**PATIENT INFORMATION**

Mother's Name: _____ Mother's Age: _____ Mother's DOB: _____

Baby's Name: _____ Baby's Age: _____ Baby's DOB: _____

Father's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

What is the reason for the consult today?

_____

_____

_____

_____

What has been done to rectify the problem to date?

_____

_____

_____

_____

**CONSENT FOR LACTATION CONSULTATION**

I understand that the consultation may include a visual and physical examination of my breasts and my baby's mouth. I understand that the advice, and educational information, supplied by the consultant is to help me learn how to successfully breastfeed my baby. I understand, however, that no guarantee is being made that I will be able to successfully breastfeed my baby. An Internationally Board Certified Lactation Consultant (IBCLC) conducts visits. I understand that any medical care or questions regarding medical care will not be provided. The consultant will supply a receipt that can be submitted to my health insurance company. This consult may or may not be covered by my health insurance company. All correspondence regarding coverage is the responsibility of the patient. University Medical Center of Princeton at Plainsboro (UMCPP) will not supply information to the health insurance company nor correspond on behalf of the patient.

The lactation consult is scheduled for one hour. It is very helpful if the consultant can evaluate a breastfeeding session at that time. The consultant may conduct a pre and post feed weight check.

Signature: _____ Date: _____

**Mother's Medical History**

Are you currently being treated for any medical condition? If so, please explain:

_____

_____

Are you currently taking any medication? If so, please list name, amount, duration and reason for medication:

_____

_____

Do you smoke? ☐ Yes ☐ No Frequency: _____

Has your vaginal bleeding stopped? ☐ Yes ☐ No

If not, describe (ex. heavy and red, light and brownish) _____

Has your period returned? _____

Do you have other children? ☐ Yes ☐ No If yes, how many?_____ Age(s)_____

Number of months/years previous children were breastfed: _____ Any problems during that time? ☐ Yes ☐ No

Are you using birth control pills? ☐ Yes ☐ No Type: _____Progestin only _____Progestin/Estrogen

Have you ever had any trauma, burns or radiation to your breasts? ☐ Yes ☐ No

Do you have a history of any of the following?

____Ankyloglossia *(tongue-tie)* does the baby's father or other close relative have a tongue-tie?

____Infertility

____History of low progesterone or miscarriages

____Diabetes

____PCOS *(polycystic ovarian syndrome)*

____ Raynaud's Syndrome

____Thyroid Disorder *(Please specify:* _____*)*

____Skin Condition (ex. eczema, psoriasis)

____ Breast Surgery *(Please specify:* _____*)*

____ Depression/Anxiety/Other Mental Health Disorder *(Please specify:* _____*)*

**PREGNANCY**

During Pregnancy, were you diagnosed with any of the following?

_____Anemia

_____Yeast Infection

_____Non-Insulin Dependent Gestational Diabetes

_____PIH *(Pregnancy Induced Hypertension)*

_____Insulin Dependent Gestational Diabetes

Did you notice breast changes during pregnancy? *(Breast enlargement, darkening of areola/nipple area)* ☐ Yes ☐ No

Were there any medical problems associated with this pregnancy? _____

**MOTHER'S LABOR HISTORY**

Delivery Hospital: _____

Pediatrician: _____

Type of Delivery: ☐ Vaginal ☐ Cesarean ☐ Vacuum Extraction ☐ Forceps

Medications received during hospital stay:

☐ Pitocin ☐ Magnesium Sulfate ☐ Narcotics ☐ Epidural ☐ Spinal ☐ General Anesthetic

☐ Antibiotics for Group B Strep ☐ Antibiotics for any other reason during or after labor (*Reason*_____)

Were there any problems associated with this delivery? _____

**BABY'S MEDICAL HISTORY: Hospital History**

Gestation (weeks): _____ How many days was baby in the hospital before discharge? _____

Birth Weight: _____ Discharge Weight:_____

Subsequent Weight Checks:

Age: _____ Weight: _____

Age: _____ Weight: _____

Age: _____ Weight: _____

Age: _____ Weight: _____

How soon after delivery, did the baby breastfeed? _____

In the hospital, how many times did the baby breastfeed in 24 hours?

