

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



Feeding Evaluation 2+Years

Please check all that applied in infancy

Breastfeeding Mother's Symptoms

Mastitis Thrush Nipple pain
 Cracked nipples Clogged breast ducts Low milk supply

Infancy Symptoms

Overall	Breastfeeding	Bottle-feeding
<input type="checkbox"/> Reflux/Frequent spit up <input type="checkbox"/> Excessive fussiness/Colic <input type="checkbox"/> Excessive Gas <input type="checkbox"/> Poor weight gain <input type="checkbox"/> Lip blisters <input type="checkbox"/> Thrush <input type="checkbox"/> Constipation <input type="checkbox"/> Loss of more than 10% of birthweight <input type="checkbox"/> Child gets tired taking breaks w/feedings	<input type="checkbox"/> Difficulty when latching <input type="checkbox"/> Unable to maintain latch <input type="checkbox"/> Shallow Latch <input type="checkbox"/> Clicking <input type="checkbox"/> Frustrated at the breast <input type="checkbox"/> Extended feedings over 40 min <input type="checkbox"/> Biting/Gumming nipples <input type="checkbox"/> Falling asleep during feedings <input type="checkbox"/> Unable to flange lips	<input type="checkbox"/> Clicking <input type="checkbox"/> Increased air intake <input type="checkbox"/> Excessive leaking/dribbling <input type="checkbox"/> Extended feedings over 30 min <input type="checkbox"/> Choking/Coughing during feedings

Current Symptoms

Headaches Snoring Mouth breathing
 Bad Breath Constipation Sleep Apnea
 Nasal Congestion Frequent thirst Morning fatigue

Explain in detail your concerns that may not be on this form

History Questionnaire	Yes	No
Does your child have a history of ear infections?		
Have you ever had concerns about your child's development or milestones?		
Has your child ever been diagnosed with ADHD or ADD?		
Have you ever been told your child has abnormal tongue movement?		
Has your child been diagnosed with TMJ?		
Eating & Tongue Function	Yes	No
Has your child ever had a swallow study?		
Has your child ever seen a specialist for feeding difficulties such as GI, Pulmonologist, Feeding therapist, etc.....?		
Can your child stick their tongue out beyond their lips?		
Can your child make a clicking noise with their tongue?		
Is your child a picky eater that avoids specific textures?		
Does your child take longer to eat during feeding time?		
Does your child have any difficulties using a straw? Ex: Biting and smashing the straw when drinking		
Does your child have any difficulties using a sippy cup? Ex: Placing lips on the spout or mouth gets tired from use		
Speech	Yes	No
Was your child ever diagnosed with a speech delay?		
Is your child a quiet talker?		
Do most people have a hard time understanding your child?		
Does your child have a difficult time pronouncing certain letters?		
If yes circle the letters L, T, D, N, S or Z		
Does your child mispronounce words? Ex: Cu for Cup, Wed for Red, Lello for Yellow,		
Dental	Yes	No
Does your child have a hard time cleaning food from their teeth?		
Has your child ever had a gap in between their teeth causing issues with feeding, drinking or speech?		
Has your child ever had issues with brushing their teeth? Ex: Pain, bleeding gums, refusing to brush		
Does your child have a history of cavities?		

CONSENT TO ACT AS A PARTICIPANT IN A RESEARCH REGISTRY

TITLE: Agave Pediatrics Tongue-tie Research Registry

PRINCIPAL INVESTIGATOR: Dr. Rajeev Agarwal

CO-INVESTIGATORS: Agave Pediatric Providers and Research Staff

SOURCE OF SUPPORT: Currently self-funded

Advancements in patient care have resulted from research involving the collection and analysis of health care records of patients with a certain disease or condition. It is anticipated that this will assist researchers with the review and study of medical records to answer questions about tongue-tie and its treatment.

If you agree to participate in the Agave Pediatrics Tongue-tie Research Registry the mother's report about breastfeeding and infants past, current and future health care record will be placed into the Research Registry. .

There will be no costs to you or your insurance provider to participate in this Research Registry.

No, you will not receive any payment for participating in this Research Registry.

Any information from your medical records that is placed into this Research Registry will be kept as confidential (private) as possible. In addition, you will not be identified by name in any publication of the results of research studies involving the use of your medical record information unless you sign a separate consent form (release) giving your permission.

Access to your identifiable medical record information contained within this Research Registry will be limited to investigators associated with the Agave Pediatrics and their research staffs. A current, complete listing of these individuals will be provided to you upon your written request.

CERTIFICATION OF INFORMED CONSENT

I certify that I have explained the nature and purpose of the Agave Pediatrics Tongue-tie Research Registry to the above-named individual, and I have discussed the possible risks and potential benefits of participation in this Research Registry. Any questions the individual has about this Research Registry have been answered, and the providers and research staff associated with Agave Pediatrics will be available to address future questions as they arise.

Patient Name

Parent Signature

Date