

Last Name _____ Boy Girl Today's date _____
Baby's due date _____ Baby's birthdate _____
Baby's name _____ Mothers name _____ Fathers name _____
Age of baby _____ Birthplace (hospital) _____ Home phone (____) _____
Address _____ City, Zip code _____
Obstetrician _____ Phone (____) _____
Pediatrician _____ Phone (____) _____
Who can we thank for the referral _____

History

Are you employed? _____ Do you plan on returning to work? _____ Continue to breastfeed? _____
Pump? _____ Number of children in the family _____ Age(s) _____
Have you breastfed before? Yes No How long? _____
Past breastfeeding problems? _____
Any history of infertility? Yes No Any chance you could be pregnant? Yes No
Did your breast increase in size while pregnant? Yes No
Are you currently taking any medications? Yes No
If yes, please name _____
 Prenatal vitamins Birth control pills Thyroid medication Antibiotics

Was your Labor and Delivery?

Easy Difficult Long Short Epidural Vaginal C-Section Forceps Vacuum Extraction
Did you have? High blood pressure Excessive bleeding Continued bright red vaginal bleeding at home
Do you smoke? Yes No If yes, how much per day? _____

Was your baby in: Newborn Nursery Special care nursery, reason _____

NICU, reason _____ Did your baby go home with you? Yes No

Has your baby ever been on antibiotics? Yes No How soon after delivery did you breastfeed? _____

Did you experience any of the following? (please check all that apply)

Attachment difficulties Sleepy baby Engorgement Sore nipples None

While in the hospital was your baby given any formula? Yes No

Was your baby given a pacifier in the hospital? Yes No Does your baby use a pacifier at home? Yes No

How many times in 24 hours are you breastfeeding? _____ For how long on each breast? _____

Are you supplementing with bottles? Formula Water Breast milk

Is the content or sleeping between feedings? Never Occasionally Often

How many times in the last 24 hours had your baby had: Wet diapers _____ BM's _____ BM's Color _____

Any family history of allergies? Yes No Latex Allergy? Yes No

Are you pumping your breasts? Yes No How many times a day? _____ How long? _____

What style of pump? Pump in Style Manvel Renting Other _____

Are you pumping both breasts? Yes No