CAP WELLNESS CENTER

Lactation Questionnaire

Please answer all questions as completely as possible

Mother's First Name: _____ Last Name: _____

Mother's Birth Date: _____ E-Mail: _____

Primary Phone #:_____

Address: _____

City: _____ State: _____ Zip: _____

Child's First Name: _____ Last Name: _____

Child's Birth Date: _____ Age: _____ □ M □ F Ht: _____ in Wt: _____ lb

How did you hear about our wellness center?_____

Please let us know any concerns with feeding you may have:

_____

Medical History

Please list any medications:

_____

Was this your first pregnancy? □ Yes □ No

If no, how many pregnancies have you had? _____

How many children do you have? _____

Were they breastfed? □ Yes □ No If so, for how long? _____

Which of the following family planning methods are planned on being used?

norplant	birth control pills	tubes tied
birth control shot	vasectomy	natural family planning
barriers	LAM	none

Are you planning to return to work? □ Yes □ No

If yes, when? _____ Full or part-time? _____

Pregnancy and Birth History

Does your baby have any known medical conditions? □ Yes □ No

If yes, please list: _____

Does your baby currently take any medication? □ Yes □ No

If yes, please list: _____

Have any of the following procedures or conditions been applicable to your breasts?

biopsy surgical breast reduction implants

lumps inverted nipple piercing

other: _____

Did any of the following conditions occur during your pregnancy?

premature labor high blood pressure anemia

gestational diabetes nausea/vomiting-severe UTI

medications other: _____

Did any of the following occur during labor and delivery**?**

pain medication blood pressure medication antibiotics

hemorrhage epidural fever induction

premature membrane rupture

Was your birth: vaginal emergency c-section planned c-section

What was your baby's gestational age at birth? _____weeks

Did any of the following occur during your baby's birth?

labor longer than 30 hours episiotomy vaginal tear

pushing longer than 2 hours forceps vacuum extraction

breech presentation rectal tear

other: _____

Did any of the following conditions occur postpartum?

urinary/other infections low blood pressure high blood pressure

excessive bleeding transfusion

other: _____

Did your baby experience any of the following after birth?

high hematocrit low blood sugar breathing difficulties

meconium aspiration jaundice

other: _____

What was your bra size before pregnancy? _____ Current bra size? _____

Have any of the following changes occurred to your breasts after birth?

hard/engorged warm leaking no changes

Breastfeeding History

How old was your baby when your first noticed breastfeeding issues? _____

Have any breastfeeding supplies been used? _____

If a pump has been used, please list the type and manufacturer: _____

Has your baby been supplemented with formula or expressed breast milk? □ Yes □ No

If yes, how often was your baby supplemented in the past 24 hours? _____

How much? _____

If yes, how was your baby supplemented?

SNS feeding cup Haberman p-syringe finger

feeding bottle Type of bottle and nipple: _____

If formula has been used, please list the type: _____

How many times has your baby been breastfed in the past 24 hours? _____

Are any of the following issues being experienced?

latch-on difficulties	preference for one breast	engorgement
baby not interested	baby always seems hungry	sleepy baby
breast pain	sore nipples	bleeding nipples
not enough milk	baby crying excessively	other: _____

Is your baby usually content or sleeping between feedings? □ Yes □ No

What is the longest time between feedings during the day? _____ At night? _____

Who decides when feeding is over? Mother Baby

How long does baby nurse at each breast? _____

Does your baby currently use a pacifier? □ Yes □ No If yes, how often? _____

In the past 24 hours, how many wet diapers and diapers with stools has baby had? _____

Were any of the stools more than a tablespoon? □ Yes □ No

How long do you desire to breastfeed your baby?

3-6 months 6-9 months 9-12 months longer than 12 months

Thank you for filling out this form.

I consent to a complete professional health examination and to any further examination procedures that the doctor/practitioner deems necessary. In the interest of integrated patient care, I give permission to providers at CAP Wellness Center and those at CAP Women's health to communicate with each other regarding my treatment and care.

Signature_____ Date: _____