THE OREGON CLINIC

Ear, Nose & Throat East

Patient Name _____
Date of Birth _____
Referring Physician _____
Date of Visit _____

Frenotomy & Frenectomy

Which pharmacy do you use (phone # or address): _____

_____

Lactation Consultant: _____

Medication Allergies

_____

Current Medications (including over-the-counter, herbal, vitamins)

_____ _____ _____

Past Medical History

Birth weight (lb/oz): _____

Present weight: _____

Received Vitamin K injections? ❑ 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 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
❑ Colic symptoms
❑ Reflux symptoms
❑ Poor weight gain
❑ Gumming or chewing of your nipple when nursing
❑ Unable to hold a pacifier in his or her mouth
❑ Short sleep episodes requiring feeding every 2-3 hours

Mother's Symptoms

❑ 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 breast
❑ Plugged ducts
❑ Mastitis or nipple thrush

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
❑ Abnormal muscle tone/seizures
❑ Rash
❑ Urinary issues
❑ Hormone problems

Physician Signature: _____ Date: _____ 8/1/19