Colic symptoms/ Baby cries a lot
<input type="checkbox"/> Hiccups often	<input type="checkbox"/> Reflux symptoms
<input type="checkbox"/> Lots of in utero hiccups	<input type="checkbox"/> Spits up often? Amount/Frequency _____
<input type="checkbox"/> Gumming or chewing the nipple	<input type="checkbox"/> Gassy (toots a lot)/ Fussy often
<input type="checkbox"/> Pacifier falls out easily or won't stay in	<input type="checkbox"/> Milk leaks out of mouth when nursing/ bottle
<input type="checkbox"/> Snoring, noisy breathing, or mouth breathing	<input type="checkbox"/> Nose sounds congested often
<input type="checkbox"/> Short sleeping and waking often	<input type="checkbox"/> Baby is frustrated at the breast or bottle
<input type="checkbox"/> Baby moves a lot in sleep/ restless sleep	

How long does baby take to eat?		How often does baby eat?		
Is your infant taking any medications?	<input type="checkbox"/> Reflux	<input type="checkbox"/> Thrush	Name of medication	
Has your infant had a prior surgery to correct the tongue or lip tie?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
When	Where	By Whom		

Do you have any of the following signs or symptoms now or in the past? Please check or elaborate as needed.

<input type="checkbox"/> Creased, flattened, or blanched nipples	<input type="checkbox"/> Poor or incomplete breast drainage
<input type="checkbox"/> Lipstick shaped nipples	<input type="checkbox"/> Decreasing milk supply
<input type="checkbox"/> Blistered or cut nipples	<input type="checkbox"/> Plugged ducts/ engorgement/ mastitis
<input type="checkbox"/> Bleeding nipples	<input type="checkbox"/> Nipple thrush
<input type="checkbox"/> Using a nipple shield	<input type="checkbox"/> Baby prefers one side over other (R/L) _____
<input type="checkbox"/> Pain (0-10) during nursing _____	<input type="checkbox"/> Feelings of hopelessness/ depression
<input type="checkbox"/> Pain (0-10) when first latching _____	

Primary Care Provider		Chiropractor/PT/CST	
Lactation Consultant		Other Therapist/ Provider	
Who referred you to us?			

FORM COMPLETION

Signature of Patient, Parent or Guardian			Date	
Form signed by			Relationship to Patient	