INFANT PRE ASSESSMENT

Patient's Name _____Birth date _____ Today's Date _____

Medical problems: _____ Heart disease _____ Bleeding disorders _____ Other_____

_____Male _____Female Birth Weight _____ Present Weight _____ Birth Hospital_____

_____Vaginal birth _____C-Section Birth Any birth complications? _____

Are you presently breastfeeding ____Yes ____No If no, how long since you stopped breastfeeding _____

Medical History:

1. Infants are usually given vitamin K at birth. Did your child receive the vitamin K shot? ____yes _____no
2. Was your infant premature? ___ Yes ___ No If yes, how many weeks? _____
3. Does your infant have any heart disease ___ Yes ___ No
4. Has your infant had any surgery? ___ Yes ___ No
5. **Has your infant experienced any of the following? Please check / circle / elaborate as needed.**

___ Shallow latch at breast or bottle
___ Falls asleep while eating
___Slides or pops on and off the nipple
___ Colic symptoms / Cries a lot
___ Reflux symptoms
___ Clicking or smacking noises when eating
___ Spits up often? Amount / Frequency_____
___ Gagging, choking, coughing when eating
___ Gassy (toots a lot) / Fussy often
___ Poor weight gain
___ Hiccups often
___ Lip curls under when nursing or taking bottle

____Gumming or chewing your nipple when nursing
____Pacifier falls out easily, doesn't like, won't stay in
____ Milk dribbles out of mouth when nursing/bottle
____ Short sleeping requiring feedings every 1-2hrs
____Snoring, noisy breathing or mouth breathing
____Feels like a full time job just to feed baby
____ Nose congested often
____ Baby is frustrated at the breast or bottle
How long does baby take to eat? _____
How often does baby eat? _____

6. Is your infant taking any medications? ___ Reflux ____Thrush Name of medication: _____

7. Has your infant had a prior surgery to correct the tongue or lip tie? If yes, when, where, and by whom?

_____

7. **Do you have any of the following signs or symptoms? Please check / circle / elaborate as needed.**

___ Creased, flattened or blanched nipples
___ Lipstick shaped nipples
___ Blistered or cut nipples
___ Bleeding nipples
Pain on a scale of 1-10 when first latching _____
Pain (1-10) during nursing: _____

___ Poor or incomplete breast drainage
___ Infected nipples or breasts
____Plugged ducts / engorgement / mastitis
____Nipple thrush
____ Using a nipple shield
____Baby prefers one side over other ____ (R/L)

Pediatrician _____Phone number: _____

Lactation Consultant _____Phone number:_____

Who referred you to us? _____

Doctor's Signature _____