| Today's Date: | Mother's Full Name: | Mother's DOB: |
|---|---|---|
| | Infant's Full Name: | Infant's DOB: |

Do you presently have, or have you ever had any of the following: Check all that apply / Add in as needed

| | | | | | |
|---|---|---|---|---|---|
| Anemia | ☐ | Liver disease | ☐ | Depression | ☐ |
| Allergy / asthma | ☐ | Thyroid disorders | ☐ | Anxiety | ☐ |
| Heart disease | ☐ | Cancer | ☐ | Infertility | ☐ |
| Diabetes | ☐ | Insulin Resistance | ☐ | Miscarriage | ☐ |
| History of gestational diabetes | ☐ | HIV / AIDS | ☐ | Abortion | ☐ |
| Hepatitis | ☐ | Kidney disease | ☐ | Polycystic Ovarian Syndrome | ☐ |
| High blood pressure | ☐ | Tuberculosis | ☐ | Eating Disorders | ☐ |
| Psychosis | ☐ | Genetic disorder | ☐ | | |

Are you currently taking any of the following medications: Check all that apply / Add in as needed:

| | | | | | |
|---|---|---|---|---|---|
| Prenatal Vitamin | ☐ | Vitamin D3 | ☐ | Iron | ☐ |
| Cold / cough medication | ☐ | Antihistamines / allergy meds | ☐ | Inhalers | ☐ |
| Antibiotics | ☐ | Aspirin/ Tylenol / Ibuprofen | ☐ | Laxatives | ☐ |
| Stool softeners | ☐ | Diuretics ("water pills") | ☐ | Prescription pain medication | ☐ |
| Diet pills | ☐ | Placenta (encapsulated or other) | ☐ | Anti-depressant | ☐ |
| Anti-anxiety | ☐ | Mood Stabilizer | ☐ | Marijuana | ☐ |
| Birth Control | ☐ | | | | |
| Herbal supplements: Please list: | ☐ | | | | |

Do you, or anyone in your household, smoke cigarettes ? YES ☐ NO ☐ If yes, who _____

BIOLOGICAL family history of any of the following (Either side of baby's family):

| | | |
|---|---|---|
| Food Allergies | ☐ | Who: |
| Environmental Allergies | ☐ | Who: |
| Breast Cancer | ☐ | Who: |
| Diabetes | ☐ | Who: |
| Genetic disorder (type: ) | ☐ | Who: |
| Thyroid disorder | ☐ | Who: |
| Postpartum depression | ☐ | Who: |
| Anxiety / Depression / Mood disorders | ☐ | Who: |

Which, if any, of the following applies to your eating habits:

| | | | | | |
|---|---|---|---|---|---|
| Vegan | ☐ | Gluten-free | ☐ | Low-carb | ☐ |
| Vegetarian | ☐ | Dairy-free | ☐ | Some caffeine | ☐ |
| Some alcohol | ☐ | | | | |

Any breast changes during pregnancy? (Check all that apply): Larger ☐ increase in visible veins ☐ darker areola ☐

Any breast changes since birth? (Check all that apply): Increase in size ☐ hard / engorged ☐ heavy ☐ leaking ☐ no changes ☐

Any surgeries involving your breasts: NONE ☐ Biopsy ☐ Lump removal ☐ Piercings ☐ Implants ☐ Reduction ☐

Including this one, how many children do you have? _____ Have you breastfed any of your other children? _____
Past difficulties with breastfeeding previous children: _____

Do you have any history of sexual abuse that you feel may cause an extra challenge for you with breastfeeding?

☐ No ☐ Yes, and it is okay to talk about ☐ Yes, but I'd rather not discuss

Will you be returning to work / school while breastfeeding: _____ If yes, Full time or Part time? _____
When: How long are you hoping to breastfeed your baby: _____ weeks / months / years

Did you have any of the following during this pregnancy:

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Premature labor | ☐ | Gestation diabetes | ☐ | High blood pressure |
| ☐ | Severe nausea / vomiting | ☐ | Anemia | ☐ | Fever |
| ☐ | Yeast infection | ☐ | Urinary tract infection | ☐ | Preeclampsia |

Medications taken during pregnancy: _____

1st 3 months of pregnancy: easy ☐ not too bad ☐ hard extremely difficult ☐ Notes: _____
2nd 3 months of pregnancy: easy ☐ not too bad ☐ hard extremely difficult ☐ Notes: _____
3rd 3 months of pregnancy: easy ☐ not too bad ☐ hard extremely difficult ☐ Notes: _____

Delivery method: Vaginal ☐ Planned C-section ☐ Unexpected C-section ☐

Are you still having any vaginal bleeding from the birth: NO ☐ YES – heavy ☐ YES -Moderate ☐ YES – light / spotting ☐

Did labor start: Spontaneously ☐ Scheduled induction ☐ Unplanned induction ☐ Did not labor (planned C-section) ☐

Gestational Age of baby at birth: _____ weeks and _____Days

Did you have any of the following during this birth:

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Labor longer than 30 hours | ☐ | Episiotomy or tear | ☐ | Breech birth |
| ☐ | Pushing for longer than 2 hours | ☐ | Forceps Delivery | ☐ | Vacuum extraction |
| ☐ | Oral pain meds (during labor) | ☐ | Epidural | ☐ | Spinal |
| ☐ | Antibiotics | ☐ | Excessive bleeding / hemorrhage | ☐ | Low blood pressure |
| ☐ | High blood pressure | | | | |

How has your recovery been?: _____

Did your baby have any of the following:

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Breathing difficulties | ☐ | High hematocrit | ☐ | Low blood sugar |
| ☐ | Jaundice | ☐ | Meconium aspiration | ☐ | Needed deep suctioning |
| ☐ | Billirubin level: _____ | ☐ | Tongue-tie | ☐ | Lip-tie |
| | | | | | |

Does your baby have any current health issues: _____ Is baby on medications?: _____

Have you or baby experienced any of the following difficulties with breastfeeding: Please check **all** that apply

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Difficulty latching | ☐ | Painful initial latch | ☐ | Painful latch throughout feed |
| ☐ | Baby sleepy at breast | ☐ | Refusal to latch | ☐ | Breast engorgement |
| ☐ | Nipple damage - soreness | ☐ | Mastitis | ☐ | Plugged ducts |
| ☐ | Nipple damage – bleeding | ☐ | Baby not gaining weight well | ☐ | Baby still losing weight |
| ☐ | Breast pain | ☐ | Milk supply concerns | ☐ | Pumping questions / concerns |
| ☐ | Sadness / Nausea at let-down | ☐ | Fast milk flow | ☐ | Other: |
| | | | | | |

Is baby being supplemented? Please check all that apply:

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Formula | ☐ | Expressed Milk (Yours) | ☐ | Milk Bank Milk |
| ☐ | Shared milk (friend / family) | ☐ | Shared milk (stranger) | | |
| | | | | | |
| ☐ | Getting bottles | ☐ | Tube at breast (SNS) / Finger | ☐ | Syringe Feeding / Cup feeding |

**In Past 24 hours**

How much supplement (other than your own milk) has baby had? _____
How many times has baby fed at your breast? _____ How many times have you pumped? _____
How many poopy diapers has baby had? _____

When feeding at the breast, does your baby typically take: One breast ☐ Both breasts ☐ Both breasts more than once ☐

Is your baby generally content between feeds: Rarely ☐ Sometimes ☐ Usually ☐

Who are your primary support people? _____