



Patient Name _____
Date of Birth _____
Date of Visit _____

Lip/Tongue Tie Form

Lactation Consultant (if you have one): _____

Medial Allergies: _____ Current Medications: _____

- Family history of Tongue Tie/ Lip Tie

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
- Reflux symptoms
- Poor weight gain
- Gumming or chewing of your nipple when nursing
- Unable to hold a pacifier in his or her mouth
- Nursing takes longer than 45 minutes per feed

Mother's Symptoms

- Creased, flattened or blanched nipples after nursing
- Cracked, bruised or blistered nipples
- Severe pain when your infant attempts to latch
- Poor or incomplete breast drainage
- Infected nipples or breasts
- Mastitis or nipple thrush

Has your baby had any of the following?

- Weight loss/gain
- Swallowing issues
- Cyanosis (turning blue)
- Breathing issues
- Reflux/vomiting/spitting up