



smileLYNN
PEDIATRIC DENTISTRY
CASEY LYNN, DMD. MS.

Patient's Name _____ Birth date _____ Today's Date _____

Medical problems: _____ Heart disease _____ Bleeding disorders _____ Other _____

____ Male ____ Female Birth Weight _____ Present Weight _____ Birth Hospital _____

____ 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
4. Has your infant had any surgery? ____ Yes ____ No

5. Has your infant experienced any of the following? Please check / circle / elaborate as needed.

- | | |
|--|---|
| ____ Shallow latch at breast or bottle | ____ Gumming or chewing your nipple when nursing |
| ____ Falls asleep while eating | ____ Pacifier falls out easily, doesn't like, won't stay in |
| ____ Slides or pops on and off the nipple | ____ Milk dribbles out of mouth when nursing/bottle |
| ____ Colic symptoms / Cries a lot | ____ Short sleeping requiring feedings every 1-2hrs |
| ____ Reflux symptoms | ____ Snoring, noisy breathing or mouth breathing |
| ____ Clicking or smacking noises when eating | ____ Feels like a full time job just to feed baby |
| ____ Spits up often? Amount / Frequency _____ | ____ Nose congested often |
| ____ Gagging, choking, coughing when eating | ____ Baby is frustrated at the breast or bottle |
| ____ Gassy (toots a lot) / Fussy often | How long does baby take to eat? _____ |
| ____ Poor weight gain | How often does baby eat? _____ |
| ____ Hiccups often | |
| ____ Lip curls under when nursing or taking bottle | |

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?

7. Do you have any of the following signs or symptoms? Please check / circle / elaborate as needed.

- | | |
|---|-------------------------------|
| ____ Creased, flattened or blanched nipples | ____ Blistered or cut nipples |
| ____ Lipstick shaped nipples | ____ Bleeding nipples |

Pain on a scale of 1-10 when first latching _____

Pain (1-10) during nursing: _____

___ Poor or incomplete breast drainage

___ Infected nipples or breasts

___ Plugged ducts / engorgement / mastitis

___ Nipple thrush

___ Using a nipple shield

___ Baby prefers one side over other ___ (R/L)

Pediatrician _____ Phone number: _____

Lactation Consultant _____ Phone number: _____

Who referred you to us? _____

Doctor's Signature _____