Julie Lee Park, DMD **(614) 636-0338** **julielee.dmd@gmail.com**

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Gender: _____ Birth Weight: _____ Current Weight: _____

Birth Hospital: _____

Lactating Parent's Name: _____ Partner's Name: _____
Phone/cell#_____

Birth: Vaginal or C-Section Birth Complications:_____

Are you presently breastfeeding? YES/NO

If no, how long since you stopped breastfeeding? _____

Medical History:

- 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 medical issues? If so, please explain:
  _____
- Does your infant have any heart disease? YES/NO
- Does your infant have any bleeding disorders? YES/NO
- Has your infant had any surgeries? YES/NO
- **Has your infant experienced any of the following? Please check and elaborate as needed.**

____ Shallow latch at breast or bottle ____ Milk dribbles out of mouth when nursing

____ Painful Nursing ____ Snoring, noisy breathing or mouth breathing

____ Reflux or frequent spit up ____ Prolonged feeding time at breast or bottle

____ Clicking/smacking noises when eating ____ Baby is frustrated at the breast or bottle

____ Gagging, chocking, coughing when eating ____ Gassy/Fussy often

____ Slow or poor weight gain ____ Lip curls under when nursing or taking bottle

How long does baby take to eat? _____

How often does baby eat? _____

How many wets in 24 hours? _____ Stools? _____

- Is your infant taking any medications? YES/NO Reflux? _____Thrush? _____

  Name of medication? _____

- Has your infant had a prior surgery to correct the tongue or lip tie? YES/NO If yes, when, where and by whom?

- Has your infant had any bodywork (PT, OT, Chiropractic, Cranial Sacral Therapy, Massage, etc.)?

- **Do you have any of the following signs or symptoms? Please check and elaborate as needed.**

  ____ Creased, flattened or blanched nipples ____ Poor or incomplete breast drainage

  ____ Lipstick shaped nipples ____ Plugged ducts/engorgement/mastitis

  ____ Damaged nipples (blisters, bruising) ____ Nipple Thrush

  ____ Using a nipple shield ____ Baby prefers one side over other? R/L

  Pain (1-10) during nursing? _____

Pediatrician _____ Fax Number: _____

Lactation Consultant: _____ Fax Number: _____

Who referred you to us? _____

Please fax this form to

Northstar Family Dental

Dr. Julie Lee Park

F: (740) 909-3909