BREASTFEEDING - PATIENT INFORMATION

PATIENT INTAKE

Consult Date: D D M M Y Y

Location:

Mother's Name:

Baby's Name:

Is this your first baby?

Yes *No, names and ages:*

Did you breastfeed them?

No Yes

Did you have fertility issues?

No Yes, please explain:

Did your breasts get bigger during pregnancy?

No Yes

Do you have any other health concerns?

No Yes, please explain:

How would you describe your current health?

Great Good OK Bad

Current medications/supplements:

Have you ever had any breast surgeries?

No Yes, please explain:

Are your breasts sore?

No Yes

Right
Left
Both

Is there damage?

stabbing/ shooting pains
heat radiating
lumps
tender or red areas
Fever and/or flu like symptoms

Are your nipples sore?

No Yes

Right
Left
Both

Is there damage?

scabbing
Bleeding
Burning
Pus
Blanching
Bruised
Itchy
Compressed
line across
stabbing/shooting pain

Do you have any leaking?

No Yes

Morning
During feeds
All the time

Type of delivery:

Vaginal C-Section VBAC

Notes:

Did you have any interventions?

Induced
Pitocin
Vaginal tearing
Vacuum extraction
Epidural
Episiotomy
Forceps

How long was your labor?

Hours:

How long did you push?

Time:

How is your postpartum bleeding?

Still heavy (over one pad every 2 hours)
Getting lighter
Hardly there
Done

How many das ago did it stop?

Have you started your period again? Y N

Was your baby vaccinated?

No Yes

Are you ingesting any of your placenta?

Yes, currently Yes, past
No

Any postpartum health concerns?

No Yes, please explain:

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Baby's Name:

Gender:

Birth date:

Guess date:

Present age:

Gestation at birth:

Birth weight:

Lowest weight:

Most recent weight:

Date/Who/Where:

How many times does your baby breastfeed in 24 hrs?

How long does your baby nurse for?

Minutes: ☐ One side ☐ Both sides

Number of wet diapers in 24 hours:

Number of dirty diapers in 24 hours:

☐ Yellow ☐ Green

☐ Brown ☐ Black

☐ Seedy ☐ Mucusy

Were there any health concerns for your baby....

after birth

☐ No ☐ Yes, please explain:

in the past

☐ No ☐ Yes, please explain:

currently

☐ No ☐ Yes, please explain:

Are you exclusively breastfeeding?

☐ No ☐ Yes

Are you using expressed breastmilk?

☐ No ☐ Yes, _____ ounces per day

Are you using any formula?

☐ No ☐ Yes, _____ ounces per day

How are you supplementing?

☐ Bottle ☐ Finger Feeding

☐ At Breast

Are you hand expressing?

☐ No ☐ Yes, _____ times per day

Are you pumping?

☐ No ☐ Yes, _____ times per day

How long do you pump per session?

Minutes: ☐ One side ☐ Both sides

How much breastmilk do you get per session?

☐ Left side ☐ Right side

How much breastmilk do you collect in 24 hrs?

☐ Ounces

What kind of pump do you use?

Do you have any leaking?

☐ No ☐ Yes

☐ Morning

☐ During feeds

☐ All the time