Lactation Assessment Form - Maternal History

Today's Date: _____ Your Name: _____

Obstetrician or PCP: _____ Phone: _____

Pediatrician (*if not All Better Pediatrics*): _____ Phone: _____

Where did you deliver? _____ How did you hear about us? _____

What is the reason for your visit today? _____

Have you seen anyone else for this problem? _____

How long are you planning to breastfeed? _____

YOUR HISTORY:

1. Did your breasts change during pregnancy (*please check*)? ☐ Yes ☐ No

If yes, please describe: _____

2. How many children do you have? _____ Did you breastfeed your other children? ☐ Yes ☐ No

If *YES*, how long did you breastfeed? _____

3. Did you nurse as long as you had wanted? ☐ Yes ☐ No If *NO*, why not? _____

Describe any problems: _____

4. Do you have a history of any of the following (check ALL those that apply)?

☐ Breast Surgery/biopsy	☐ Thyroid Problem	☐ Diabetes	☐ Emotional abuse
☐ Cystic Breasts	☐ Hormone Problem	☐ High Blood Pressure	☐ Physical abuse
☐ Breast Infection (mastitis)	☐ Infertility	☐ Depression/Anxiety	☐ Asthma
☐ Yeast Infection/Thrush	☐ Ovarian Cyst(s)	☐ Migraine headaches	☐ Sensitivity to latex

5. *Other Allergies:* ☐ Yes ☐ No If *YES,* please list allergies: _____

6. *Alcohol Use:* ☐ Never ☐ Occasionally (1-2 per week) ☐ Daily: number of drinks/day: _____

7. *Have you ever smoked cigarettes?* ☐ Yes ☐ No If *YES*, number of packs per day: _____

8. *Please list any other medical problems:*

_____ _____ _____

_____ _____ _____

9. *Please list* **ALL** *medications, herbs, or vitamin supplements you are taking:*

_____ _____ _____

_____ _____ _____

_____ _____ _____

10. Do any of the following apply to THIS pregnancy or birth (check ALL those that apply)?

☐ Pre-term labor	☐ Cesarean Birth	☐ Large Blood loss	☐ Vacuum
☐ Induced	☐ Antibiotic	☐ Tear or Episiotomy	☐ Forceps
☐ Epidural/Spinal	☐ Other pain medications	☐ Return of menstrual cycle	

How long was your labor? _____ How long did you push? _____

Describe any problems during pregnancy, labor, birth or recovery period:

_____

_____

****PLEASE MAKE SURE TO FILL OUT THE OTHER SIDE OF THIS SHEET****

Lactation Assessment Form - Infant History

BABY'S HISTORY:

Your Baby's Name: _____ Baby's Birthdate: _____ Due Date: _____

Birth Weight: _____ Weight at Hospital Discharge: _____

Most Recent Weight: _____ Any Other Weights: _____

11. Do any of the following apply to your baby during or after birth (check ALL those that apply)?

☐ Baby in NICU at any time ☐ Excessive crying ☐ Gassy ☐ Thrush/Yeast
☐ Jaundice (yellow skin) ☐ Antibiotic ☐ Reflux ☐ Meconium in amniotic fluid (green)
☐ Spits up frequently ☐ Diaper rash ☐ Fussy ☐ Received bottle of formula or breastmilk

12. Please describe your breastfeeding experience in the hospital (check ALL those that apply)?

☐ Skin-to Skin immediately after delivery ☐ Saw a Lactation Consultant before discharge
☐ First breastfeeding within ONE hour after birth ☐ Taught how to hand express
☐ Baby roomed-in (even overnight) ☐ Taught how to use a breast pump

Do you think you received enough help during your stay? ☐ Yes ☐ No

Anything else you would like us to know about your hospital experience?

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13. Please answer and describe the following about breastfeeding your baby in the last 24 hours:

Latching? ☐ Yes ☐ No ☐ Sometimes How long do feedings last? _____
Number of breastfeedings? _____ Takes both breasts at feeding? ☐ Yes ☐ No
Minutes of regular swallowing during feeding: _____ Using a pacifier? ☐ Yes ☐ No
Number of wet diapers: _____ Number of dirty diapers: _____ Color of dirty diapers: _____
Do you have a breast pump? ☐ Yes ☐ No If *YES,* name of pump: _____
What size pump breast shield? ☐ 21 mm ☐ 24 mm ☐ 27 mm ☐ 30 mm ☐ 36 mm Other _____
Using the pump? ☐ Yes ☐ No If *YES,* how often? _____
Were you able to collect milk? ☐ Yes ☐ No If *YES,* how much? _____
Giving bottles of breastmilk? ☐ Yes ☐ No If *YES,* how much and how often? _____
Giving formula? ☐ Yes ☐ No If *YES,* how much and how often? _____
Using nipple shield? ☐ Yes ☐ No If *YES,* what brand? _____ What size? _____

How would you generally describe your baby's behavior?

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14. Pain

Any pain with breastfeeding? ☐ Yes ☐ No Any pain with pumping? ☐ Yes ☐ No
If *YES*, when did the pain begin? _____ If *YES*, when did the pain begin? _____
How long does it last? _____ How long does it last? _____
Where is the pain? _____ Where is the pain? _____
Rate your pain from 0-10 (10 is worst pain) _____ Rate your pain from 0-10 (10 is worst pain) _____
What makes the pain worse? _____ What makes the pain worse? _____
What helps the pain? _____ What helps the pain? _____

Any other information you would like us to know?

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15. Signature

Person completing this form: _____ Print: _____

Relationship to infant: _____ Date Completed: _____

For Office Use Only:

☐ Assessment and evaluation completed. IBCLC to evaluate and provide education.
Physician: _____ Date Reviewed: _____
Acknowledgement: _____ Date Reviewed: _____