Mother's Name: _____
Mother's Date of Birth: _____Age: _____
Addresss:_____
City/State/Zip Code: _____
Phone: Home _____Cell_____
Email: _____
Preferred method of communication: Call home / Call cell / Email / Text
Mother's OB/Midwife: _____
Medical Group Name:_____
Address: _____
_____
Phone: _____ Fax _____

Baby's Name: _____
Baby's Date of Birth: _____ Birth weight: _____
Gestational age at birth: _____ wks Age today: _____
Birth hospital/location _____
Date of last pediatric visit: _____Weight: _____
Date of next scheduled pediatric visit: _____
Baby's Father's Name:_____
Baby's Pediatrician: _____
Medical Group Name: _____
Address: _____
_____
Phone: _____ Fax _____

In your own words, describe the reason for this visit and what you have tried, if anything, to resolve the issue(s) of concern: _____
_____

FAMILY HISTORY

Does anyone on either side of the baby's family have any of the following?

☐ Allergies to food; list food: _____
☐ Environmental allergies ☐ Asthma ☐ Eczema
☐ Hay fever ☐ Diabetes ☐ Genetic disease
☐ Thyroid disease ☐ Other_____

What age were you when you had your first menstrual period? _____
☐ Regular ☐ Irregular

Do you smoke? ☐ Yes ☐ No
If yes, how often? _____

Was this your first pregnancy? ☐ Yes ☐ No
If no, how many pregnancies have you had?_____
How many children?_____

How long did you breastfeed your other child(ren)? _____

Any difficulties getting pregnant? ☐ Yes ☐ No
If fertility medications used, name of med: _____

If you are using hormonal birth control, what are you taking and how old was your baby when you started? _____

Are you currently on maternity leave? ☐ Yes ☐ No

Will you be returning to work/school?

☐ No ☐ Not sure ☐ Yes, full time ☐ Yes, part time
☐ Profession: _____ Returning to work when baby is _____ weeks old

PREGNANCY AND BIRTH HISTORY

Are you taking any of the following?

☐ Prenatal vitamins ☐ Iron ☐ Antihistamines
☐ Cold remedies ☐ Antibiotics ☐ Birth control pills
☐ Pain medication; name, dose, frequency: _____
☐ Supplement to increase milk supply; name, dose, frequency:
_____
☐ Other_____

Have you ever had any of the following problems or procedures related to your breasts?

☐ Biopsy (side and year _____)
☐ Lumpectomy (side and year _____)
☐ Implants (year _____)
☐ Breast reduction surgery (year _____)
☐ Nipple problems: _____
☐ Other surgeries or injuries to the chest area _____

Do you presently have or have you ever had any of the following?

☐ Anemia ☐ Diabetes ☐ Thyroid disorders
☐ Depression ☐ Sexual abuse ☐ Eating disorder
☐ Polycystic ovarian syndrome ☐ Other_____

Did you have any of the following during this pregnancy?

☐ Premature labor ☐ Gestational diabetes ☐ High blood pressure
☐ Nausea/vomiting-severe ☐ Anemia ☐ Other_____

Did you have any of the following during this labor and delivery?

☐ Premature rupture of membranes ☐ Medications to control pain
☐ Medications to control high blood pressure ☐ Epidural
☐ Antibiotics
☐ Medications to induce or speed labor (If so how long during labor was this drug administered?_____hours)
☐ Hemorrhage or excessive blood loss requiring transfusion (if so how much blood was lost_____)
☐ Other_____

What type of delivery did you have with this birth?

☐ Vaginal ☐ Forceps ☐ Vacuum
☐ Unplanned cesarean birth; reason: _____
☐ Planned cesarean birth; reason: _____
☐ Induction; reason: _____

Did you have any of the following with this birth?

