



Patient's Name _____ Date of Birth _____ Today's Date _____

Medical Problems _____ Heart disease _____ Bleeding disorders _____ Other _____

Male _____ Female _____ Home birth _____ Hospital birth _____ Vaginal birth _____ C-Section _____

Are you presently breastfeeding? YES ___ NO ___ If no, how long since you stopped breastfeeding? _____

MEDICAL HISTORY: Has your child ever experienced any of the following problems or treatments?

1. Infants are usually given Vitamin K at birth to prevent bleeding in the first 8 weeks of life. Did you sign any waiver to refuse the administration of Vitamin K? YES ___ NO ___
2. Was your infant premature? YES ___ NO ___
3. Does your infant have any heart disease? YES ___ NO ___
4. Has your infant had any surgery? YES ___ NO ___
5. Is your infant taking any medications? Reflux ___ Thrush ___ Other ___ Name of medication _____
6. Has your infant experienced any of the following?

___ Poor latch	___ Gaging
___ Falls asleep while attempting to latch	___ Hiccups
___ Slides off nipple when attempting to latch	___ Clicking
___ Colic symptoms	___ Gassiness
___ Reflux symptoms (due to excessive clicking and air intake)	___ Waking up congested
___ Poor weight gain	___ Snoring
___ Gumming or chewing of your nipple when nursing	___ Heavy breathing
___ Unable to hold a pacifier in his/her mouth	___ Sleep apnea
___ Short sleep episodes requiring feeding every 1-2 hours	
7. Has your infant had a prior surgery to correct a tongue or lip tie? YES ___ NO ___
If yes, when and where? _____
8. Do you have any of the following signs or symptoms?

___ Creased, flattened, or blanched nipples after nursing ___ Blistered or cut nipples ___ Severe pain when your infant attempts to latch ___ Poor or incomplete drainage ___ Infected nipples or breasts ___ Plugged ducts or mastitis ___ Nipple thrush	Birth Weight _____ Present Weight _____ Dr. Prater may administer acetaminophen on infants over 2 months prior to surgery. Has your infant received any type of pain medication today? YES ___ NO ___ Is it okay to give your infant pain medication? YES ___ NO ___
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Pediatrician _____ Phone number _____

Address _____ City _____ State _____ Zip _____

Lactation Consultant _____ Phone number _____

Address _____ City _____ State _____ Zip _____

Referred by _____ Phone number _____

Address _____ City _____ State _____ Zip _____

Did you use the internet to find our website? YES ___ NO ___

Have you visited our website?