Lactation Visit Intake Form

The Birth Center Holistic Women's Healthcare, LLC

Today's Date______________________

Mother's full name____

Infant's full name____

Infant DOB______________ Infant Birth Weight_____________ Lowest Known Weight & When___________

OB_______________________ Pediatrician__________________________

Delivery: Vaginal or C/S Weeks Pregnant at Delivery?__________ Complications after birth?____________

Complications during pregnancy or at birth?____

Mother's History:

Weight:___________ Height:_____________ Allergies:____

Current Medications:____

Current Birth Control:___________________________ Has your period yet returned? **Y/N**

Do you plan on returning to work or school? **Y/N** If yes, when? _______________________________________

Do you own a Breast Pump? **Y/N** Brand of Breast Pump:____

Do you have a history of:

Y/N Thyroid Disorder **Y/N** Breast Surgery **Y/N** Fertility Treatments

Y/N Anxiety/Depression Current Therapist____

Do you smoke? **Y/N** Do you feel safe at home? **Y/N**

Do you have any dietary restrictions? **Y/N** List restrictions:____

Is this your first child? **Y/N** Ages of older children:____

Did you take a breastfeeding class during this pregnancy? **Y/N**

Did you notice your breasts getting larger during this pregnancy? **Y/N**

Other notable medical history:____

Notable family history:____

Infant Medical History:

Was your infant in the NICU? **Y/N** Why and for how long?____

Has your infant had formula since birth? **Y/N**

Other notable infant history:____

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For LC'S Use: Mother's BP: ___________________

Birth/Recovery:____

____

STS after birth? **Y/N** Latch after birth? **Y/N** How did that feel?_______________________________________

How was breastfeeding in hospital? Help from LC? Nurses?____

____

Discharge weight:_____________________Discharge Feeding Plan:____

L2?_________________ 1st Ped Appt?____

How was feeding at home in early days? ____

How currently feeding baby?____

How often are feeds?_________________ 1 or both breasts?______Waking baby to feed?__________________

Pumping History:____

Main Concerns/Questions:____

Infant Assessment: Upper Lip:____________ Tongue:____________ Palate:_____________ Suck:_____________

Weight: ____________ lbs/oz _____________grams

General Impression____

Breast Assessment: Pain?____

Breasts: Right____ Left____

Nipples: Right____ Left____

Breastfeeding Assessment: Transfer R______________ Transfer L_______________ Nipple Shield Size________

General Impression of BF session____

____

Pumping Assessment: Flange size____________ Output R__________________ Output L____________________

Pre/Post Feed? _____________ Changes Made____

General Impression of Pump session____