INFANT SYMPTOM QUESTIONNAIRE

First name: _____ Last name: _____ DOB: _____

Lactation Consultant: _____ Date of Visit: _____

Birth weight (lb/oz): _____

Present weight: _____

Received Vitamin K injections?	☐ Yes	☐ No
Did you complete any fertility treatment to conceive?	☐ Yes	☐ No
Was your infant premature?	☐ Yes	☐ No
Did you have a C-section?	☐ Yes	☐ No
Was a vacuum or forceps used for delivery?	☐ Yes	☐ No
Does your infant have any heart disease?	☐ Yes	☐ No
Has your infant had any surgery (Including circumcision)?	☐ Yes	☐ No
Has patient had prior surgery to correct the tongue or lip tie?	☐ Yes	☐ No

If yes, when/by whom? _____

Baby's Symptoms

- ☐ Poor latch
- ☐ Falls asleep while attempting to nurse
- ☐ Slides off the nipple when attempting to latch
- ☐ Chronic burping, flatulence or hiccups
- ☐ Reflux symptoms (chronic spit up, gagging, or vomiting)
- ☐ Poor weight gain
- ☐ Gumming or chewing of your nipple when nursing
- ☐ Unable to hold a pacifier in his or her mouth
- ☐ Wanting to feed very frequently (every 1-1.5 hours)
- ☐ Breast milk leakage from mouth, nose or both
- ☐ Bottle supplementation
- ☐ Favoring one side while feeding
- ☐ Does not like to be put in the car seat
- ☐ Head is usually tilted to one side
- ☐ Clenches fists during feeding
- ☐ Jaw tremors during feeding

Mother's Symptoms ☐ Mother is not breastfeeding

- ☐ Creased, flattened or blanched nipples after nursing
- ☐ Cracked, bruised or blistered nipples
- ☐ Bleeding nipples
- ☐ Severe pain when your infant attempts to latch
- ☐ Poor or incomplete breast drainage
- ☐ Infected nipples or breasts
- ☐ Plugged ducts
- ☐ Mastitis or nipple thrush
- ☐ Use of Nipple Shield
- ☐ Breastfeeding, but no symptoms

Family History of ☐ Tongue Tie ☐ Lip Tie

Has your baby had any of the following?

- ☐ Weight loss/gain
- ☐ Nasal obstruction
- ☐ Swallowing issues
- ☐ Cyanosis (turning blue)
- ☐ Breathing issues
- ☐ Reflux/vomiting/spitting up
- ☐ Bleeding problems

_____ _____

Parent/Guardian Signature Date