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Mother's Name

Baby's Name

Consultation Date

LACTATION INTAKE HISTORY (MULTIPLES)

Problem: nipple pain latch breast refusal undersupply oversupply slow weight gain multiples other _____

Others consulted about this breastfeeding issue: LC doctor nurse LLL friend family doula other _____

YOUR HEALTH HISTORY

Any history of: thyroid ovarian cyst PCOS diabetes (type I II) other: _____

Medications currently taking (including herbs and vitamins): _____

Breast surgery or injury: none reduction mastopexy augmentation biopsy injury other Date: _____

Conceive easily: yes no (how long: _____) IVF IUI (donated: sperm egg neither)

Miscarriages: no yes (# _____) Reason: unknown _____

Number of other pregnancies: _____ Number of other children living: _____

BREASTFEEDING HISTORY

Number of other children breastfed: _____ How long other child(ren) breastfed: #1: _____ wks mos yrs

#2: _____ wks mos yrs | #3: _____ wks mos yrs | #4: _____ wks mos yrs | #5: _____ wks mos yrs

How did breastfeeding go with the older child(ren): easy difficult (describe): _____

THIS PREGNANCY

Breast changes: enlargement tenderness leaking areola darkening Bed Rest: no yes (start week: _____ until week _____)

Any complications: no yes: _____

Vaginal bleeding now: light mod heavy over

LABOR

Pregnancy length: _____ wk _____ day How labor began: spontaneous induced (how: pitocin cervical gel other: _____)

Where: home birth ctr hospital other Labor: _____ hrs Pushing: _____ min Delivery: vag (VBAC) vacuum forceps C-sect

Medications during labor: pitocin epidural (#cm when started: _____) narcotic (demerol, nubain) other _____

Antibiotics: no yes (reason: strep B fever C-sect other _____) Hemorrhage: no yes (med to stop: _____)

LABOR EXPERIENCE: _____

HOSPITAL / POSTPARTUM

Baby #1 first nursing: _____ min /hrs after birth easy difficult Sides: 1 2 did not occur

Complications: jaundice hypoglycemia other _____ How treated: _____

Circumcision (Day _____) Pacifier: no yes (when began: day _____) Separation: none some night mostly nursery NICU

Baby #2 first nursing: _____ min /hrs after birth easy difficult Sides: 1 2 did not occur

Complications: jaundice hypoglycemia other _____ How treated: _____

Circumcision (Day _____) Pacifier: no yes (when began: day _____) Separation: none some night mostly nursery NICU

Baby #3 first nursing: _____ min /hrs after birth easy difficult Sides: 1 2 did not occur

Complications: jaundice hypoglycemia other _____ How treated: _____

Circumcision (Day _____) Pacifier: no yes (when began: day _____) Separation: none some night mostly nursery NICU

Baby #4 first nursing: _____ min /hrs after birth easy difficult Sides: 1 2 did not occur

Complications: jaundice hypoglycemia other _____ How treated: _____

Circumcision (Day _____) Pacifier: no yes (when began: day _____) Separation: none some night mostly nursery NICU

When milk came in: day _____ not noticed slight mod heavy INPATIENT BREASTFEEDING EXPERIENCE: _____

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LACTATION INTAKE HISTORY (MULTIPLES) — PAGE TWO

AT HOME

FEEDINGS: How often: ____ min/hrs **LATCHING:** easy difficult impossible **Who ends:** me baby **Avg length:** ____ min

Nipple pain: none some moderate severe **Which nipple(s):** L R **When began:** ____ days weeks months

SUPPLEMENTING: no yes **When began:** ____ days **How:** tube bottle cup syringe dropper spoon finger-feeder

When: before nursing after **How often:** every feed ____ x/day **How much:** ____ oz/cc feeding **What:** pumped milk formula

HAND EXPRESSING: no yes **When began:** ____ day(s) **How often:** ____ times per day **Avg amt:** _____

PUMPING: no yes **When began:** ____ days **How often:** ____ times per day **Avg amt:** _____ **Flange size (imprinted on side):** _____

Pump condition: new used (how long: ____ mths/hrs) **Pump Type:** rental owned (brand: _____)

POST-DISCHARGE BREASTFEEDING EXPERIENCE: _____

WHERE BABIES SLEEP: in our room in their room(s) other: _____ **What babies sleep in:** our bed sidecar crib or bassinet

NUMBERS

DIAPER OUTPUT HISTORY – Last 24 hours					
	BABY #1	BABY #2	BABY #3	BABY #4	
Stool Quantity					
Stool Amount	<input type="checkbox"/> More than a spoonful	<input type="checkbox"/> More than a spoonful	<input type="checkbox"/> More than a spoonful	<input type="checkbox"/> More than a spoonful	
Stool Color	<input type="checkbox"/> Black <input type="checkbox"/> Brown <input type="checkbox"/> Green <input type="checkbox"/> Yellow	<input type="checkbox"/> Black <input type="checkbox"/> Brown <input type="checkbox"/> Green <input type="checkbox"/> Yellow	<input type="checkbox"/> Black <input type="checkbox"/> Brown <input type="checkbox"/> Green <input type="checkbox"/> Yellow	<input type="checkbox"/> Black <input type="checkbox"/> Brown <input type="checkbox"/> Green <input type="checkbox"/> Yellow	
BABIES' WEIGHT HISTORY					
DATE	WHERE WEIGHED	BABY #1	BABY #2	BABY #3	BABY #4
BIRTH					

Attend mothers' group: no yes (Where: _____)

Want to breastfeed: ____ months years until babies wean self **Returning to work (outside home):** no yes (At ____ weeks months)