Dr. Krizman
INTEGRATIVE DENTISTRY

Patient Name: _____
Mom/Dad Name:_____
Date of Birth: _____
Referring Provider: _____
Date of Visit: _____

Frenotomy and Frenectomy

Lactation Consultant: _____

Medication Allergies: _____

Current Medications (include over-the-counter, herbal, vitamins): _____

Medical History

Birth Weight: _____ **Current Weight:**_____

Received Vitamin K injections? **No** **Yes**
Was your infant premature? **No** **Yes**
Does your infant have heart disease? **No** **Yes** **If yes,** _____
Has your infant had any surgery? **No** **Yes** **If yes,** _____
Has your baby had prior surgery to correct tongue / lip tie? **No** **If yes, when / by whom?**
_____

Circle all that apply:

Baby's Symptoms
Poor latch
Falls asleep while attempting to latch
Colic
Reflux
Poor weight gain
Gumming or chewing nipple while nursing
Unable to hold a pacifier in his/ 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 infant attempts to latch
Poor or incomplete breast drainage
Infected nipples or breasts
Plugged ducts
Mastitis or nipple thrush

Family history of Tongue Tie? **No** **Yes**

Family history of Lip Tie? **No** **Yes**

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

Doctor Signature: _____**Date**_____