Breastfeeding History

Today's Date: _____

Date of Referral:_____

Mother's Information:

Last Name:	First Name:	Middle Name:
Birth date (dd-mmm-yyyy)	Age:	
Alberta Health Care #:		
Address:		
Phone (home):	Phone (cell):	
E-mail address:		

**** Would you be open to completing a short, anonymous internet survey after attending our clinic that will let us know how we are doing and help to improve our services?**

Yes No

Baby's Information:

Last Name:	First Name:	Middle Name:
Birth date (dd-mmm-yyyy):		Age today:
Gender: M F		
Alberta Health Care #:		

General Information:

What is your main breastfeeding concern?_____

_____

What would you like to accomplish from this referral?_____

_____

How did you hear about this clinic?_____

Referring Doctor's Name:_____

Family Doctor/Pediatrician:_____

Have you seen anyone else about your breastfeeding issues? If so, who?_____

What have you tried so far?_____

_____

How long do you hope to breastfeed?_____

What is your goal (circle all applicable)?

Sole breastfeeding Breast + expressed milk Breast +formula Sole formula

What kind of delivery did you have (circle all applicable)?

Vaginal Vacuum Forceps C-section

Mother's Medical History:	**Yes**	**No**	**If Yes, please elaborate**
Do you have any medical conditions?			
Did you have significant blood loss after delivery?			
Have you ever had thyroid problems?			
Have you ever had diabetes?			
Have you ever had polycystic ovary syndrome?			
Have you ever had infertility?			
Have you ever had anemia?			
Have you ever had a history of depression?			
Do you feel your mood is low at the moment?			
Have you had any breast surgery?			
Are you on any prescription medications?			
Do you take any herbal medications?			
Do you have any allergies?			
Do you smoke?			
Do you drink alcohol?			
Do you use any street drugs?			
Do you have any other children?			
If so, did you breastfeed them? How long?			

Baby's Medical History:	**Yes**	**No**	**If Yes, please elaborate**
Was the baby born prematurely?			
Does the baby have any medical concerns?			
Has the baby had any jaundice?			
Is the baby on any medication?			
Does the baby have any allergies?			

What was baby's birth weight? _____
When was the baby last weighed? _____
Weight at that time: _____

Baby's Feeding History:

How many times in a 24 hour period does the baby feed at the breast?_____
Do you schedule feeds or feed "on demand"?_____
What cues does the baby exhibit when hungry? _____
Does the baby feed on both breasts with every feed (y/n)? _____
How many minutes per breast does the baby feed?_____
How many bottles of pumped breast milk does your baby get in a 24 hour period?_____
How much pumped breast milk is in each bottle?_____
How many bottles of formula does your baby get in a 24 hour period? _____
How much formula is in each bottle?_____
If your baby gets formula or pumped milk, is this (circle all that apply):

after breastfeeding in place of a breastfeeding before breastfeeding

Baby's Output:

How many wet diapers does the baby have in a 24 hour period?_____
How many stools does the baby have in a 24 hour period?_____
Are the stools soft (y/n)?_____

Pumping:

Do you have or rent a breast pump (y/n)?_____If so, what kind?_____
How many times per day do you pump?_____
Do you pump one breast or both each time?_____
How many minutes per breast do you pump?_____
How much milk do you produce when pumping?_____

Common Concerns:

Latch:	**Yes**	**No**
Do you have inverted or flat nipples?		
Do you have nipple pain?		
Do your nipples hurt more at the **beginning** of feeds?		
Are your nipples cracked or damaged?		
Do you find it awkward to position your baby for breastfeeding?		

Yeast:	**Yes**	**No**
Has the baby had any diaper rash?		
Has the baby had any thrush (yeast in the mouth)?		
Have you or baby been on antibiotics recently?		
Do your nipples hurt more at the **end** or **after** feeds?		
Do you have shooting pains in the breast after feeds?		
Do you have any vaginal itching or unusual discharge?		

Low Supply:	**Yes**	**No**
Is the baby gaining weight well?		
Does the baby feed vigorously?		
Can you hear the baby swallow?		
Does your baby seem satisfied after feeding at the breast?		
Do you feel that your breasts are fuller before feeds?		
Do you feel that your breasts are softer after feeds?		

Overactive Milk Ejection Reflex:	**Yes**	**No**
Is your baby fussy and/or gassy?		
Does your baby choke or sputter at the breast?		
Does your baby pull off & on the breast?		
Does your baby have green stools?		
Does your milk spray out or leak often?		
Do your breasts often feel engorged?		

Miscellaneous	**Yes**	**No**
Does your baby refuse the breast?		
Do you have any white spots in or on the nipple?		
Do your nipples turn white after feeds?		
Do you have any painful lumps in the breast?		