

CAPITAL AREA PEDIATRICS LACTATION INTAKE FORM

BASIC DEMOGRAPHIC DATA

Mother's Name: _____

Mother's age: _____

Baby's full name: _____

Baby's date of birth: _____

PRIMARY CONCERNS FOR TODAY'S VISIT/REASON FOR VISIT (CHECK ANY THAT APPLY):

- Poor or slow weight gain
- Milk supply concerns
- Painful latch
- Other concerns:

WHO REFERRED YOU TODAY?

- Self
- Provider (who?): _____
- Another lactation consultant or lactation support person

GOALS FOR BREAST/BREASTMILK FEEDING:

SOCIAL HISTORY

Support at home

- Yes
- No
- Details:

Maternity leave

- Yes
- No
- Stay at home mom

Returning to work

- No
- Not sure
- Yes, full-time when baby is _____ weeks old
- Yes, part-time when baby is _____ weeks old
- Not applicable

MATERNAL HISTORY

Medical Conditions (past or present)

- Allergies – foods: _____
 - Allergies – Seasonal/environmental (season/type): _____
 - High blood pressure (prior to getting pregnant)
 - Thyroid disorder (high or low?): _____
 - Eating disorder
 - Weight loss surgery
 - Anxiety disorder
 - Anemia
 - Diabetes
 - GI disorders
 - PCOS
 - Pituitary disorder
 - Heart disease
 - Cancer
 - Depression
 - Sexual abuse
 - Other: _____
- _____
- _____
- _____

Breast History (please include approximate date or your age)

- Reduction: _____
- Augmentation: _____
- Biopsy: _____
- Lumpectomy: _____
- Nipple problems: _____
- Other chest surgeries/injuries: _____

Pregnancy and Fertility

Problems getting pregnant?

- No
 - Yes _____
- _____
- _____

Problems staying pregnant?

- No
 - Yes _____
- _____
- _____

Breast changes during pregnancy

Cup size

- 1 cup size
- 2 cup sizes
- 3+ cup sizes
- No change
- Not sure

Areola

- Darkened
- Larger
- No change
- Not sure
- Other

Medical complications during pregnancy

- Premature labor
- Gestational diabetes
- Urinary or other infection
- High blood pressure
- Anemia
- Fever
- Other: _____

Breastfeeding

Past experience?

- Yes (how long): _____
- No

Type of experience?

- Successfully
- Yes with problems (please explain): _____

- Stopped due to problems
- Never attempted

POSTPARTUM HISTORY

Complications

- Urinary/other infection
- High blood pressure
- Low blood pressure
- Retained placenta
- Hemorrhage requiring transfusion
- Other

Current Medications

- Prenatal MVI
 - DHA supplement
 - Antibiotics (what type): _____
 - Iron
 - Antihistamines (what type): _____
 - Laxatives/Stool softeners
 - Cold remedies (what type): _____
 - Diet pills
 - Aspirin
 - Diuretics
 - Antacids
 - Pain medication (what type): _____
 - Milk supply supplements (what type): _____
 - Oral contraceptives (what type): _____
 - Other _____
-
-
-
-

Previous Medications

- Medications that you used to take that you have been advised not to use during breastfeeding or have safety questions about while breastfeeding: _____
-
-
-
-

INITIAL BREASTFEEDING HISTORY

Time to breast

- <1 hour
- 1-3 hours
- 4-10 hours
- >10 hours
- Never nursed

Was baby's first feed at the breast?

- Yes
- No

Did you see a lactation consultant in the hospital?

- Yes
- No

Where any recommendations made, problems with nursing identified, instructions given or devices started by the lactation consultant?

Engorgement

- Milk not yet in
- 48 hours
- 72 hours
- 4th day
- 5th day
- Not sure

Let Downs

- No sensation
- Tingling or Burnings
- Leaking
- Uterine cramping

Support Devices

- Nipple shield (brand/size): _____
- Breast shell
- Gel pads
- Supplemental feeding device (type/method): _____
- Lanolin
- All Purpose Nipple Ointment (APNO): _____

PUMPING HISTORY

Are you currently doing any pumping?

- Yes
- No

If you are pumping, how often are you pumping and for how long? _____

Do you have any past experience with pumping?

- Yes
- No

Were you advised by anyone to start pumping?

- Yes
- No

What type of pump do you have at home?

- Hospital grade pump (brand): _____
- Double electric pump (brand): _____
- Single electric pump (brand): _____
- Hand pump (brand): _____

Is this pump new with the birth of this child?

- Yes
- No

Have you contacted your insurance company about whether they will supply you with a new pump with the birth of this child?

- Yes
- No

Would you like information about questions to ask your insurance company about this benefit?

- Yes
- No

OTHER INFORMATION

Is there anything else you would like for us to know regarding our visit today?_____
