INFANT HEALTH QUESTIONNAIRE (IHQ)

PATIENT DEMOGRAPHICS

First Name:________________ Middle Initial:_____ Last Name:______________________
Date of Birth: ______________________ Age: ______________________
Gender: __________________________ SSN: ___________________________
Address: ____
City: __________________________ State:____ Zip Code:__________________

PARENT/CAREGIVER CONTACT INFORMATION

Parent/Guardian Full Name: ________________________ Relationship to Patient: ________
Parent/Guardian Full Name: ________________________ Relationship to Patient: ________
Preferred Contact Number (for Dr. Green's follow-ups):______________________________
Email: ____

PRIMARY CARE/OTHER PROVIDER INFORMATION

Pediatrician's Office: ____
Pediatrician's Name: ____
Lactation Consultant/IBCLC: ____
Bodyworker/Chiropractor:____
Referred by: ____
Reason(s) for appointment:

Upper Lip Tie Tongue Tie Consult Myofunctional Therapy Consult

MEDICAL HISTORY

Please include surgeries, illness, or hospitalizations (ex. NICU stay, Jaundice)

Treatment	Doctor/Provider	Date of Treatment

SIGNIFICANT BIRTH HISTORY:

Please list any significant occurrences that may have occurred during birth, pre or post-natal.

____
____
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Ryan P. Robinson, DDS, DABCP, DABDSM, DABCDSM, QOM-D | Joanna G. Green, DDS, QOM-D tel 302.239.1757 | fax 302.285.2264 | contact@painandsleepcenter.com | www.painandsleepcenter.com

If male, is he circumcised? YES or NO
If yes, any complications noted at procedure?____

CURRENT MEDICATIONS
Please include all current prescriptions, over-the-counter, vitamins, herbs, etc.

Medication	Dosage	Reason for Taking

Was a Vitamin K shot given at birth: YES or NO

Baby's Medical History:
___ Cleft lip/ palate
___ Heart defect
___ Family hx of bleeding disorders
___ Bleeding hx with baby
___ Hernia
___ Family hx of keloids or aggressive healing/scarring
___ Hx of Jaundice (Treatment: ______________________________________)

FEEDING HISTORY
Baby's Feeding Symptoms (Please check all that apply):
___ Poor quality latch
___ Long/short feedings
___ Clicking while nursing
___ Gumming/ chewing
___ Poor weight gain
___ Gassy
___ Falls asleep prematurely while nursing
___ Slides off breast
___ Reflux
___ Pacifier problems
___ Lip blister or callus
___ Torticollis
___ Weighted feeds? How much was transferred in how much time?_____________________

Please elaborate on any specific feeding symptoms listed above. ________________________
____
____
____
____

Mother's symptoms (please check all that apply):
___Pain or nipple damage: Indicate mild, moderate or severe
___Poor/ incomplete drainage
___Infected nipples
___Vasospasm
___Mastitis/ thrush
___Low/high milk supply

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ADDITIONAL INFORMATION

Is there anything else you would like us to know?

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SIGNATURE

Patient Name:____

*Parent/Guardian Signature:*____

Date: _________________

DOCTORS USE ONLY

Lip classification(Stanford):I___II ____III ____ Evaluation: __________________________

Tongue classification(Coryllos):I___II ____III ____IV ____ Evaluation:________________________

Treatment:____

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