BREASTFEEDING CLIENT HISTORY

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Date:_____ Client Name: _____ Baby's Name:_____ Baby's Birth Date: _____

Baby's Birth Weight _____ Discharge Weight_____ Baby's Current Weight: _____ Baby's age today_____

What is your ultimate breastfeeding goal: Exclusive breastfeeding Breastfeed and pump/bottle-feed

Pump exclusively and bottle-feed Breastfeed and supplement (no plans to pump) Unsure Whatever Happens

Ideally, I want to breastfeed: 0-4 mths 4-6 mths 6-12 mths 12-24 mths 24-36 mths Until my baby self-weans

Reason for today's visit_____

What would you like me to know about baby or yourself so I can help you be successful?_____

_____

_____

How many times does baby feed at the breast in 24 hrs? _____ Does he/she breastfeed during the night?_____

How many pee diapers in 24 hours? _____ How many bowel movements?_____Describe bowel movement:s
Yellow and seedy green frothy mucousy other_____

List Number of: ___Pregnancies ___Full-term babies delivered ___Premature babies delivered ___Miscarriages

_____babies you have breastfeed previously If so, how long did you breastfeed? _____

PERSONAL HISTORY Your birth date _____ Phone number _____Email _____

Please circle if you have the following: High Blood Sugar Low Blood Sugar Asthma Eczema High Blood Pressure
Low Blood Pressure Thyroid Problems Allergies: if yes, type _____

Depression or Mental Illness: if yes, when and describe_____

Breast Surgery/Trauma: if yes, describe_____

PRENATAL HISTORY

Yes No - This pregnancy was planned.

Yes No - I became pregnant easily.

Yes No - I attended childbirth education classes.

Yes No - I attended prenatal breastfeeding classes.

Yes No - I took a prenatal vitamin regularly during pregnancy.

Yes No - I took other medications/supplements while pregnant. If yes, what? _____

Yes No I experienced breast changes during this pregnancy (increase in size, more tender, sore nipples).

Yes No - I had complications with this pregnancy. If yes, describe_____

During this pregnancy, I drank and/or used: Tobacco Alcohol Caffeinated substances Other social drugs

During this pregnancy, I was under the care of a: Midwife OB/GYN Family Practice Doctor Other_____

Name of care provider/Name of practice _____

Yes No - This healthcare provider discussed breastfeeding with me prior to birth

Yes No He/She is supportive of me breastfeeding

BIRTH HISTORY

Due Date_____ Birth Date_____ Number of days / weeks: “Early” or “Late”_____

Baby was born in: __Hospital delivery room ___Birth center ___Home Other: _____

Which hospital/midwife did you deliver at?_____

My labor was _____ hours long. I pushed for _____ hours/mins.

Were you induced? Yes No If yes, for what reason? _____

Yes No - I was given medications during labor. Please circle all that apply. Antibiotics IV Fluids Pitocin Cytotec/Cervidil Epidural Narcotics Spinal General anesthesia Other: _____

Yes No - There were complications during labor. If yes, describe_____

Baby was born vaginally c section

During delivery, did any of the following occur? Please circle all that apply. Use of vacuum Use of forceps

Cord around baby’s neck or body Episiotomy Compound presentation (baby’s head presenting w/ another body part)

Who attended the birth? (father, parent, doula, etc)_____

Overall, were you happy with the birth? Yes No Somewhat
Explain:_____

Were you given medications after delivery? Stool softeners Antibiotics Iron Other _____

Pain medication If yes, which ones? _____

I was discharged from the hospital / birthing center when baby was _____ days old.

Baby was discharged from hospital when he/she was _____ days / weeks old.

Yes No - Did you have a postpartum hemorrhage? If yes, how much blood did you lose? _____

Yes No – Has your vaginal bleeding stopped? If yes, when did bleeding stop? _____

If no, describe (color, flow, clots?)_____

Did you have retained placenta? If yes, how was it treated?_____

NUTRITION

Since baby was born, my appetite has: __Significantly increased __Significantly decreased

I eat ___meals each day. I eat ___snacks each day. What foods do you typically eat? _____

Yes No – My urine is a pale yellow color by noon

I am taking vitamins/supplements, check all that apply - Prenatal vitamin Calcium Iron Other_____

Yes No - I take herbal supplements or drink herbal teas. If yes, what and why? _____

Yes No - I am taking my encapsulated placenta.

Yes No - I currently take medications. If yes, please list _____

Yes No - I drink / eat dairy products. If yes, please list types and how much._____

Yes No - I am on a special diet. (weight loss, gluten free, low sodium, vegetarian, vegan, dairy free, etc.)

I currently drink or use: Tobacco Alcohol Caffeinated substances Other social drugs

Yes No - Is there a smoker in the home? If yes, who?_____

Baby is around people who smoke: Never Rarely Occasionally Often

LIFESTYLE

Overall, my health is _____

I feel: Exhausted Slightly tired Like I am getting enough rest

My sleeping pattern currently looks like: _____

Yes No - I have help at home. (housework, meal prep, errands, etc.)

Yes No - I plan to go back to work. When? _____

Who will care for your baby? _____

Yes No - I plan on pumping. Yes No - I have experience with pumping Yes No - I have experience w/ hand expression.

Yes No - I own a pump. Electric Manual Brand/Model _____

Are you currently pumping now? If so, how often? _____ How long do you pump?_____ Flange size?_____

With this baby, I have experienced:

Mastitis	Right Breast	Left Breast	Breast Infection	Right Breast	Left Breast
Engorgement	Right Breast	Left Breast	Sore/cracked nipples	Right Breast	Left Breast When?_____
Thrush	Right Breast	Left Breast	Plugged ducts	Right Breast	Left Breast When?_____
Abscesses	Right Breast	Left Breast	Blebs (Milk Blisters)	Right Breast	Left Breast

Yes No Not Sure - I feel like I make enough milk to feed my baby.

Yes No - I have a noticeable milk ejection reflex (let down). What does it feel like to you?_____

Yes No - My baby was given to me immediately after birth. If not, we were separated for:_____ hours

Reason:_____

Yes No - I breastfed within the first hour after delivery

Yes No - The baby breastfed well at the first feeding

My milk “came in” on the _____ day.

Yes No - I had sore nipples the first week.

Yes No - Did you pump the first week? If yes, why? _____