North Tampa Breastfeeding Center, LLC Intake Form

BREASTFEEDING QUESTIONNAIRE **TODAY'S DATE**_____ Location of visit? Office____ Home___Other____

Mothers Last Name:_____ **First Name:**_____

DOB_____ **Phone #**_____

Email_____ **Current Address**_____

Infant's Last Name:_____ **Infant's First:** _____**DOB**_____

Birth Weight_____ **Discharge Weight**_____

Where did you deliver?_____ **Who is your pediatrician?** _____

FAMILY HISTORY

DOES ANYONE ON EITHER SIDE OF THE BABY'S FAMILY HAVE ANY OF THE FOLLOWING? (Check)

allergies to foods___milk Intolerence___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? _____ **REGULAR OR IRREGULAR**

WAS THIS YOUR FIRST PREGNANCY? (Check) yes__no___ if no, how many pregnancies?_____**how many**

Children ?_____**Did you breastfeed your other children?**_____

WHICH OF THE FOLLOWING FAMILY PLANNING METHODS ARE YOU USING OR DO YOU PLAN TO USE? (Check)

IUD__birth control shot___barriers___birth control pills___vasectomy___natural family planning___tubes tied___other___ none

WILL YOU BE RETURNING TO WORK? (CIRCLE) yes no

WHEN?_____

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? (Check) 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? (Check)

Biopsy__ lumpectomy__ implants__ breast reduction surgery__ nipple surgery__ nipple piercings__ I&D for abscess__

other_____

_____

DO YOU PRESENTLY *HAVE* OR EVER *HAD* or *EXPERIENCED* ANY OF THE FOLLOWING conditions or surgeries ? (Check)

anemia__allergy/asthma___food allergy___diarrhea (chronic)___heart disease___diabetes___hepatitis___venereal disease__

high blood pressure___liver disease___thyroid disorders___miscarriages___hemorrhoids___cancer___infertility___abortions___

depression/anxiety___sexual abuse___PTSD___abnormal pap smear___eating disorder___kidney/bladder disease or infection__

psoriasis__eczema__yeast infections___tuberculosis___polycystic ovarian syndrome___gastric-bypass___mastitis__

Any Surgeries? _____

other_____

DID YOU HAVE ANY OF THE FOLLOWING DURING THIS PREGNANCY? (Check) *premature labor__PUPS__*

gestational diabetes___high blood pressure___nausea/vomiting-severe___anemia___fever___urinary tract infection___

placenta previa hemorrhage___depression___

other_____

DID YOU HAVE ANY OF THE FOLLOWING DURING THIS LABOR AND DELIVERY? (Check)

premature rupture of membranes___drugs to control pain__drugs to control high blood pressure___epidural___general___

fever__antibiotics___pitocin___hemorrhage-if so how much blood was lost? _____

other_____

WHAT TYPE OF DELIVERY DID YOU HAVE WITH THIS BIRTH? (Check) *vaginal__ emergency c-section___*

planned c-section___

GESTATIONAL AGE OF BABY AT BIRTH?_____WEEKS

DID YOU HAVE ANY OF THE FOLLOWING WITH THIS BIRTH? (Answer) *How long was your labor?___*

episiotomy or tear?___ how long did you push?____breech presentation?____forceps delivery?____vacuum extraction?___

nuchal cord?____meconium present?____deceleration or tachycardia with baby during labor?____

did you get lactation help in hospital?____did baby go to breast 1 hour of birth?____

other_____

DID YOU EXPERIENCE ANY POSTPARTUM COMPLICATIONS? (Check) *urinary/other infections___low blood pressure___*

fever___high blood pressure___excessive bleeding or hemorrhaging___

other_____

DID THE BABY HAVE ANY OF THE FOLLOWING AFTER BIRTH? (Check) *breathing difficulties____high hematocrit___*

low blood sugar___meconium aspiration___jaundice (highest bili level__) photo therapy____baby in NICU____how long?____

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

DIFFICULTIES?_____

HAVE YOU USED ANY BREASTFEEDING SUPPLIES OR PUMPS?_____Type of PUMP_____
HAS YOUR BABY BEEN SUPPLEMENTED WITH ANY OF THE FOLLOWING? *NONE___water____formula*

expressed breastmilk____TYPE OF FORMULA_____

IF SO, HOW WAS THE BABY SUPPLEMENTED? *feeding tube____finger feeding___cup feeding____bottle___TYPE*

of BOTTLE_____

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?

(Check) *less than 6 times___less than 8 times___8-10 times___more than 12 times*

ARE YOU EXPERIENCING ANY OF THE FOLLOWING? (Check) *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_____
_____

IS THE BABY CONTENT OR SLEEPING BETWEEN FEEDINGS? (Check) *never___occasionally___often___*

WHAT IS THE LONGEST TIME YOUR BABY HAS GONE BETWEEN FEEDINGS?

DAY:_____

NIGHT:_____

WHO DECIDES WHEN THE FEEDING IS OVER? (Check) *Mother___ or Baby___ HOW LONG DOES BABY NURSE AT*

BREAST?_____ ONE BREAST OR BOTH BREAST

HOW MANY MONTHS DO YOU WISH TO BREASTFEED YOUR BABY? 1 MONTH 2-3 MONTHS 3-6 MONTHS

6-9 MONTHS 12 MONTHS LONGER THAN 12 MONTHS

ARE YOU PRESENTLY USING A PACIFIER? yes or no

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

IBCLC ONLY:
(Brief mom dx)
_____
_____
_____

(Brief baby dx)
_____
_____
_____

North Tampa Breastfeeding Center, LLC

Consent for Services:

- Consultation may include assessment of the mothers breasts, oral assessment, feeding observation of the mother and baby breastfeeding, analysis of data relating to the breastfeeding situation, techniques for improving breastfeeding, and sometimes use of breastfeeding equipment.
- The purpose of the breast examination is for assessment purposes only and is not for evaluating breast masses.
- The lactation specialist may make referrals on behalf of me and my baby. If a referral is given with physician recommendations, this is a recommendation only and I may choose my own healthcare provider.
- Program staff at NO time will promote or support the use of alcohol, drugs or smoking during lactation.
- If NTBC holds a breastfeeding support group, I may attend at anytime for additional support.
- Maternal Instincts may contact me through phone, text, or email for follow-up breastfeeding support.
- Photos of my child's mouth (for referral purposes) and/or support groups (for internal purposes) may be taken. I can tell one of the lactation specialists if I do not want to be a part of any photography. _____ Initial

I have had the Participant Rights and Responsibilities & Summary of Privacy Practices explained to me and received a copy.
_____ Initial

I authorize the Lactation Consultant to perform a breast examination as necessary and also an assessment of the baby feeding.

Participant Signature: _____Date: _____ Staff Signature:_____ Date: _____