☐ Total labor longer than 30 hours ☐ Episiotomy or tear
☐ Pushing stage longer than 2 hours ☐ Breech presentation
☐ Tear that involved the rectum (3rd or 4th degree laceration)
☐ Other_____

Did you experience any postpartum complications?

☐ Urinary/other infections ☐ Low blood pressure

☐ High blood pressure ☐ Excessive bleeding or hemorrhaging

☐ Retained placenta

☐ Other_____

Gestational age of your baby at birth?_____weeks

Did your baby have any of the following after birth?

☐ Breathing difficulties ☐ Low blood sugar

☐ Meconium aspiration ☐ Jaundice (highest bili level_____)

☐ Other_____

BREASTFEEDING HISTORY

Does your baby have any known health problems? ☐ Yes ☐ No
If yes, please explain _____
Is your baby currently on any medications? ☐ Yes ☐ No
If yes, please explain _____

What is your baby's most common state?

☐ Sleeping/Sleepy ☐ Quiet Alert/Calm

☐ Fussy ☐ Crying

Is your baby waking on his/her own for feeding?

☐ All feedings ☐ Most feedings

☐ Some feedings ☐ Must wake for all feedings

Pacifier use:

☐ None ☐ Rarely ☐ Sometimes ☐ Often

Number of diapers in the last 24 hours: _____
Wet: _____ Stools: _____ Color of stools: _____

Where is your baby sleeping at night?

☐ His/her own room ☐ Crib/Bassinet next to my bed

☐ Co-sleeper ☐ In my bed

☐ On top of my chest while I sit/lie in my ☐ bed ☐ couch ☐ recliner

Did you take a prenatal breastfeeding class? ☐ Yes ☐ No
If yes, where? _____

Bra size before pregnancy?_____ ***Now?***_____

Breast changes since the birth?

☐ Hard/engorged ☐ Heavy ☐ Warm ☐ Leaking

☐ No changes ☐ Day milk "came in": _____ days postpartum

Did a lactation consultant assess breastfeeding before hospital discharge?
☐ Yes ☐ No
If yes, please share what you were told about how your baby was breastfeeding _____

How old was your baby when you first realized that you were having breastfeeding difficulties?_____

If your baby is not breastfeeding for every feeding, main reason why:

☐ Nipple pain/injury ☐ Baby can't latch ☐ Baby refuses breast

☐ Other _____

In the past 24 hours, how many times has your baby been fed? _____

How many of these feedings were at the breast? _____

Are you letting your baby finish one breast before offering the second breast? ☐ Yes ☐ No, I switch after _____ minutes

Is your baby receiving supplements?

☐ No ☐ Breastmilk ☐ Formula

If so, how is your baby supplemented?

☐ At Breast Feeding tube ☐ Finger feeding ☐ Cup feeding

☐ Bottle (type of bottle_____)

If you are pumping, what type of pump are you using?

☐ Manual ☐ Hospital rental ☐ Electric double/single; brand: _____

How much milk are you expressing? _____ oz. Per session

Does one breast produce significantly more milk than the other?

☐ Yes, right ☐ Yes, left ☐ No

Has your baby ever had any formula? ☐ Yes ☐ No
If yes, please describe when your baby was first given formula and why it was given: _____

If your baby is receiving formula regularly:

Brand _____ Amount given at each feeding: _____

Total ounces a day: _____ ☐ Giving bottles instead of breast

☐ Using at breast supplementer ☐ Giving bottles after breastfeeding

Do you have support at home with baby care? _____

Is your family supportive of breastfeeding?

☐ Yes ☐ No ☐ They claim to be but make negative comments; if so, how are you handling this situation? _____

Have you attended a La Leche League or hospital-based moms group meeting?
☐ Yes ☐ No

If you have received help from another lactation consultant or breastfeeding helper, please share any of the information already received; describe what helped and what did not: _____

_____

_____

_____

What are your breastfeeding goals? _____

_____

_____

Is there anything else you want me to know? _____

_____

_____

_____