Birth & Breastfeeding Connection

Date:________________ Email address:_______________________________

Client Name:__________________________Age:______ DOB:______GA ____Occupation_______________________

Address: ____

Phone number:_____________________Father's name:_____________________ Dr/Midwife:______________________

Infant's Name:_____________________________DOB:______________ Present age:__________ Sex: M / F

Pediatrician/Family MD:_________________________ Place you gave birth:_________________________________

Describe breastfeeding problem:____

Pre-pregnancy weight:_________ Weight gain during pregnancy:_____________

Did you experience breast changes during pregnancy Y / N

Circle and surgeries or procedures that you have undergone:

Augmentation Lift Lumpectomy Cyst aspiration

Reduction Biopsy Cyst Removal When:_____________________

Have you ever been in an accident that caused trauma to your breast or chest wall? Y / N

If yes, please describe:____

Have you ever had infertility treatments? Y / N Date and type:____

Number of pregnancies:_________ Number of living children:_________ Miscarriages:__________

Have you ever been hospitalized for any reason (even during this pregnancy) other than childbirth?________________

If, yes, reason:____

Circle any that have ever applied to you:

High blood pressure	Hepatitis	Alcohol Abuse
Diabetes	Heart problems	Drug Abuse
Herpes	Eating Disorder	Polycystic Ovarian Syndrome
Hypoglycemia	Depression	Recurrent Vaginal Yeast Infections
Thyroid	Smoking	Other: ____________________________

Are there any other health problems we should know about?____

Describe any complications with the birth of your baby:____

Circle all that apply:

Vaginal	Spinal	Hemorrhage
C-Section	Forceps	Pre-term Labor
Epidural	Vacuum	Difficulty w/placenta removal

List any prescription medication:____

OTC medications, vitamins or herbal supplements:____

____

List any food or drug allergies:____

Was your baby admitted to the Special Care Nursery?_______Was your baby referred to a specialist? Y /N

Circle all that apply:

Jaundice	Tongue Tie	Heart Rate Concerns	Excess Weight Loss
Cleft Lip & Palate	Chromosomal Disorder	Problems Maintaing Temp	

Infants' Birth Weight:_______Discharge Weight:_________ Last Weight:_______Date & Location___________

Have you supplemented your baby with formula? Y / N If so, please describe:_____________________________

____

Have you been given a breastfeeding plan? Y / N Have you been seen by a lactation consultant? Y / N

Are you following this plan? Y / N?

What time did your infant last eat? _______ _______minutes at breast/________ amount by bottle

By signing, I certify that the above information is correct to the best of my knowledge, and I understand that ay of this information may be discussed during my appointment.

Signature:____ Date:___________________________________