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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	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful
Stool Color	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ 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)

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