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Mother's Name

Baby's Name

Consultation Date

LACTATION INTAKE HISTORY

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 _____

Ultimate breastfeeding goal: breastfeed exclusively pump exclusively bf and pump bf and supplement unsure whatever happens

YOUR HEALTH HISTORY

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

Medications currently taking (including herbs and vitamins): _____

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

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

Abortion(s): no yes (# _____ year(s) _____) **Miscarriage(s):** no yes (# _____ year(s) _____)

Miscarriage(s) reason(s): 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 in first trimester leaking areola darkening **Any complications:** no yes: _____

Bed Rest: no yes (start week: _____ until week _____) **Reason:** _____ **Pregnancy length:** _____ wks _____ day(s)

LABOR

How labor began: spontaneous induced (how: pitocin cervical gel membrane ruptured 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

1st nursing: _____ min /hrs after birth easy difficult **Sides:** 1 2 did not occur

1st 24 hours frequency: every _____ hours **2nd 24 hours frequency:** every _____ hours **3rd 24 hours frequency:** every _____ hours

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

Milk came in: day _____ not noticed slight mod heavy **Baby complications:** jaundice hypoglycemia other _____

How treated: _____

INPATIENT BREASTFEEDING EXPERIENCE: _____

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LACTATION INTAKE HISTORY (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/yrs) **Pump Type:** rental owned (brand: _____)
POST-DISCHARGE BREASTFEEDING EXPERIENCE: _____

Vaginal bleeding now: light moderate heavy over **Color:** bright red dark red brown

WHERE BABY SLEEPS: in our room in her/his room other: _____ **What baby sleeps in:** our bed sidecar crib or bassinet

NUMBERS

BABY'S WEIGHT HISTORY					
DATE	WHERE WEIGHED		WEIGHT		
BIRTH					
DIAPER OUTPUT HISTORY					
	Last 24 Hours	Last 25-48 Hours	Last 49-72 Hours	Last 73-96 Hours	Last 97-120 Hours
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	<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	<input type="checkbox"/> Black <input type="checkbox"/> Brown <input type="checkbox"/> Green <input type="checkbox"/> Yellow

Attend breastfeeding group: no yes (Where: _____)

Ideally, want to breastfeed: ____ months years until baby weans self **Returning to work (outside home):** no yes (At ____ weeks months)