LACTATION CONSULTATION HEALTH INTAKE FORM **TODAY'S DATE**_____

MOTHER'S NAME_____**DOB**_____
INFANT'S NAME_____**DOB**_____

IN YOUR OWN WORDS DESCRIBE ANY FEEDING PROBLEMS THAT CONCERN YOU:

_____
_____
_____
_____

HEALTH, PREGNANCY AND BIRTH HISTORY

DOES ANYONE ON EITHER SIDE OF THE BABY'S FAMILY HAVE ANY OF THE FOLLOWING? (CIRCLE)
food allergies environmental allergies asthma eczema hay fever breast cancer
diabetes genetic disease thyroid disease alcoholism tongue tie
other_____

DO YOU PRESENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CIRCLE)
anemia allergy/asthma diarrhea (chronic) heart disease diabetes hepatitis herpes
high blood pressure liver disease thyroid disorders miscarriages hemorrhoids cancer
fertility issues abortions depression sexual abuse abnormal pap smear constipation
eating disorder kidney/bladder disease or infection yeast infections tuberculosis polycystic ovarian syndrome
other_____

ARE YOU TAKING ANY OF THE FOLLOWING? (CIRCLE)
prenatals iron antihistamines pain pills aspirin cold remedies antibiotic laxatives
diuretics antacids birth control pills diet pills fish oil stool softener
probiotics herbs (list):_____)
Other Rx/supplements_____
SPECIAL DIETARY CONSIDERATIONS: _____
DO YOU SMOKE? _____CONSUME ALCOHOL?_____FREQUENCY?_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING PROCEDURES RELATED TO YOUR BREASTS? (CIRCLE)
biopsy lumps implants chest tube breast reduction nipple problems
other _____

CONCEPTION WAS: (CIRCLE)
uncomplicated took more than 6mos was via IVF/IUI/ adoption/surrogate used
other:_____

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WHAT AGE WERE YOU WHEN YOU HAD YOUR FIRST MENSTRUAL PERIOD? _____REGULAR OR IRREGULAR

NUMBER OF PREGNANCIES:_____ **NUMBER OF LIVE BIRTHS**_____**NUMBER OF LOSSES**_____
OTHER CHILDREN NAME(S) AND DATE(S) OF BIRTH:_____
PREVIOUS BREASTFEEDING ISSUES? EXPLAIN:_____

WHICH OF THE FOLLOWING FAMILY PLANNING METHODS ARE YOU USING OR DO YOU PLAN TO USE? (CIRCLE)
Norplant injection (Depo) barriers birth control pills vasectomy natural family planning/rhythm tubes tied Nuvo ring IUD (copper or Mirena) none
Other:_____

WILL YOU BE RETURNING TO WORK? (CIRCLE) YES/NO Full/Part time When? _____

DID YOU HAVE ANY OF THE FOLLOWING DURING THIS PREGNANCY? (CIRCLE)
Preterm labor infection/fever gestational diabetes high blood pressure nausea/vomiting severe anemia
other_____

DID YOU HAVE ANY OF THE FOLLOWING DURING THIS LABOR AND DELIVERY? (CIRCLE)
Premature/artificial rupture of membranes pain meds high blood pressure epidural fever antibiotics GBS+ Y or N Pitocin/induction meds episiotomy/tear hemorrhage/excessive bleeding
other:_____
Labor hrs:_____ Pushing hrs/mins:_____ **BIRTH PRESENTATION**: breech. posterior asynclitic brow
other:_____

WHAT TYPE OF DELIVERY DID YOU HAVE WITH THIS BIRTH? (CIRCLE)
Vaginal (uncomplicated VBAC forceps vacuum) Cesarean (planned/emergency
Other birth details:_____

GESTATIONAL AGE OF BABY AT BIRTH? _____ weeks _____days **Location of delivery** _____

