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Symptom's Checklist

Patient's name: _____ Birthdate: _____ Today's date: _____

Parent's name: _____ Referred by: _____

Past Medical History

Birth weight (lb/oz): _____ Present weight (lb/oz): _____

Received Vitamin K injections YES / NO

Family History of Blood Disorders YES / NO

Was your infant premature? YES / NO If yes, gestation age (wks): _____

Does your infant have any heart disease? YES / NO If yes, _____

Has your infant had any surgery? YES / NO If yes, _____

Has patient had prior surgery to correct the tongue or lip ties? **YES / NO** If yes, when/ by whom? _____

Baby's Symptoms

- Poor latch
- Falls asleep when attempting to nurse
- Milk spilling out of mouth when nursing
- Choking on milk
- Colic symptoms
- Reflux/vomiting/spitting up
- Poor weight gain
- Gumming or chewing your nipple when nursing
- Unable to hold a pacifier in his/her mouth
- Short sleep episodes requiring feeding every 2-3 hours
- Reduce elevation of the tongue
- Unable to stick tongue out
- Clicking

Mother's Symptom

- Breast milk supply reduced
- Severe pain when your infant attempts to latch
- Mastitis or nipple thrush
- Breast damage:
 - cracking
 - bleeding
 - compression

Family History of Tongue Tie _____ Lip Tie _____

Pediatrician: _____ Phone number: _____

Lactation Consultant: _____ Phone number: _____

Has your pediatrician evaluated the tongue and lip attachments: No _____ YES _____