BREASTFEEDING QUESTIONNAIRE

TODAY'S DATE_____

MOTHER'S NAME_____DOB_____ INFANT'S NAME_____DOB_____

IN YOUR OWN WORDS DESCRIBE ANY BREASTFEEDING CONCERNS YOU MAY HAVE OR WHAT PROMPTED YOU TO SEEK GUIDENCE:

_____

_____

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FAMILY HISTORY

DOES ANYONE ON EITHER SIDE OF THE BABY'S FAMILY HAVE ANY OF THE FOLLOWING? (CIRCLE) allergies to foods environmental allergies asthma eczema hay fever breast cancer diabetes genetic disease thyroid disease
other_____

WHAT AGE WERE YOU WHEN YOU HAD YOUR FIRST MENSTRUAL PERIOD? _____ ARE YOUR PERIODS REGULAR? _____.CYCLE LENGTH:_____

WAS THIS YOUR FIRST PREGNANCY? _____ Number of prior pregnancies?_____ did you breastfeed your other children?_____ How long? _____

WHICH OF THE FOLLOWING FAMILY PLANNING METHODS ARE YOU USING OR DO YOU PLAN TO USE?
Norplant birth control shot barriers birth control pills vasectomy fertility awareness other natural family planning/rhythm tubes tied none other:_____

WILL YOU BE RETURNING TO OUTSIDE WORK/SCHOOL? yes no At how many week months/years postpartum?_____FULL TIME?_____PART TIME?_____

PREGNANCY AND BIRTH HISTORY

DOES YOUR BABY HAVE ANY KNOWN HEALTH PROBLEMS? _____

IS THE BABY CURRENTLY ON ANY MEDICATIONS?_____

ARE YOU TAKING ANY OF THE FOLLOWING? (CIRCLE) prenatal vitamin-mineral iron antihistamines cold remedies antibiotics aspirin laxatives diuretics/water pills antacids birth control pills pain pills diet pills herbs
other_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING PROCEDURES RELATED TO YOUR BREAST? (CIRCLE) biopsy lumps implants breast reduction surgery nipple problems
other_____

DO YOU PRESENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CIRCLE) anemia allergy/asthma diarrhea (chronic) heart disease diabetes hepatitis venereal disease high blood pressure liver disease thyroid disorders miscarriages hemorrhoids cancer infertility abortions depression sexual abuse abnormal pap smear constipation eating disorder kidney/bladder disease or infection yeast infections tuberculosis polycystic ovarian syndrome
other_____

DID YOU HAVE ANY OF THE FOLLOWING DURING THIS PREGNANCY? (CIRCLE) premature labor gestational diabetes high blood pressure nausea/vomiting-severe anemia fever urinary tract infection medications other_____

DID YOU HAVE ANY OF THE FOLLOWING DURING THIS LABOR AND DELIVERY? (CIRCLE) premature rupture of membranes Anesthetic/Analgesic Narcotics drugs to control high blood pressure epidural /Spinal fever antibiotics Pitocin other labor inducing/augmenting drugs hemorrhage - if so how much blood was lost_____pints,
other significant labor/birth information_____

HOW WAS THIS BABY BORN? vaginal at home waterbirth vaginal at hospital emergency c-section elective c-section don't know(adopted/surrogate) baby not born yet
GESTATIONAL AGE OF BABY AT BIRTH?_____WEEKS

DID YOU HAVE ANY OF THE FOLLOWING WITH THIS BIRTH? (CIRCLE) total labor longer than 30 hours episiotomy or tear pushing stage longer than 2 hours breech presentation tear that involved the rectum (3rd or 4th degree laceration) forceps delivery vacuum extraction other_____

DID YOU EXPERIENCE ANY POSTPARTUM COMPLICATIONS? urinary/other infections low blood pressure high blood pressure excessive bleeding retained placenta
other_____

DID THE BABY HAVE ANY OF THE FOLLOWING AFTER BIRTH? breathing difficulties circulation difficulties high hematocrit low blood sugar meconium aspiration jaundice vaccinations
other_____

WHAT WAS YOUR BRA SIZE: BEFORE PREGNANCY_____ NOW_____ CHANGES SINCE THE BIRTH? hard/engorged heavy warm leaking no changes

BREASTFEEDING HISTORY

HOW OLD WAS YOUR BABY WHEN YOU FIRST REALIZED THAT YOU WERE HAVING BREASTFEEDING CHALLENGES?_____

HAVE YOU USED ANY BREASTPUMPS?_____Type of PUMP_____OTHER BREASTFEEDING SUPPLIES?_____

HAS YOUR BABY BEEN SUPPLEMENTED WITH ANY OF THE FOLLOWING? water formula cow milk goat milk plant milk(soy,almond etc) expressed breastmilk donor breastmilk
TYPE/BRAND OF FORMULA OR SUPPLEMENTAL MILK_____

IF SO, HOW WAS THE BABY SUPPLEMENTED? at-breast feeding tube at-finger feeding tube cup feeding spoon feeding bottle TYPE/BRAND_____

IF SUPPLEMENTS HAVE BEEN USED, HOW OFTEN IN PAST 24 HOURS? _____HOW MUCH PER FEEDING?_____

HOW MANY TIMES IN THE PAST 24 HOURS HAVE YOU BREASTFED YOUR BABY? (CIRCLE) less than 6 times less than 8 times 8-10 times more than 12 times

ARE YOU EXPERIENCING ANY OF THE FOLLOWING? (CIRCLE) latch-on difficulties engorgement sleepy baby sore nipples preference for one breast baby not interested cracked/bleeding nipples breast pain feeling that there is not enough milk baby crying excessively baby always seems hungry
other_____

WHAT IS THE LONGEST TIME YOUR BABY HAS GONE BETWEEN FEEDINGS? DAY:_____ NIGHT:_____

WHO DECIDES WHEN THE FEEDING IS OVER? (CIRCLE) Mother or Baby HOW LONG DOES BABY NURSE AT BREAST?_____ ONE BREAST OR BOTH BREASTS?

HOW LONG DO YOU WISH TO BREASTFEED YOUR BABY? 1-3 MONTHS 3-6 MONTHS 6-9 MONTHS 9-12 MONTHS 12-18 MONTHS 18-24 MONTHS MORE THAN 24 MONTHS

ARE YOU PRESENTLY USING A PACIFIER? yes or no BRAND?_____WHY?_____HOW OFTEN? _____

IN THE PAST 24 HOURS, HOW MANY? WET DIAPERS_____ STOOLS_____ WERE THE STOOLS BIGGER THAN A TABLESPOON? yes no

MATERNAL DIET/OTHER INFORMATION

HOW WOULD YOU DESCRIBE YOUR DIET? mostly organic/GMO-free somewhat organic inorganic sugar-free low sugar some sugar gluten-free some gluten(wheat) no oats oats dairy-free some dairy vegan vegetarian no meat some meat no eggs some eggs other:_____

DO YOU LIVE OR WORK ON OR NEAR A FARM WHERE PESTICIDES ARE SPRAYED?_____ DO YOU PRACTICE YOGA?_____

ARE YOU CO-SLEEPING?_____ DO YOU PRACTICE BABYWEARING?_____ hard structured carrier soft structured carrier asian carrier sling cloth wrap

IS THERE ANYTHING ELSE YOU WOULD LIKE TO MENTION THAT MIGHT AFFECT BREASTFEEDING OR THAT YOU ARE INTERESTED IN LEARNING MORE ABOUT?

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