Breastfeeding Clinic-Initial Consult

Baby_____ **Mom**_____

Today's Date:_____ **M T W TH F S Time:**_____

Delivering Hospital: [ ] Mission [ ] Saddleback [ ] Hoag [ ] UCI [ ] Kaiser

OB Doctor:_____ **Pediatrician:**_____

Email:_____ **Phone:**_____

MOM'S History

Which Baby is this for you: [ ] 1st [ ] 2nd [ ] 3rd [ ] _____

Did you have any problems getting pregnant or history of infertility? [ ]No [ ] Yes

Did your breasts change, become darker, or get larger during pregnancy? [ ] No [ ] Yes

Have you breastfed previous children [ ] No [ ] Yes-**For how long** _____

Were there any problems with breastfeeding [ ] No [ ] Yes

Explain _____

Do you currently have any medical or health related problems? [ ] No [ ] Yes

[ ] Thyroid [ ] Anemia [ ] Allergies [ ] Diabetes (type 1 or 2) [ ] Gestational Diabetes

[ ] PCOS [ ] History of or current depression [ ] gynecologic disorders

History of surgery: List type of surgery and dates performed _____

Breast Surgery [ ] Augmentation [ ] reduction [ ] lumpectomy

Do you have any medicine allergies? [ ] No [ ] Yes, _____

Are you Allergic to Latex [ ] No [ ] Yes **Allergy to adhesive tape** [ ] No [ ] Yes

Do you have any food allergies? [ ] No [ ] Yes, _____

What Medications are you currently taking? [ ] Welbutrin [ ] Allergy Medications

[ ] Motrin [ ] Tylenol [ ] Vicodin [ ] Percocet [ ] Antibiotics [ ] Anti-fungal [ ] Iron

[ ] Synthroid [ ] Birth Control [ ] Vitamins [ ] Stool Softeners [ ] Fenugreek/More milk plus

[ ] Other_____ Herbal supplements_____

Are you on any special Diet? [ ] No [ ] Yes, _____

Religious or Cultural practices pertaining to Medical Care?

_____

Delivery Information

Prenatal: Any problems during your pregnancy? [ ] No [ ] Yes *check below*

[ ] preterm labor [ ] gestational diabetes [ ] high blood pressure [ ] toxemia [ ] eclampsia

[ ] other, _____

Due date_____ Delivery Date_____Baby's age today_____

Type of delivery: [ ] Vaginal [ ] cesarean *planned//emergency* [ ] induction

Did you receive epidural anesthesia? [ ] No [ ] Yes, how many hours _____

Any complications with the delivery or hospital stay? [ ] No [ ] Yes

Please explain:_____

Infant History

[ ] Boy [ ] Girl [ ] Twin **Birth weight_____Discharge weight_____**

Baby's most recent weight_____Date_____

Any medical/Health Problems? [ ] none [ ] weight loss [ ] jaundice [ ] low blood sugar

[ ] Down syndrome [ ] Tied tongue [ ] other _____

Breastfeeding History and Current Feeding Patterns

Did you have any problems breastfeeding in the hospital? [ ] No [ ] Yes

[ ] Sleepy Baby [ ] Fussy Baby [ ] Suck Problems [ ] Jaundice [ ] Tongue Tie [ ] Latch

[ ] Sore nipples [ ] Flat nipples [ ] LPI [ ] Mother-baby Separation

Hospital Plan of Care:_____

What current problems or concerns are you experiencing now?

Please check all that apply:[ ] Sleepy Baby [ ] Fussy Baby [ ] Suck Problems [ ] Jaundice

[ ] Latch Problems [ ] Refusing Latch [ ] Not enough milk [ ] Engorgement [ ] Soreness

[ ] Cracked Bleeding nipples [ ] Flat/Inverted Nipples [ ] Thrush [ ] Mastitis [ ] other

Are you using a breast pump? [ ] No [ ] Yes, if so type_____

How often_____ How much milk do you express_____

How many times have you breastfed your baby in the last 24 hours?_____

How would you describe these feeding? [ ] Well [ ] Fair [ ] Poor

Are you currently using any breastfeed devices: [ ] nipple shield [ ] SNS [ ] Tube

In the past 24 hours: how many wet diapers_____ poopy diapers_____ color_____

Is your baby getting other milk feeding in addition to breastfeeding? [ ] No [ ] Yes

If yes, how much and how often:

[ ] Pumped Breast milk: How much given_____ How many times_____

[ ] Formula: Type _____ How much given_____How many times_____

Is your baby getting any other fluids besides breast milk or formula? [ ] No [ ] Yes

Is your baby on any current medications or treatments _____

How long do you desire to Breastfeed? [ ] 6 months [ ] 1year [ ] as long as possible

Do you have any other questions or concerns about you or your baby? [ ] No [ ] Yes

If Yes, Please describe:

_____

_____

_____