TOT (Tethered Oral Tissues)
QUESTIONNAIRE FOR BREAST FED BABIES

PATIENT INFORMATION	PARENT/GUARDIAN INFORMATION
FIRST & MIDDLE NAME: _____ LAST NAME: _____ PREFERRED NAME:_____ ☐ MALE ☐ FEMALE **ADDRESS:** STREET:_____ CITY: _____ POSTAL CODE _____ _____ Box #:_____ HOME PHONE NUMBER: _____-_____-_____ PREFERRED CONTACT METHOD-please circle one PHONE TEXT EMAIL DATE OF BIRTH: _____ _____ _____ MONTH DAY YEAR	PARENT ONE NAME: _____ MR/MS/MRS PARENT TWO NAME: _____MR/MS/MRS EMAIL: _____ EMAIL:_____ **ADDRESS**: ☐SAME AS PATIENT ☐ DIFFERENT FROM PATIENT If different: please fill out: _____ _____ HOW DID YOU HEAR ABOUT US? PLEASE PROVIDE SITE/SUPPORT GROUP/PROFESSIONAL _____
PARENT ONE INSURANCE INFORMATION EMPLOYER _____ INSURANCE CARRIER _____ PLAN POLICY NUMBER _____ DIV. NO. _____ CERTIFICATE/SIN NUMBER _____ DATE OF BIRTH:_____DD/MM/YY	**PARENT TWO INSURANCE INFORMATION** EMPLOYER _____ INSURANCE CARRIER _____ PLAN POLICY NUMBER _____ DIV. NO. _____ CERTIFICATE/SIN NUMBER _____ DATE OF BIRTH:_____DD/MM/YY

GP/PEDIATRICIAN _____ PHONE NUMBER_____
ADDRESS_____ EMAIL_____
Has your physician evaluated your infant's lip and tongue ties? ☐ Yes ☐ No

Have you seen one of the following: PLEASE CHECK ONE: ☐LACTATION CONSULTANT ☐SPEECH THERAPIIST

☐OMT ☐CHIROPRACTOR ☐OTHER MEDICAL PROFESSIONAL_____

NAME_____ PHONE NUMBER_____
ADDRESS_____ EMAIL_____
_____

DENTIST _____ PHONE NUMBER_____
ADDRESS _____ EMAIL _____

_____

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Contd.

☐ Home Birth ☐ Hospital (name) _____ ☐ Vaginal birth ☐ C-Section Birth
Birth weight _____ Present weight _____

1. Are you presently breastfeeding? ☐Yes ☐ No
   If no, how long since you stopped breastfeeding? _____
2. Are you presently using a nipple shield? ☐ Yes ☐ No
3. Are you choosing not to breastfeed? ☐ Yes ☐ No
4. Are you pumping breast milk? ☐ Yes ☐ No
5. Are you supplementing using a bottle? ☐ Yes ☐ No
6. Are you using a SNS (feeding tube) device? ☐ Yes ☐ No
7. Do you or any immediate family members have any bleeding disorders? ☐ Yes☐ No

Medical History: Has your child experienced any of the following problems or treatment?

1. Infants are usually given vitamin K at birth to prevent bleeding in the first 8 weeks of life. Did you sign any wavier 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 child taking any medications ☐ Yes ☐ No
   ☐Reflux meds ☐Thrush meds ☐ other _____

Name of medications _____

6. Jaundice? ☐ Yes ☐ No
7. Cleft lip/palate? ☐ Yes ☐ No
8. Other: _____

Mother's symptoms

☐ Creased, cracked or blanching of nipples
☐ Gumming or chewing of the nipples
☐ Infant unable to achieve a successful, tight latch
☐ Infected nipples or breast
☐ Plugged Ducts
☐ Nipple Thrush
☐ Feelings of depression
☐ Over supply of breast milk
☐ Painful latching of infant onto the breast
☐ Bleeding, cracked or cut nipples
☐ Poor or incomplete breast drainage
☐ Abraded nipples
☐ Mastitis
☐ Under supply of breast milk

Infant's Symptoms

☐ Difficulty in achieving a good latch
☐ Falls to sleep while attempting to nurse
☐ Reflux (Clicking, swallowing air during nursing)
☐ Short sleep episodes (feeding every 1-2 hours)
☐ Unable to keep a pacifier in the infant's mouth
☐ Only sleeping when held upright position, in car seat
☐ Gagging when attempting to introduce solid foods
☐ Waking up congested at nap time
☐ Slides off the breast when attempting to latch
☐ Poor weight gain
☐ Apnea- snoring, heavy noisy breathing
☐ Waking up congested in the morning
☐ Milk leaking out sides of mouth during feedings

_____ _____ _____
Printed Name Parent/Guardian Signature Date