Heal Tongue and Lip Tie Clinic - Lactation History

So that we can provide you and your children with the best possible care, please complete this Medical History Form. Each question is relevant to the treatment we will be providing for your child and is confidential.

Infant Name: _____ Date of Birth:_____

HAS YOUR CHILD EXPERIENCED ANY OF THE FOLLOWING?		**DETAILS / COMMENTS**
Is child currently under a Medical Practitioner's care?		Y ☐ N ☐
Difficult Birth?		Y ☐ N ☐
Was your Infant Premature?		Y ☐ N ☐
Poor Weight Gain		Y ☐ N ☐
Still breastfeeding?		Y ☐ N ☐ If no, at what age did you wean?_____ If Yes please tick Exclusively ☐ Expressed Breast Milk ☐ Mixed Formula ☐
INFANT RELATED ISSUES re Breast feeding	**0 = Never 1= Rarely 2= Sometimes 3= Often 4=Always**	
Poor or shallow latch (nipple feeding)		0 1 2 3 4
Slides off the nipple after latches		0 1 2 3 4
Gumming or chewing of your nipples when nursing		0 1 2 3 4
Falls asleep while nursing (prior to the end of the feed / after only a short feed)		0 1 2 3 4
Colic Symptoms / Excess Gas		0 1 2 3 4
Reflux Symptoms		0 1 2 3 4
Extended nursing episodes		0 1 2 3 4
Short sleep episodes		0 1 2 3 4
Green poos		0 1 2 3 4
Unable to hold a pacifier in his or her mouth (dummy)		0 1 2 3 4
Has a side preference when feeding		0 1 2 3 4
Pulls body off the breast during the feed		0 1 2 3 4
Gags Easily		0 1 2 3 4
Clicking when feeding		0 1 2 3 4
Vomits		0 1 2 3 4
MOTHER'S BREAST-RELATED ISSUES		
Creased, flattened or blanched nipples during/after nursing?		0 1 2 3 4
Cracked or blistered nipples (Please indicate which)		0 1 2 3 4
Bruised or Bleeding nipples? (Please indicate which)		0 1 2 3 4
Pain during latching/feeding? (Please indicate which)		0 1 2 3 4
Use of nipple shield?		0 1 2 3 4
Poor or incomplete breast drainage?		0 1 2 3 4
Infected nipples/ breast/Mastitis? (Please indicate which)		0 1 2 3 4
Nipple thrush?		0 1 2 3 4
Low milk supply?		0 1 2 3 4
Feeling anxious or stressed		0 1 2 3 4
Feelings of guilt or depression (Please indicate which)		0 1 2 3 4
_____		

Parent/Responsible Party's Signature: _____ Date_____

Relationship to infant/child: _____

Please fill this in and bring it to your appointment