

MATERNAL/INFANT INFORMATION

Date: _____
 Mother's Name: _____
 Mother's Date of Birth: _____
 Address: _____
 City/State/Zip Code: _____
 Home Phone: _____
 Cell Phone: _____
 Email: _____
 Mother's OB/Midwife: _____
 Address: _____
 Telephone: _____

Baby's Name: _____
 Baby's Date of Birth: _____
 Birth Weight: _____
 Weight at Discharge: _____ Age at Discharge: _____
 Last Weight: _____ Date: _____
 Number of diapers in the last 24 hours:
 Wet: _____ Bowel Movements: _____
 Baby's Pediatrician: _____
 Address: _____
 Telephone: _____

Health & Breastfeeding History

In your own words, describe the reason for this visit:

Health History

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

- Allergies to food; list food(s): _____
 Environmental allergies Asthma Eczema
 Hay fever Breast cancer Diabetes
 Thyroid disease Other _____

Does your health history include any of the following?

- Liver disease High blood pressure
 Anemia Irregular menstrual cycles
 Diabetes Other _____

Was this your first pregnancy? Yes No

If no, how many pregnancies? ____ How many children? ____

Did you breastfeed your other child(ren)? Yes No

If yes, how long? _____

Any difficulties getting pregnant? If yes, were fertility medications used? _____

Are you using hormonal birth control? Yes No

If yes, what are you taking, and how old was the baby when you started? _____

Have you used hormonal birth control in the past and, if so, for how many years? _____

Are you taking any of the following?

- Prenatal/Multi vitamin Antihistamine Diet pills
 DHA supplement Laxatives Aspirin
 Antibiotics Cold remedies Diuretics
 Iron supplements Pain medication Antacids
 Antidepressants Other _____

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

- Breast reduction Biopsy Implants
 Nipple problems Lumpectomy
 Other surgeries/injuries in the chest area: _____

Did you have any of the following during this pregnancy?

- Premature labor Fever Anemia
 Gestational diabetes Urinary tract infection
 Other _____

Did you take any medications? Yes No

List: _____

What type of delivery did you have with this birth?

- Vaginal Assisted vaginal (vacuum or forceps)
 Unplanned cesarean birth Emergency cesarean birth
 Planned cesarean birth; reason: _____
 Induction; reason: _____

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

- Premature rupture of membranes Antibiotics
- Epidural Other drugs for pain
- Drugs to induce or speed labor (If so, how long was this drug administered?) _____ Hrs.
- Total labor longer than 30 hours
- Pushing stage longer than 2 hours Episiotomy
- Tear Breech presentation
- Umbilical cord complications
- Hemorrhage (if so, how much blood was lost? _____ Pts.)
- Other complications of labor and delivery, please describe: _____

Gestational age of baby at birth: _____ weeks

Did you experience any of the following postpartum complications?

- Urinary/Other infection Low blood pressure
- High blood pressure Excessive bleeding
- Retained placenta
- Other: _____

Did baby have any of the following during or after birth?

- Meconium aspiration Breathing difficulties
 - Low blood sugar Jaundice
- If jaundice, bilirubin levels: _____
- Any other complications? _____

What was your bra size before pregnancy? _____
Now? _____

Breast changes since birth:

- No changes Hard/engorged Heavy
- Warm Leaking
- Day noticed milk "come in": _____ days postpartum

Breastfeeding History

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

Is the baby content or sleeping between feedings?
 Often Occasionally Never

What is the longest time your baby has gone between feedings? Daytime _____ Nighttime _____

In the past 24 hours, how many times has your baby been fed? _____ **How many of these feedings were at the breast?** _____ **Minutes per feeding?** _____

Are you letting baby finish one breast before offering the second breast? Yes No

OR Are you switching breasts after a certain time on the first breast? Yes No

If yes, after how many minutes do you switch? _____

If you are not breastfeeding, are you pumping? Yes No
If yes, how often? _____ times/24 hrs.

Type of pump you are using? _____

How much milk are you expressing? _____ ozs./per session

Does one breast produce significantly more milk than the other? Yes No If yes, which one: R L

If you are not breastfeeding at every feeding, what are you supplementing your baby with?

Expressed milk Formula; brand: _____

How often are you supplementing? _____ times/24 hrs.

How is the supplement given?

Finger feeding Feeding tube Syringe
 Cup Bottle; brand: _____

How much per supplement? _____ ozs./per feeding

How many hours between feedings? _____ hours

Do you have support at home with baby care?

Yes No

Is your family supportive of you breastfeeding?

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

Have you received any help with breastfeeding from any of the following?

Lactation Consultant La Leche League Leader
 Other volunteer breastfeeding counselor

What is the name of the person who helped you? _____

If you have received help, 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? _____

This information is true and correct to the best of my knowledge.

Signature _____