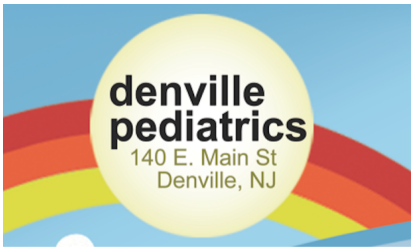

Denville Pediatrics
Labrini Stathopoulos, MD, FAAP, IBCLC
Registered Lactation Consultant

Mother's Name: _____DOB:_____ Today's Date: _____

Child's Name: _____DOB:_____

Please describe any feeding problems that are of concern: _____

_____

_____

MATERNAL HISTORY

Please list any allergies to medications or foods: _____

Any health problems? Please check all that apply

- ☐ high blood pressure
- ☐ PCOS
- ☐ hyperthyroidism
- ☐ hypothyroidism
- ☐ anemia
- ☐ yeast infection
- ☐ breast reduction
- ☐ breast augmentation
- ☐ infertility
- ☐ eczema
- ☐ anxiety/depression
- ☐ diabetes
- ☐ smoker
- ☐ breast surgery
- ☐ tongue-tie
- ☐ breast abnormalities
- ☐ flat/inverted nipples
- ☐ no breast changes

What age were you when you had your first menstrual period? _____ Regular or Irregular? _____

How many pregnancies? _____ How many children? _____

Did you breastfeed your other children? YES / NO

If no, what caused you to not breastfeed? _____

If yes, how long did you nurse them? _____

Please list all medications you took during your pregnancy and now (including over-the-counter/herbs) _____

_____

Will you be returning to work? YES / NO If so, when? _____ FULL TIME / PART TIME?

PREGNANCY & BIRTH HISTORY

Did you have any of the following during this labor and delivery?

- ☐ Ruptured membranes over 24hrs
- ☐ Magnesium for PIH
- ☐ Drugs to control pain
- ☐ Epidural over 10hrs
- ☐ Fever
- ☐ Antibiotics
- ☐ Retained placenta
- ☐ Meconium
- ☐ Vacuum extraction
- ☐ Infection
- ☐ Spinal headache
- ☐ Emergency c-section
- ☐ Forceps
- ☐ Labor over 30hrs
- ☐ Separated from infant at birth
- ☐ Twins
- ☐ Stressful delivery
- ☐ Swelling
- ☐ Postpartum hemorrhage
- ☐ Hemorrhage
- ☐ 3rd/4th degree tear
- ☐ blood transfusion
- ☐ breech c-section
- ☐ push over 2hrs

INFANT'S MEDICAL HISTORY

Does your baby have any known health problems? (jaundice, low blood sugars, diaper rash, tongue-tie, NICU admission)

_____

_____

baby's highest bilirubin level (jaundice) _____ how old was the baby for last bili check?_____

is the baby currently on any medications? _____

gestational age of baby at birth? _____ weeks

baby's birth weight: _____lbs _____oz

baby's discharge weight: _____lbs _____oz date of discharge: _____/_____/_____

baby's current weight: _____lbs _____oz

BREASTFEEDING HISTORY

How old was your baby when you first realized that you were having breastfeeding difficulties? _____

Are you experiencing any of the following? Please check all that apply

☐ latch-on difficulties	☐ preference for one breast	☐ excessive crying	☐ slow weight gain of baby
☐ engorgement	☐ baby refuses to nurse	☐ baby always seems hungry	☐ milk never "came in"
☐ sleepy baby	☐ cracked/bleeding nipples	☐ low milk supply	☐ pump dependent
☐ sore nipples	☐ breast pain	☐ over supply of milk	

What did the lactation consultant do in the hospital to help with breastfeeding? _____

_____

Have you used any breastfeeding supplies or pumps? YES / NO if so, what supplies? _____

What type of pump? _____ When did you start pumping? _____

Has your baby been supplemented with any of the following?

☐ none ☐ water ☐ formula ☐ expressed breastmilk

if supplemented with formula, what kind? _____

How was your baby supplemented?

☐ feeding tube ☐ finger feeding ☐ cup feeding ☐ bottle

How many months do you wish to breastfeed?

☐ 1 month ☐ 2-3 months ☐ 3-6 months ☐ 6-12 months ☐ longer than 12 months

******* FOR THE FOLLOWING SECTION THINK BACK TO THE PREVIOUS 24 HOURS*******

how many times have you given a supplement? _____

how much per feeding? _____

how many times did you pump? _____

how much milk did you obtain from each breast when you pump? _____

how many times have you breastfed your baby? _____

is the baby content in between feedings? never occasionally often

what is the longest time your baby has gone between feedings? day: _____ night: _____

who decides when the feeding is over? MOTHER / BABY how long does baby nurse at breast? _____

how many: wet diapers _____ stools _____ spit ups/emesis _____

NIPPLE/BREAST PAIN – ONLY COMPLETE IF YOU ARE HAVING PAIN

When did you start having nipple pain? _____ right / left / both

When does the nipple pain occur?

- ☐ as baby latches on
- ☐ during the entire feed
- ☐ starts out ok, then hurts more
- ☐ hurts on/off
- ☐ hurts after the feed
- ☐ hurts at times unrelated to a feeding
- ☐ hurts all the time

Describe the pain: check all that apply

- ☐ tugging
- ☐ tingling
- ☐ irritating
- ☐ rubbing
- ☐ scraping
- ☐ aching
- ☐ throbbing
- ☐ itching
- ☐ pinching
- ☐ sharp
- ☐ biting
- ☐ stinging
- ☐ shooting
- ☐ burning
- ☐ other

describe nipple shape when baby comes off breast:

- ☐ normal
- ☐ elongated
- ☐ creased
- ☐ ridged
- ☐ pinched
- ☐ lipstick tube
- ☐ peaked
- ☐ smashed
- ☐ pointed
- ☐ stepped on
- ☐ flattened
- ☐ squished
- ☐ other

does your nipple turn white at the end of the feeding? YES / NO
does your nipple turn white at any other time? YES / NO

is your nipple a different color from usual?

- ☐ No change
- ☐ Lighter
- ☐ Pink
- ☐ Deep pink
- ☐ Red
- ☐ Purple
- ☐ Blanched white
- ☐ White stripe

Is there any nipple damage?

- ☐ Abrasion
- ☐ Crack
- ☐ Blister
- ☐ Scab
- ☐ Piece missing
- ☐ Bleeding
- ☐ Other

Does your nipple hurt when you use a pump? YES / NO
Are you experiencing breast pain? YES / NO
Describe your breast pain:

- ☐ Aching all over
- ☐ Tingling sensation
- ☐ Shooting
- ☐ Burning
- ☐ Radiates down my arm
- ☐ Radiates to my back
- ☐ After feedings
- ☐ During feedings
- ☐ All the time
- ☐ At times not related to feedings
- ☐ Other

What are you doing to deal with the pain?_____

_____