

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

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

Baby complications: jaundice hypoglycemia other _____ How treated: _____

INPATIENT BREASTFEEDING EXPERIENCE: _____

INTAKE HISTORY

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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:** bottle cup syringe dropper spoon finger-feeder tube
When: before nursing after **How often:** every feed ___ x/day **How much:** ___ oz/cc /feeding **What:** formula pumped milk
PUMPING: no yes **When began:** ___ days **How often:** ___ x/day **Avg amt:** _____ **Flange size (imprinted on side):** _____
Pump condition: new used (how long: ___ mths/ys) **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 co-sleeper crib/bassinet

NUMBERS

BABY'S WEIGHT HISTORY		
DATE	WHERE WEIGHED	WEIGHT
BIRTH		

DIAPER OUTPUT HISTORY					
DAY	Last 24 Hours	Last 25-48 Hours	Last 49-72 Hours	Last 73-96 Hours	Last 97-120 Hours
No. of Stools					
Stool Qty	<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 mothers' group: no yes (Where: _____)
Ideally, want to breastfeed: ___ months years until baby weans self **Returning to work (outside home):** no yes (At ___ wks mos)