BREAST FEEDING QUESTIONNAIRE/HEALTH HISTORY

Please fill out the following form **PRIOR** to our visit. ALL information is confidential (See HIPPA FORM), and will help in obtaining a better understanding of whatever lactation issue you are experiencing. *Thank you.*

Name of Mother _____ Name of Baby _____M/F
Address _____ Name of Support Person (s) _____
_____ _____
_____
Email _____
Phone number _____ cell # _____
(best time to call _____am/pm)
MAJOR CONCERN or REASON CONSULTAION REQUESTED:
_____
_____
_____
Referral/or where did you get my contact information? _____

DATE OF BIRTH (baby) _____
Baby's DUE DATE _____ Current age of baby _____
Pediatrician/Name of Practice _____ # _____
Office Address: _____
_____
_____
*a copy of Lactation Report can be sent to your baby's doctor/nurse practitioner if you would like (consent form allows.)
It is usually best to work with a team approach to resolve lactation issues.

---------- **MOTHER'S MEDICAL HISTORY**----------
Age: _____
Hospital that you gave birth at? _____ OB/Midwife? _____
What # child is this for you? _____

Did you breastfeed or try to breastfeed other child(ren)? _____Length of time? _____
HOW was that breastfeeding experience?
_____
_____

Type of birth?

( ) spontaneous vaginal birth ( ) Primary or first cesarean birth
( ) vacuum used ( ) Repeat cesarean birth
( ) forceps used
Reason for cesarean birth ( ) Repeat C/S ( ) other: _____
Complications with birth?
_____
_____
Anesthesia? Type? ( ) Epidural ( ) Spinal ( ) General (put to sleep) other? _____

PAGE 2. CONT'D. BREASTFEEDING QUESTIONNAIRE/HEALTH HISTORY

Pregnancy History: Did you have any of the following conditions?

( ) breast changes during pregnancy (increase in size/color of areola/tenderness)
( ) Diabetes ( ) diet controlled ( ) required insulin ( ) Gestational ONLY
( ) Pre-term Labor Bedrest ( ) Treated with medication(s)? _____
( ) Prolonged 2nd stage/pushed > 2 hours
( ) high blood pressure/Pre-Eclampsia
Did you receive medications for this or Magnesium Sulfate IV? _____
( ) Infertility history
( ) Polycystic ovarian syndrome
( ) Hypothyroidism/Hyperthyroidism (under or active thyroid) – circle one
Medication? _____/dosage? _____
( ) Hepatitis ( ) HIV or liver problems ( ) Zika Virus diagnosis
( ) experienced previous loss/miscarriage
( ) Eating disorder
( ) history of gastric bypass surgery
( ) vegan diet or any other special diet
( ) Depression
( ) Other _____

Any other medically significant history for **you**? (NOT family history)

( ) heart disease
( ) renal disease
( ) Liver disease
( ) breast surgeries (i.e. biopsy, lumpectomy, piercings, Reduction or Augmentation? Year?
_____
( ) eczema
( ) environmental allergies ( ) seasonal allergies ( ) food allergy _____
( ) asthma
( ) genetic disorder or disability _____
( ) anxiety or depression
( ) OTHER:
_____
CURRENT MEDICATIONS & DOSE TAKEN/HOW OFTEN:
(I.e. pain meds, antihistamines, antibiotics, diet pills, herbal supplements, thyroid medicine, blood pressure medicine, vitamins, birth control/ Antidepressants/ other?)

_____ _____
_____ _____
*We can look up any medications to see if they are compatible with breastfeeding (L1 – L5 Dr. Hale information) or how they may affect milk supply.
** ALWAYS consult your baby's doctor concerning medication safety while nursing or pregnant
What birth control method are you using or do you plan to use in the future?
_____
Will you be returning to full time school or employment? _____
Have you called your insurance company regarding obtaining a breast pump? _____

PAGE 3. CONT'D. BREASTFEEDING QUESTIONNAIRE/HEALTH HISTORY

---------- MOTHER & BABY HISTORY----------

When did baby first go skin-to-skin after birth? _____
When did baby first breastfeed/latch or attempt to? _____
Would you describe it as slightly tender ( ) OR Very Painful ( )
Did your nipples get cracks/blisters or breaks in the skin?
_____
What have you tried to treat sore nipples? _____
Do they seem to be getting better or worse? _____
Did you room-in 24 hours per day? _____

Was your baby in the Neonatal Intensive Care Unit (NICU)? _____
For HOW LONG? _____ REASON? _____
WHEN did you start using a pump if you were separated from your baby? _____
How often did you pump? _____# per 24 hours
Were you measured for the correct shield/flange size? _____
Type of pump used? _____ ( ) purchase pump ( ) Hospital grade pump
Did you HAND EXPRESS? _____
Where you able to get colostrum? _____ Milk? _____
Has your milk increased? "Come in" _____ (breasts become fuller/engorged?) _____
IF pumping, how much on average are you able to pump? _____mls/ounces
Did your baby latch correctly in the hospital? _____ did you work with RN/LC? _____
Were the nurses or IBCLCs helpful? _____

Interventions used? ( ) Nipple Shield/size _____/Brand _____
( ) use of any formula supplementation Brand of formula _____
( ) Syringe feeding ( ) cup or spoon feeding?
( ) Supplemental Nursing System (tube @ breast)
( ) Finger feedings ( ) Bottle or Paced Bottle feeding
( ) Pacifier use ( ) pumping and/or hand expression used
Have you attended a Support Group upon discharge? _____ Where? _____

----------**BABY HISTORY** ----------
BIRTH WEIGHT _____LBS _____OUNCES
DISCHARGE WEIGHT _____
Age of baby? _____ has baby started weight RE-gain? _____
Most current weight? _____ back to birthweight at 10-14 days? _____
# of feedings in 24 hours? _____ average duration of feeding _____minutes ONE/Both ____
# of wet diapers in 24 hours? _____
# of stools and quality/color of stools? _____ _____
Do you hear SWALLOWING when baby nurses? _____
Do your breasts feel softer after baby nurses? _____
Was baby diagnosed with a Tongue tie? Lip tie? _____ Frenotomy done? _____
Did baby have Jaundice? _____
Any other problems diagnosed? _____ (hematoma-bruised head/shoulder dystocia…)

Thank you. I look forward to working with you and your little one.