Orange County Pediatric Dentistry
Dr. Dayna Olstein
Dr. Arielle Rolon

Infant Assessment Sheet

PATIENT INFORMATION

First Name		**Last Name**				**Birth Date**	
Gender	❑ Male ❑ Female	**Birth Weight**		**Present Weight**		**Birth Location**	
❑ Vaginal Birth ❑ C-Section Birth		**Any birth complications?**					
Are you breastfeeding or pumping?	❑ Yes ❑ No	**If no, how long since you stopped breastfeeding?**					
Infants are usually given vitamin K at birth. Did your child receive the vitamin K shot?						❑ Yes ❑ No	
Was your infant premature?	❑ Yes ❑ No	**If yes, how many weeks?**					
Does your infant have any heart disease?	❑ Yes ❑ No	**Known bleeding disease?**	❑ Yes ❑ No				
Any other medical conditions?							
Has your infant had any surgery?	❑ Yes ❑ No	**What type?**					

Has your infant experienced any of the following? Please check or elaborate as needed.

- ❑ Shallow latch at breast or bottle
- ❑ Falls asleep in the middle of a feed
- ❑ Slides or pops on and off the nipple
- ❑ Gagging, choking, or coughing when eating
- ❑ Poor or slow weight gain
- ❑ Hiccups often
- ❑ Lots of in utero hiccups
- ❑ Gumming or chewing the nipple
- ❑ Pacifier falls out easily or won't stay in
- ❑ Snoring, noisy breathing, or mouth breathing
- ❑ Short sleeping and waking often
- ❑ Baby moves a lot in sleep/ restless sleep
- ❑ Lip curls under when nursing or taking bottle
- ❑ Clicking or smacking noises when eating
- ❑ Sucking blisters or callouses on lips
- ❑ Colic symptoms/ Baby cries a lot
- ❑ Reflux symptoms
- ❑ Spits up often? Amount/Frequency _____
- ❑ Gassy (toots a lot)/ Fussy often
- ❑ Milk leaks out of mouth when nursing/ bottle
- ❑ Nose sounds congested often
- ❑ Baby is frustrated at the breast or bottle
- ❑ Constipation or irregular stools
- ❑ Baby seems always hungry and not full

How long does baby take to eat?		**How often does baby eat?**	
Anything else?			
Is your infant taking any medications?	❑ Reflux ❑ Thrush	**Name of medication**	
Any prior surgery to correct the tongue- or lip-tie?	❑ Yes ❑ No	**When**	**Where**
How are you doing mentally/ emotionally?			

Do you have any of the following signs or symptoms now or in the past? Please check or elaborate as needed.

- ❑ Creased, flattened, or blanched nipples
- ❑ Lipstick shaped nipples
- ❑ Blistered or cut nipples
- ❑ Using a nipple shield
- ❑ Pain (0-10) during nursing _____
- ❑ Feelings of hopelessness/ depression
- ❑ Poor or incomplete breast drainage
- ❑ Decreasing milk supply
- ❑ Plugged ducts/ engorgement/ mastitis
- ❑ Nipple thrush
- ❑ Pain (0-10) when first latching _____
- ❑ Baby prefers one side over other (R/L) _____

Primary Care Provider	
Lactation Consultant	
Other Therapist/ Provider	
Who referred you to us?	

FORM COMPLETION

Signature of Patient, Parent or Guardian		**Date**	
Form signed by		**Relationship to Patient**	
Doctor's Signature			