RICHMOND PEDIATRIC DENTISTRY & ORTHODONTICS

Infant's Name _____Birth Date _____ Today's Date _____

_____Male _____Female Birth Weight _____ Present Weight _____ Birth Location_____

_____Vaginal birth _____C-Section Birth Any birth complications? _____

Are you presently breastfeeding ____Yes ____No If no, how long since you stopped breastfeeding _____

Medical History:
1. Infants are usually given vitamin K at birth. Did your child receive the vitamin K shot? ___Yes ___No
2. Was your infant premature? ___ Yes ___ No If Yes, how many weeks? _____
3. Does your infant have any heart disease ___ Yes ___ No or known bleeding diseases? ___Yes ___ No
4. Has your infant had any surgery? ___ Yes ____ No
5. Has your infant experienced any of the following? Please check / circle / elaborate as needed.

___ Falls asleep in the middle of a feed
___ Gagging, choking, or coughing when eating
___ Hiccups often ___ Lots of *in utero* hiccups
___ Pacifier falls out easily or won't stay in
___ Short sleeping and waking often
___ Baby seems always hungry and not full
___ Lip curls under when nursing or taking bottle
___ Sucking blisters or callouses on lips
___ Reflux symptoms
___ Gassy (toots a lot) / Fussy often
___ Nose sounds congested often
How long does baby take to eat? _____

___ Shallow latch at breast or bottle
___ Slides or pops on and off the nipple
___ Poor or slow weight gain
___ Gumming or chewing the nipple
___ Snoring, noisy breathing, or mouth breathing
___ Baby moves a lot in sleep/restless sleep

___ Clicking or smacking noises when eating
___ Colic symptoms / Baby cries a lot
___ Spits up often? Amount / Frequency_____
___ Milk leaks out of mouth when nursing/bottle
___ Baby is frustrated at the breast or bottle
How often does baby eat? _____

6. Is your infant taking any medications? ___ Reflux ____Thrush Name of medication: _____

7. Has your infant had a prior surgery to correct the tongue or lip tie? If yes, when, where, and by whom? _____

8. Do you have any of the following signs or symptoms now or in the past? Please check/circle/elaborate.

___ Creased, flattened, or blanched nipples
___ Blistered or cut nipples
___ Nipple thrush
___ Decreasing milk supply
___ Baby prefers one side over other ____ (R/L)
Pain on a scale of 1-10 when first latching _____
Pain (1-10) during nursing _____

___ Lipstick shaped nipples
___ Bleeding nipples
___ Poor or incomplete breast drainage
___ Plugged ducts / engorgement / mastitis
___ Using a nipple shield
___ Feelings of hopelessness / depression

Primary Care Provider _____ Chiropractor/PT/CST_____

Lactation Consultant _____ Other Therapist/Provider_____

Who referred you to us? _____ How far away do you live? _____

Doctor's Signature _____