QUICK LACTATION SUPPORT

Phone: 325.669.6624 | Email: aquick@quicklactationsupport.com

Lactation Support Intake Form

Maternal History

Today's Date: _____ Your Name: _____

Obstetrician or PCP: _____ Phone: _____

Pediatrician: _____ Phone: _____

Where did you deliver? _____

How did you hear about us? _____

Reason for your visit today: _____

Have you seen anyone else for this problem? ○ Yes ○ No

How long are you planning to breastfeed? _____

Did your breasts change during pregnancy? ○ Yes ○ No If yes, describe: _____

How many children do you have? _____ Did you breastfeed your other children? ○ Yes ○ No

If YES, how long did you breastfeed? _____

Did you nurse as long as you wanted? ○ Yes ○ No If NO, why not? Describe any problems: _____

History (check all that apply):

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

Other Allergies: ○ Yes ○ No _____

Alcohol Use: ○ Never ○ Occasionally (1–2/week) ○ Daily: #/day _____

Have you ever smoked cigarettes? ○ Yes ○ No If YES, packs/day: _____

Other medical problems: _____

Medications, herbs, vitamins: _____

Applies to this pregnancy/birth (check all that apply):

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

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

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

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Infant History

Baby's Name: Birthdate: Due Date:

Birth Weight: Weight at Hospital Discharge:

Most Recent Weight: Any Other Weights:

Do any of the following apply to your baby? (check all that apply)

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

Breastfeeding experience in the hospital (check all that apply)

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

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

Anything else about your hospital experience:

Feeding 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: 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 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 ○ N

If YES, how much? Giving bottles of breastmilk? ○ Yes ○ No How much/how often?

Giving formula? ○ Yes ○ No How much/how often?

Using nipple shield? ○ Yes ○ No Brand: Size:

How would you generally describe your baby's behavior?

Pain

Any pain with breastfeeding? ○ Yes ○ No When did it begin? How long does it last?

Where is the pain? Rate pain 0–10: What makes it worse?

What helps the pain?

Any pain with pumping? ○ Yes ○ No When did it begin? How long does it last?

Where is the pain? Rate pain 0–10: What makes it worse?

What helps the pain?

Any other information you would like us to know?