

Infant Assessment Sheet



Patient's Name: _____ Birth Date: _____ Today's Date: _____

Medical Problems: _____ Heart Disease: _____ Bleeding Disorders: _____ Other: _____

Male: _____ Female: _____ Birth Weight: _____ Present Weight: _____ Birth Hospital: _____

Vaginal Birth: _____ C-Section Birth: _____ Any birth complications? _____

Pediatrician: _____ Phone Number: _____

Lactation Consultant: _____ Phone Number: _____

Who referred you to us? _____

Are you presently breastfeeding? Yes _____ No _____ If no, how long since you stopped breastfeeding? _____

Medical History:

1. Infants are usually given a vitamin K at birth. Did your child receive the vitamin K shot? Yes _____ No _____

2. Was your infant premature? Yes _____ No _____ If yes, how many weeks? _____

3. Does your infant have any heart disease? Yes _____ No _____

4. Has your infant had any surgery? Yes _____ No _____

5. Has your infant experienced any of the following? Please check/circle/elaborate as needed

- Shallow latch at breast or bottle
Falls asleep while eating
Slides or pops on and off the nipple
Colic symptoms / Cries a lot
Reflux symptoms
Clicking or smacking noises when eating
Spits up often? Amount / Frequency
Gagging, choking, coughing when eating
Gassy (toots a lot) / Fussy often
Poor weight gain
Hiccups often
Lip curls under when nursing or taking a bottle
Gumming or chewing your nipple when nursing
Pacifier falls out easily, doesn't like, won't stay in
Milk dribbles out of mouth when nursing/bottle
Short sleeping requiring feedings every 1-2 hrs
Snoring, noisy breathing or mouth breathing
Feels like a full time job just to feed baby
Nose congested often
Baby is frustrated at the breast or bottle
How long does baby take to eat?
How often does baby eat?

6. Is your infant taking any medications? Reflux _____ Thrush _____ Name of medication: _____

7. Has your infant had a prior surgery to correct the tongue or lip tie? If yes, when, where, and by whom?

8. Do you have any of the following signs or symptoms? Please check / circle / elaborate as needed

- Creased, flattened or blanched nipples
Lipstick shaped nipples
Blistered or cut nipples
Bleeding nipples
Pain on a scale of 1-10 when first latching
Pain on a scale of 1-10 when nursing:
Poor or incomplete breast drainage
Infected nipples or breasts
Plugged ducts / engorgement / mastitis
Nipple Thrust
Using a nipple shield
Baby prefers one side over the other (R / L)

Doctor: _____