Altoona Pediatric Dental

Jenifer Wolfe, DDS

Patient Name:		Today's Date:
Date of Birth:	Birth Weight:	Present Weight:
Pediatrician:		Lactation Consultant:
How did you hear about us?		

Has your child experienced any of the following problems or treatment/s?
Received vitamin K injections? ☐ No ☐ Yes
Was your infant premature? ☐ No ☐ Yes Gestation Age:_____weeks
Has your infant had any surgery? ☐ No ☐ Yes
Does your infant have any heart condition or disease? ☐ No ☐ Yes
Is your infant taking any medications or supplements (including natural)? ☐ No ☐ Yes
If yes, please list: _____.
Has your infant had surgery to correct the tongue or lip tie? ☐ No ☐ Yes
If yes, please list when and where: _____.
Family History of tongue tie or lip tie? ☐No ☐Yes

Baby's Symptoms

☐ Poor latch
☐ Falls asleep while attempting to nurse
☐ Slides off the nipple when attempting to latch
☐ Colic symptoms
☐ Reflux symptoms
☐ Poor weight gain
☐ Gumming or chewing of your nipple when nursing
☐ Unable to hold a pacifier in his or her mouth
☐ Short sleep episodes requiring feeding every 2-3 hours
☐ Milk leaks out of the side of mouth

Has your infant received any medication today (pain)?
☐ No ☐ Yes (If yes, please list)_____.

Mother's Symptoms

☐ Creased, flattened or blanched nipples after nursing
☐ Cracked, bruised or blistered nipples
☐ Bleeding nipples
☐ Poor or incomplete breast drainage
☐ Severe pain when your infant attempts to latch (Vasospasm)
☐ Infected nipples or breasts
☐ Plugged ducts
☐ Mastitis or nipple thrush