DID YOU EXPERIENCE ANY POSTPARTUM COMPLICATIONS? (CIRCLE)
infection (type:_____) Low/high blood pressure excessive bleeding/hemorrhaging retained placenta
other_____

AFTER BIRTH DID THE BABY HAVE...? (CIRCLE)
breathing difficulties meconium aspiration high hematocrit low blood sugar jaundice (highest bili level_____)
other_____

DOES YOUR BABY HAVE HEALTH PROBLEMS? EXPLAIN_____

IS THE BABY CURRENTLY ON ANY MEDICATIONS?_____

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LACTATION SPOT

BREASTFEEDING HISTORY

WHEN DID BREASTFEEDING DIFFICULTIES BEGIN?_____

DID YOU EXPEREINCE BREAST CHANGES IN PREGNANCY? Y or N

BREAST CHANGES SINCE THE BIRTH? hard/engorged heavy warm leaking no changes

WHAT WERE THE FIRST SEVERAL DAYS OF FEEDING LIKE?_____
_____

WHAT DOES YOUR FEEDING ROUTINE LOOK LIKE NOW?
_____
_____
_____

HAVE YOU USED ANY BREASTFEEDING SUPPLIES OR PUMPS? Y or N **Type of PUMP**_____
Frequency of pumping?_____ **YIELD WHEN PUMPING (oz/mls per session**)_____**Flange size**?_____

HAS YOUR BABY BEEN SUPPLEMENTED WITH ANY OF THE FOLLOWING?
NONE water/glucose water your expressed breastmilk donor milk formula (brand_____)
other:_____

IF SO, HOW WAS THE BABY SUPPLEMENTED?
feeding tube finger feeding cup feeding bottle TYPE of BOTTLE_____
Other_____ Pacifier? Y or N Type:_____

IF SUPPLEMENTING, HOW OFTEN IN PAST 24 HOURS? _____**HOW MUCH PER FEEDING**?_____

HOW MANY TIMES IN THE PAST 24 HOURS HAVE YOU BREASTFED YOUR BABY? (CIRCLE)
less than 6 times less than 8 times 8-10 times more than 12 times

ARE YOU EXPERIENCING ANY OF THE FOLLOWING? (CIRCLE)
using a nipple shield latch-on difficulties engorgement sore nipples sleepy baby
preference for one breast baby not interested baby always seems hungry baby crying excessively
cracked/bleeding nipples breast pain feeling that there is not enough milk
baby's active suckling less than 5 min/sleepy at breast
other_____

IS THE BABY CONTENT BETWEEN FEEDINGS? (CIRCLE)
never occasionally often comments_____

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WHAT IS THE AVERAGE TIME BETWEEN FEEDINGS? DAY:_____hrs **NIGHT**:_____hrs

HOW LONG DOES A NURSING SESSION LAST?_____
BABY TAKES: (CIRCLE) one breast both breasts
WHO DECIDES WHEN THE FEEDING IS OVER? (CIRCLE) Mother or Baby

HOW MANY MONTHS DO YOU WISH TO BREASTFEED YOUR BABY?
1 MONTH 2-3 MONTHS 3-6 MONTHS 6-9 MONTHS 12 MONTHS LONGER THAN 12 MONTHS
OTHER:_____

IN THE PAST 24 HOURS, HOW MANY?
Wet diapers_____ stools_____ stool color:_____
IS YOUR BABY: (CIRCLE) GASSY SPITTING UP HICCUPPING OTHER:_____

HOW WOULD YOU DESCRIBE YOUR GENERAL MOOD: (select all that apply)
happy sad depressed anxious nervous stressed foggy detached worried
ecstatic fragile up-and-down exhausted overwhelmed scared other_____

FAMILY SITUATION: PARTNER SUPPORTIVE? Y / N

Notes:_____
_____
_____
_____
_____

Anything else you want the Lactation Consultant to know?
_____
_____
_____
_____
_____
_____

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