Mother's Name:____
Mother's Date of Birth: ____________________Age:________________
Address:____
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 medication: _____________________

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 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
☐ Severe nausea/ vomiting ☐ 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 postpartum complications?
☐ Urinary/ other infections ☐ Low blood pressure
☐ High blood pressure ☐ Retained placenta
☐ Excessive bleeding or hemorrhaging
☐ Other ____

Gestational age of your baby at birth? ____________ weeks

Did your baby have any of the following after birth?
☐ Breathing difficulties ☐ Low blood sugar
☐ Suctioning for meconium ☐ 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 ☐ Yes, breastmilk ☐ Yes, formula

If so, how is your baby supplemented?
☐ At breast with a 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 receiving is formula regularly:
Brand ___________ Amount given at each feeding: _____________
Total ounces a day: ___________
☐ Giving bottles instead of breast
☐ Using an at-breast supplementer
☐ Giving bottles after breastfeeding

Do you have support at home with baby care? ☐ Yes ☐ No

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?
____
____
____

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