Birth & Breastfeeding Connection

Date:_____ Email address:_____
Client's Name:_____Prounons_____Age:_____ DOB:_____
Weeks Gestation _____
Occupation_____
Address:_____
Phone #:_____Partner's name:_____
Dr/Midwife practice and location:_____
Infant's Name:_____DOB:_____ Present age:_____ Sex: M / F
Pediatrician/Family MD:_____ Place you gave birth:_____
Describe your feeding concerns:
1)_____
2)_____
3)_____

Describe your feeding goals: _____
_____
On a scale of 1-10 (1- flexible and 10 - no wiggle room) how would you rank your goal achievement: 1 2 3 4 5 6 7 8 9 10

Please describe your current diet: VG GF V DF (circle any that apply)
_____
_____
_____

Pre-pregnancy weight:_____ Weight gain during pregnancy:_____
Did you experience breast changes during pregnancy, such as an increase in size: Y / N
Did you have the sensation of your milk "coming in"? If yes, what day of life?_____

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	Physical limitations
Anxiety	Autism	Neurodivergent _____ (please elaborate on the back so I can support you better)

Are there any other health problems concerns that I should know about to assist you more appropriately?_____
_____

Describe any complications with the birth of your baby:_____

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Circle all that apply:

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

Describe your current family/social support:_____
_____
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 Maintaining Temp	

Infants' Birth Weight:_____Discharge Weight:_____ Last Weight:_____Date & Location_____
(If older than one month, please give all recorded weights and dates:
_____ _____ _____ _____

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?

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:_____