BREASTFEEDING HISTORY TODAY'S DATE_____

CLIENT'S NAME_____AGE_____BABY'S NAME_____AGE_____

DATE/TIME OF BIRTH_____TYPE OF DELIVERY □vaginal □VBAC □emergency C/S □planned C/S

BABY'S GESTATIONAL AGE _____BIRTH-WEIGHT_____LOWEST WEIGHT/DATE _____

CURRENT WEIGHT_____ALL OTHER AVAILABLE WEIGHTS_____

(continue on back if necessary)

DID BABY HAVE IMMEDIATE SKIN-TO-SKIN CONTACT_____WHEN DID BABY LATCH_____

APPROXIMATELY HOW MANY TIMES DID BABY BREASTFEED ON DAY 1_____DAY 2_____DAY 3_____

DESCRIBE YOUR BREASTFEEDING EXPERIENCE FOR THE FIRST WEEK AFTER BIRTH

_____

_____

_____

DID YOU EXPRESS MILK IN THE FIRST WEEK □hand expression □electric pump □hand pump

FREQUENCY AND AMOUNT OF MILK EXPRESSION IN FIRST WEEK_____

WAS BABY SUPPLEMENTED IN FIRST WEEK □breastmilk □glucose water □formula/type _____

HOW WAS THE BABY SUPPLEMENTED □NG tube □finger/syringe □cup □SNS □bottle/type _____

FREQUENCY/AMOUNT_____

HOW MANY WET DIAPERS/STOOLS DAY 1___/___ DAY 2___/___ DAY 3___/___ DAY 4___/___ DAY 5___/___

WHEN DID BABY HAVE FIRST YELLOW STOOL_____WHEN DID BABY REGAIN BIRTH-WEIGHT_____

HOW MANY TIMES DOES BABY BREASTFEED IN 24 HOURS_____DO YOU HEAR SWALLOWING_____

IS THE BABY CONTENT OR SLEEPING BETWEEN FEEDINGS □never □occasionally □often □usually

LONGEST TIME BETWEEN FEEDINGS DAY_____NIGHT_____ DOES BABY WAKE TO FEED_____

WHO DECIDES WHEN FEEDING IS OVER_____ HOW LONG DOES BABY NURSE_____

ONE OR BOTH BREASTS_____DO BREASTS SOFTEN_____

IN THE PAST 24 HOURS, HOW MANY WET DIAPERS_____ STOOLS_____SIZE OF STOOL_____

SUPPLIES USED □nipple shield □lactaid □SNS □everter □pump Type of pump_____

ARE YOU EXPRESSING MILK_____FREQUENCY/DAY_____ AMOUNT/DAY_____ □storing □supplementing

IS BABY CURRENTLY SUPPLEMENTED □breastmilk □glucose water □formula/type _____

(specify powder, ready-to-feed, or concentrate)

HOW IS BABY SUPPLEMENTED □NG tube □finger/syringe □cup □SNS □bottle/type _____

FREQUENCY/AMOUNT_____

DOES BABY EAT SOLIDS_____TYPE_____AMOUNT/FREQUENCY_____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING □latch-on difficulties □engorgement □heavy lochia □sore nipples □preference for one breast □baby not interested □cracked/bleeding nipples □breast pain □sleepy baby □perception of low milk supply □baby crying excessively □baby always hungry □sad feelings during milk let-down □other_____

DOES BABY HAVE ANY KNOWN HEALTH PROBLEMS_____

PACIFIER_____FREQUENCY _____REASON_____

WHAT ARE YOUR BREASTFEEDING CONCERNS

_____

_____

_____

WHAT ARE YOUR BREASTFEEDING GOALS

_____

_____

_____

DESCRIBE ANY HELP YOU HAVE RECEIVED OR INTERVENTIONS YOU HAVE TRIED

_____

_____

_____

HOW LONG DO YOU PLAN TO BREASTFEED YOUR BABY_____

RETURNING TO WORK _____WHEN_____FULL TIME_____PART TIME_____

HEALTH HISTORY

DOES ANYONE ON EITHER SIDE OF THE BABY'S FAMILY HAVE ANY OF THE FOLLOWING □food allergies □environmental allergies □asthma □eczema □hay fever □ breast cancer □diabetes □genetic disease □thyroid disease □other_____

AGE OF FIRST MENSTRUAL PERIOD _____ □regular □irregular

WHICH OF THE FOLLOWING FAMILY PLANNING METHODS ARE YOU USING OR DO YOU PLAN TO USE
□Norplant □birth control shot □barriers □B.C.P. □I.U.D. □vasectomy □N.F.P. □tubes tied □none

PLEASE LIST ALL MEDICATIONS, HERBS, TINCTURES, TEAS, OILS, OR HOMOEPATHICS YOU ARE USING OR HAVE USED DURING PREGNANCY OR SINCE BIRTH

HAVE YOU EVER HAD ANY OF THE FOLLOWING RELATED TO YOUR BREAST □biopsy □lumps □implants □breast reduction surgery □stretch marks □other_____

DO YOU PRESENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING □anemia □diabetes □allergy/asthma □heart disease □polycystic ovarian syndrome □high blood pressure □liver disease □thyroid disorder □infertility □kidney/bladder disease or infection □yeast infections □eating disorder □depression □miscarriages □STD □constipation □insulin resistance □other_____

DIET □balanced □high protein □low fat □vegetarian □weight loss □special diet □elimination diet
APPETITE □excellent □good □missing meals □poor appetite □eating disorder
ALCOHOL USE □N/A □occasional □regular OTHER □recreational drugs □cigarettes □cigarette smoking in home

PREGNANCY AND BIRTH HISTORY

HOW MANY PREGNANCIES_____HOW MANY CHILDREN_____WERE THEY BREASTFED_____

ANY DIFFICULTIES BREASTFEEDING PREVIOUS CHILDREN_____

PREGNANCY COMPLICATIONS □infertility □previous miscarriages □IVF □premature labor □anemia □UTI □infection □preeclampsia □PIH □gestational diabetes □hyperemesis □medications _____ □other_____

DID BREAST SIZE CHANGE DURING PREGNANCY_____ WHEN_____

DID YOU EXPRESS COLOSTRUM DURING PREGNANCY_____WHEN_____

LABOR/ DELIVERY □vaginal □VBAC □emergency C/S □planned C/S Baby's gestational age _____ □P.R.O.M. □GBS+ □induction □antibiotics □pain medication _____ □epidural □spinal □general anesthesia □Pitocin how long_____ □I.V. fluids for _____ hours how many I.V. bags _____ □high blood pressure medication pushing stage _____ hours length of labor _____ hours □hemorrhage how much _____

DID YOU HAVE ANY OF THE FOLLOWING WITH THIS BIRTH □total labor longer than 30h □episiotomy □tear □breech presentation □asynclitic □posterior □forceps delivery □vacuum extraction □pushing stage longer than 2h □hemorrhage □fever □antibiotics □other_____

DID THE BABY HAVE ANY OF THE FOLLOWING AFTER BIRTH □breathing difficulties □low blood sugar □immediate cord clamping □meconium /amniotic fluid □jaundice highest bili level _____ current level _____ □other _____ APGAR _____

POSTPARTUM COMPLICATIONS □U.T.I. □infections □low/high blood pressure □hemorrhage □pain □other_____

DESCRIBE YOUR BIRTH EXPERIENCE

_____

_____

_____

IS THERE ANYTHING ELSE YOU WOULD LIKE ME TO KNOW ABOUT YOU AND YOUR BABY

LC NOTES