Breastfeeding Resources
First Visit

Mother History ***Medical & Pregnancy History***

Date: _____ Your name: _____ Your DOB: _____

Who referred you to our office? _____

Briefly state why you are here today. _____

_____

THIS BIRTH

Where was baby born?

Delivery Type: Vaginal C/S VBAC

Induced? Y / N Epidural? Y / N

Any problems with your…

Pregnancy? _____

Labor/Delivery? _____

Postpartum? _____

Medications taken during pregnancy:

_____

ALLERGIES

Medication _____

Foods/Other _____

FAMILY HISTORY

Your children	DOB	Breastfed how long?	General Health

FAMILY/WORK LIFE

Who lives with you? Circle all that apply.

Spouse/Partner #__ Children Parent(s) Other_____

Work outside home? ☐ Yes *PT / FT* ☐ No

Occupation? _____

Date returning to work? _____

Marital Status? Single Married

Do you smoke? Yes No

Any household members smoke? Yes No

PAST AND CURRENT MEDICAL HISTORY

Number of pregnancies? _____

Any miscarriage/terminations? _____

Any history of the following (circle)?

Diabetes	Infertility
Thyroid issues	Hypertension
Polycystic Ovarian Syndrome	Past breastfeeding problems
Mood issues (includes depression/anxiety/PPD)	Personal or family history of breast cancer

Any other significant medical problems, conditions or hospitalization? _____

_____

Medications/supplements taking now: _____

_____

SURGICAL HISTORY

(Please include cesarean deliveries and breast surgeries)

Date	Surgery type

REVIEW OF SYMPTOMS

Recent/current problems with the following? (circle)

High blood pressure	Shortness of breath
Abnormal blood sugar	Headaches
Visual changes	Fever or chills
Breast pain	Nipple pain
Breast lump	Swelling in legs/hands?
Concerns about your mood or emotions	Joint/back muscle pain

Other things we should know about? _____

_____

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Baby History ***Feeding/Pumping***

Date: _____ Baby's name: _____ Baby's DOB: _____

Briefly state why you are here today. _____

_____

MEDICATIONS/SUPPLEMENTS

List any that baby is taking currently:

_____

_____

MEDICAL ISSUES

Low blood sugar? _____

Jaundice? _____

Reflux? _____

Surgeries? _____

Hospital readmission? _____

NICU stay? _____

Other _____

BABY'S BIRTH

Due Date: _____

Birth weight: _____

Discharge weight, if known: _____

Baby's lowest wt and date: _____

REVIEW OF SYMPTOMS

wet diapers in 24 hours: _____

soiled diapers in 24 hours: _____

Typical stool color: _____

Extra sleepy/hard to wake? _____

Fussy/crying a lot? _____

Excessive spit up? _____

Discomfort with spit up? _____

PREVIOUS THERAPIES

List any previous therapies/treatments received since baby's birth (physical therapy, chiropractic, frenotomy etc.)

Date	Treatment type

FEEDING/PUMPING HISTORY

Approximately how many times does your baby *typically* BREASTFEED in a 24-hour period?

_____

Approximately how many ounces of EXPRESSED BREASTMILK does baby *typically* get in a 24-hour period?

_____

Approximately how many ounces of FORMULA does baby *typically* get in a 24-hour period?

_____

Approximately how many <u>times</u> do you *typically* PUMP OR HAND EXPRESS in a 24-hour period?

_____

Approximately how many <u>total ounces</u> do you *typically* PUMP OR HAND EXPRESS in a 24-hour period?

_____

Is your baby also eating solids? Yes / No