

**MOTHER / INFANT FOLLOW-UP ASSESSMENT**

Patient's Name \_\_\_\_\_ Birth date \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Procedure \_\_\_\_\_ Tongue? \_\_\_\_ Lip? \_\_\_\_ Buccal Cheek Ties? \_\_\_\_

Birth Weight \_\_\_\_\_ Weight at initial visit \_\_\_\_\_ Weight today \_\_\_\_\_

**Have you noticed any changes since the procedure for your baby? Please check if improved.**

- |   |  |
|---|--|
| <input type="checkbox"/> Deeper latch at breast or bottle                     | <input type="checkbox"/> Less gumming or chewing your nipple             |
| <input type="checkbox"/> Less falling asleep while eating                     | <input type="checkbox"/> Pacifier stays in easier                        |
| <input type="checkbox"/> Slides or pops on and off the nipple less            | <input type="checkbox"/> Milk dribbles out of mouth less                 |
| <input type="checkbox"/> Less colic symptoms/crying                           | <input type="checkbox"/> Sleeping longer                                 |
| <input type="checkbox"/> Less reflux  | <input type="checkbox"/> Less snoring or mouth breathing                 |
| <input type="checkbox"/> Less clicking or smacking noises                     | <input type="checkbox"/> Less moving around in sleep                     |
| <input type="checkbox"/> Less spit up / <input type="checkbox"/> More spit up | <input type="checkbox"/> Nose congested less often                       |
| <input type="checkbox"/> Less gagging, choking, coughing when eating          | <input type="checkbox"/> Baby is less frustrated at the breast or bottle |
| <input type="checkbox"/> Less gassy / Less fussy                              | How long does baby take to eat? _____                                    |
| <input type="checkbox"/> Better weight gain                                   | How often does baby eat? _____   |
| <input type="checkbox"/> Less hiccups   |  |
| <input type="checkbox"/> Lip doesn't curl under anymore                       |  |

Has anything worsened? If so, explain:

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**Have you noticed any changes in your symptoms since the procedure? If bottle-feeding: \_\_\_\_ N/A**

- |  |  |
|--|--|
| <input type="checkbox"/> Less creased, flattened or blanched nipples                         | <input type="checkbox"/> Improved breast drainage                    |
| <input type="checkbox"/> Less lipstick shaped nipples  | <input type="checkbox"/> Less infected nipples or breasts            |
| <input type="checkbox"/> Less blistered or cut nipples                                       | <input type="checkbox"/> Less plugged ducts / engorgement / mastitis |
| <input type="checkbox"/> Less bleeding nipples   | <input type="checkbox"/> Less nipple thrush                          |
| <input type="checkbox"/> Somewhat less pain <input type="checkbox"/> Significantly less pain | <input type="checkbox"/> Less using a nipple shield                  |
| Pain before procedure (scale of 1-10) _____  | <input type="checkbox"/> Baby doesn't prefer one side over other     |
| Pain now (scale of 1-10) _____   |  |

Were you able to stretch the sites 3-4 a day? How'd it go? \_\_\_\_\_

How was your experience at our office? \_\_\_\_\_

Any other comments? \_\_\_\_\_

Thank you!

OU Pediatric Dental Specialty Clinic