☐ Less than 8 times ☐ 8 – 12 times (every 2-3 hours) ☐ More than 12 times

Did you have any of the following problems with your breasts or with breastfeeding while in the hospital?

☐ Sore nipples (has this resolved? ☐ Yes ☐ No)

☐ Sleepy baby ☐ Latching difficulties ☐ Engorgement

Was the baby given a pacifier in the hospital? ☐ Yes ☐ No

Does the baby currently use a pacifier? ☐ Yes ☐ No

Did your milk come in between day 3 and 5? ☐ Yes ☐ No

Was the baby exclusively breastfed or did the baby receive supplementation? _____

If the baby was supplemented, did the baby receive formula or expressed breast milk? _____

What was the reason for the supplementation? _____

Was the baby supplemented using a bottle or another feeding method? _____

Were you pumping your breasts in the hospital? ☐ Yes ☐ No

Reason: _____

Do you have a pump at home? ☐ Yes ☐ No Brand and type: _____

Did the baby room in and breastfeed at night or was the baby sent to the newborn nursery to be bottle-fed?

☐ Roomed in ____ out of ____ nights ☐ Bottle fed in nursery ____ out of ____ nights

Was in the baby in the Neonatal Intermediate Care (NICU) nursery? _____

If yes, why was the baby admitted to NICU: _____

How long was the baby in the NICU? _____

How was the baby fed in the NICU? _____

In the hospital, was the baby treated for any of the following:

☐ breathing problems ☐ hyperbilirubinemia (jaundice) ☐ hypoglycemia (low blood sugar)

☐ fever ☐ meconium aspiration

If so, how was the baby treated? _____

Were you informed of any other health issues pertaining to the baby?

_____

Is the baby currently being treated for any health conditions? If so, please list condition and any medications the baby is taking: _____

**BREASTFEEDING HISTORY**

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

☐ Cracked/bleeding nipples

☐ Engorgement

☐ Nipple pain *(describe*_____*)*

☐ Breast pain *(describe*_____*)*

☐ Baby fussy at breast *(describe*_____*)*

☐ Baby always seems hungry ☐ Baby pulls at breast

☐ Baby falls asleep quickly at breast ☐ Overactive let down at beginning of feed

Since the baby's birth, have you been diagnosed with any of the following?

☐ Mastitis ☐ Plugged Ducts ☐ Bacterial Infection (in nipple or breasts)

☐ Other *(describe*_____*)*

Do you wear an underwire bra? ☐ Yes ☐ No Do you wear breast pads? ☐ Yes ☐ No

**CURRENT FEEDINGS**

How many times in 24 hours are you currently breastfeeding your baby?

☐Less than 8 times ☐8-12 times ☐More than 12 times

Is the baby receiving any supplementation? ☐ Yes ☐ No

If Yes, is the baby receiving Expressed Breast Milk, formula or a combination?

Approximately how much supplementation is the baby taking in a 24 hour period? (Please mark below)

Expressed breast milk_____oz/24 hours Formula _____oz/24 hours

Are you currently pumping? ☐ Yes ☐ No

How many times do you pump in a 24 hour period? _____

_____number of minutes per pumping session _____oz. average amount yielded per session

How long does the baby nurse on each breast? _____

Who typically ends the feeding? ☐mom ☐baby

On average, how many wet diapers does your baby have in 24 hours? _____

On average, how many soiled diapers does your baby have in 24 hours? _____

Does the baby spit up? ☐Never ☐Occasionally ☐Often

How would you describe your baby's temperament? _____

What soothing techniques help your baby? _____

**Family History**

Does anyone in the baby's family have any allergies? Please describe_____

Has anyone in the family had a recent illness? ☐ Yes ☐ No

**Breastfeeding Plans**

What is your long-term breastfeeding plan? _____

Are you returning to work? ☐ Yes ☐ No Status: ☐part time ☐ full time

Occupation/Employer: _____

Breastfeeding plans while working: _____

*Thank you. Please print this out and bring it with you to the consult.*