



## LACTATION SERVICES HISTORY FORM

Mother's Name: \_\_\_\_\_ Baby's Name: \_\_\_\_\_ DOB \_\_\_\_\_

Father's Name: \_\_\_\_\_ Address \_\_\_\_\_

Phone # \_\_\_\_\_ or \_\_\_\_\_

### Birth History

OB/Midwife \_\_\_\_\_ Phone #: \_\_\_\_\_

Pediatrician \_\_\_\_\_ Phone #: \_\_\_\_\_

Type of Delivery: \_\_\_ Vaginal \_\_\_ Cesarean \_\_\_ Vacuum Extraction \_\_\_ Forceps

Medications Received During Hospital Stay:

\_\_\_ Pitocin \_\_\_ Narcotics \_\_\_ Epidural \_\_\_ Spinal \_\_\_ Antibiotics

Difficult delivery? \_\_\_\_\_

### Mother's Medical History

Current medical conditions? \_\_\_\_\_

Current medication? \_\_\_\_\_

Do you smoke? \_\_\_ amount \_\_\_\_\_ Vaginal bleeding? Y or N If yes, Light Medium Heavy

Do you have other children? \_\_\_\_\_ Number \_\_\_\_\_ Age(s) \_\_\_\_\_

Months/years previous children were breastfed \_\_\_\_\_ Problems \_\_\_\_\_

Diabetes Y or N \_\_\_ Gestational \_\_\_ Insulin Dependent

Infertility \_\_\_ Thyroid Disorders \_\_\_ Other \_\_\_\_\_

Breast Surgery (Please specify) \_\_\_\_\_

Baby Blues/Anxiety/Depression \_\_\_\_\_

Breast changes during pregnancy? Y or N / Inverted nipples? Y or N \_\_\_\_\_

Family Allergies? \_\_\_\_\_

Feeding Goals: Breast \_\_\_\_\_ Bottle \_\_\_\_\_ Combo \_\_\_\_\_

RN Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**History of Baby's Birth/Hospital Feeding/Medical Concerns**

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Baby's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gestation (Weeks) \_\_\_\_\_

Birth Weight \_\_\_\_\_ Discharge Weight \_\_\_\_\_ Discharge Date \_\_\_\_\_ (Baby)

Subsequent Weight Checks:

Baby's Age \_\_\_\_\_ Weight \_\_\_\_\_

Age \_\_\_\_\_ Weight \_\_\_\_\_

Age \_\_\_\_\_ Weight \_\_\_\_\_

In the hospital, did your baby need Supplements? Y or N

Breast Milk \_\_\_\_\_ Formula \_\_\_\_\_ Amount \_\_\_\_\_ Frequency \_\_\_\_\_ Method \_\_\_\_\_

Infant admitted to Neonatal ICU? Y or N Days \_\_\_\_\_ Reason \_\_\_\_\_

Medical concerns/Medications \_\_\_\_\_

**Breast Health**

Do you have any of the following problems with your breasts or breastfeeding?

\_\_\_ Sore Nipples \_\_\_ Cracked/bleeding nipples \_\_\_ Inverted

\_\_\_ Engorgment \_\_\_ Plugged ducts \_\_\_ Redness \_\_\_ Infection

Currently Pumping? Y or N Frequency \_\_\_\_\_ Amount \_\_\_\_\_

**Current Feedings**

Frequency \_\_\_\_\_ Duration \_\_\_\_\_

Behavior \_\_\_\_\_ Latching \_\_\_\_\_

Positions= Football \_\_\_\_\_ Cross Cradle \_\_\_\_\_ Cradle \_\_\_\_\_ Side Lying \_\_\_\_\_

Supplementing with formula or expressed breast milk? \_\_\_\_\_

Frequency \_\_\_\_\_ Type \_\_\_\_\_

Amount \_\_\_\_\_ Reason \_\_\_\_\_

Wet Diapers= How many \_\_\_\_\_ per 24 hrs. Color \_\_\_\_\_ Crystals \_\_\_\_\_

Poopy Diapers= How many \_\_\_\_\_ per 24 hrs. Color \_\_\_\_\_ Amount \_\_\_\_\_

Vitals (optional) Temp \_\_\_\_\_ Heart \_\_\_\_\_ Resp. \_\_\_\_\_

Notes \_\_\_\_\_

*RN Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_