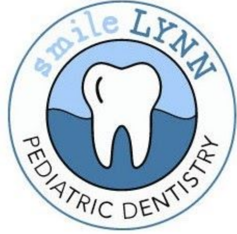

smileLYNN
PEDIATRIC DENTISTRY
CASEY LYNN, DMD. MS.

MOTHER / INFANT FOLLOW-UP ASSESSMENT

Patient's Name ______________________________Birth date ________________ Today's Date ___________________

Date of Procedure _______________ Tongue? ____ Lip? ____ Buccal Cheek Ties? ____

Birth Weight _____________ Weight at initial visit ____________ Weight today ___________

Have you noticed any changes since the procedure for your baby? Please check if improved.

___ Deeper latch at breast or bottle
___ Less falling asleep while eating
___ Slides or pops on and off the nipple less
___ Less colic symptoms/crying
___ Less reflux
___ Less clicking or smacking noises
___ Less spit up / ____ More spit up
___ Less gagging, choking, coughing when eating
___ Less gassy / Less fussy
___ Better weight gain
___ Less hiccups
___ Lip doesn't curl under anymore

____Less gumming or chewing your nipple
____Pacifier stays in easier
____ Milk dribbles out of mouth less
____ Sleeping longer
____ Less snoring or mouth breathing
____ Less moving around in sleep
____ Nose congested less often
____ Baby is less frustrated at the breast or bottle
How long does baby take to eat? _____________
How often does baby eat? ___________________

Has anything worsened? If so, explain:
____

Have you noticed any changes in your symptoms since the procedure? If bottle-feeding: _____ N/A

___ Less creased, flattened or blanched nipples
___ Less lipstick shaped nipples
___ Less blistered or cut nipples
___ Less bleeding nipples
___ Somewhat less pain ____ Significantly less pain
Pain before procedure (scale of 1-10) ________
Pain now (scale of 1-10) _______

___ Improved breast drainage
___ Less infected nipples or breasts
___Less plugged ducts / engorgement / mastitis
____Less nipple thrush
____Less using a nipple shield
____Baby doesn't prefer one side over other

Were you able to stretch the sites 4-6x a day? How'd it go? ________________________________
How was your experience at our office? ____

Any other comments?____

Thank you!

Dr. Lynn