Infant Questionnaire

Today's Date_____

INFANT:

Patient's Name: _____ Birth Date: _____

Form Filled out by: _____Relationship to Child: _____

Pediatrician: _____Phone Number: _____

Lactation Consultant: _____Phone Number: _____

Main Concern: _____

Are you presently breastfeeding ____yes ____ no

- If no, how long since you stopped breastfeeding? _____

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

_____

Has **YOUR INFANT** experienced any of the following? Please elaborate if needed.

____Shallow latch at breast or bottle
____Colic symptoms/Cries a lot
____Reflux symptoms
____Clicking or smacking noises when eating
____Spits up often? Amount/Frequency_____
____Gagging/Choking/Coughing when eating
____Gassy
____Poor weight gain
____Lip curls under when nursing or taking bottle
____Pacifier falls out easily
____Baby is frustrated at the breast or bottle
____How long does baby take to eat?_____
____How often does baby eat? _____

Has your infant taken any medication for reflux? _____

MOTHER:

Do **YOU** have any of the following signs or symptoms? Please elaborate if needed.

____Creased/flattened or blanched nipples
____Blistered or cut nipples
____Bleeding nipples
____Mastitis
____Using a nipple shield
Pain (1-10) during nursing:____

- Please rate from 1-10, 10 being worst