

MOTHER / INFANT FOLLOW-UP ASSESSMENT

Infant's Name _____ Birth date _____ Today's Date _____

Date of Procedure _____ Tongue? ____ Lip? ____ Buccal Cheek Ties? ____

Birth Weight _____ Weight at initial visit _____ Weight today _____ Change _____

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"/> Lips flip out better / not curling under as much |
| <input type="checkbox"/> Less falling asleep while eating | <input type="checkbox"/> Less gumming or chewing the nipple |
| <input type="checkbox"/> Slides or pops on and off the nipple less | <input type="checkbox"/> Pacifier stays in better |
| <input type="checkbox"/> Less colic symptoms/crying | <input type="checkbox"/> Milk dribbles/leaks out of mouth less |
| <input type="checkbox"/> Less reflux | <input type="checkbox"/> Sleeping longer |
| <input type="checkbox"/> Less clicking or smacking noises | <input type="checkbox"/> Less snoring or mouth breathing |
| <input type="checkbox"/> Less spit up / <input type="checkbox"/> More spit up | <input type="checkbox"/> Less moving around in sleep |
| <input type="checkbox"/> Less gagging, choking, coughing when eating | <input type="checkbox"/> Nose congested less often |
| <input type="checkbox"/> Less gassy / Less fussy | <input type="checkbox"/> Baby babbles more or <input type="checkbox"/> makes new sounds |
| <input type="checkbox"/> Less constipation / regular stools now | <input type="checkbox"/> Baby is less frustrated at the breast or bottle |
| <input type="checkbox"/> Better weight gain | <input type="checkbox"/> Eats solid foods better (if applicable) |
| <input type="checkbox"/> Happier baby than before | How long does baby take to eat? _____ |
| <input type="checkbox"/> Less hiccups | How often does baby eat? _____ |

Has anything worsened? If so, explain:

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 (baby gets more) |
| <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) _____ | <input type="checkbox"/> Better milk supply |
| <input type="checkbox"/> Better emotional state / more confident | |

How are you doing mentally/emotionally? _____

Were you able to stretch the sites 4x a day? Any issues? _____

How was your experience at our office? _____

Any other comments? _____

Thank you!

Dr. Jamshidi & Team

