Christine Fischer-Rothman, PhD, IBCLC - Phone 617 447 8411

BREASTFEEDING QUESTIONNAIRE

TODAY'S DATE ___________________

MOTHER'S NAME ___________________________________ DOB ____ / ____ / ____
INFANT'S NAME _____________________________________ DOB ____ / ____ / ____

FAMILY HISTORY

DOES ANYONE ON EITHER SIDE OF THE BABY'S FAMILY HAVE ANY OF THE FOLLOWING?
□ allergies to foods □ 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? ____________

Menstrual Periods? □ REGULAR □ IRREGULAR

Youngest age started on birth control pills? _____________________

WAS THIS YOUR FIRST PREGNANCY? □ YES □ NO If no, how many pregnancies? ____________

How many children? ____________ Did you breastfeed your other child(ren)?_______________

Longest previous breastfeeding experience? ________________ number of months

WHICH OF THE FOLLOWING FAMILY PLANNING METHODS ARE YOU USING OR DO YOU PLAN TO USE?
□ norplant □ birth control shot □ barriers □ birth control pills □ vasectomy
□ tubes tied □ natural family planning/rhythm □ none

WILL YOU BE RETURNING TO WORK? □ YES □ NO

Age baby will be when returning to work? _________________

FULL TIME?____________PART TIME_____________

Type of job? ____

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?

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□ 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?

□ lumps

□ fibrocystic disease

□ biopsy – if biopsy, year done: ___________ □ Right breast or □ Left breast

Nipple or areola involved in biopsy? - □ YES □ NO

□ IMPLANTS – If implants, year done: _________ Incision location? □ areola □ under side of breast

Implant located? □ under muscle □ over muscle Cup size of breast before implant? _________ Cup size after? ________

Where breast same size before implants? □ YES □ NO

Explain?____

□ Breast REDUCTION SURGERY – If reduction, year done: ____________ If reduction, areola relocated: □ YES □ NO

Other

NIPPLE PROBLEMS: □ piercing □ inverted □ flat

Other

DO YOU PRESENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? □ anemia □ heart disease □ allergy/asthma □ diarrhea (chronic) □ herpes □ abortions □ diabetes □ hepatitis □ cancer □ venereal disease □ high blood pressure □ liver disease □ thyroid disorders □ miscarriages □ hemorrhoids □depression □ sexual abuse □ abnormal pap smear □ constipation □ eating disorder □ yeast infections □ kidney/bladder disease or infection □ tuberculosis □ polycystic ovarian syndrome

□ infertility – If infertility treatments were used, what treatments:

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DID YOU HAVE ANY OF THE FOLLOWING DURING THIS PREGNANCY? □ **premature labor**
□ **gestational diabetes** □ **high blood pressure** □ **nausea/vomiting-severe** □ **anemia** □ **fever**
□ **urinary tract infection** □ **placenta previa** □ **preeclampsia** □ **low amniotic fluid**
Other

MEDICATIONS - If medications during pregnancy, name of medication and trimester used:

DID YOU HAVE ANY OF THE FOLLOWING DURING THIS LABOR AND DELIVERY?
□ **premature rupture of membranes** □ **epidural** □ **pitocin** □ **preeclampsia** □ **fever**
□ **high blood pressure** □ **antibiotics**
Drugs to control pain – name:____

Drugs to control high blood pressure – name: ____________________________________

Drugs to induce or speed labor – name: ____________________________

Hemorrhage - if so how much blood was lost ____________________ **pints**

LABOR - ___________ **hours active labor** _________ **hours pushing stage**

Other

WHAT TYPE OF DELIVERY DID YOU HAVE WITH THIS BIRTH?
□ **vaginal** □ **emergency c-section** □ **planned c-section**
GESTATIONAL AGE OF BABY AT BIRTH? ______________ **WEEKS (weeks pregnant)**

DID YOU HAVE ANY OF THE FOLLOWING WITH THIS BIRTH? □ **episiotomy or tear**
□ **tear that involved the rectum (3rd or 4th degree tear or laceration)** □ **breech presentation**
□ **forceps** □ **vacuum extraction**

Other

DID YOU EXPERIENCE ANY POSTPARTUM COMPLICATIONS?
□ **urinary/other infections** □ **low blood pressure**
□ **high blood pressure** **What was highest or lowest BP?** __________________

Other

DID THE BABY HAVE ANY OF THE FOLLOWING AFTER BIRTH?
□ **taken to NICU -** ______**hours -** _______ **days**
□ **breathing difficulties** □ **high hematocrit** □ **low blood sugar** □ **low saturation**
□ **meconium aspiration** □ **irregular heart rate**

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□ **jaundice - highest bilirubin level ____________ □ deep suctioning**
□ **IV-fluids or medications – If medications, name or type of medication:**

WHAT WAS YOUR BRA SIZE: BEFORE PREGNANCY _________ NOW _________
CHANGES IN BREAST SINCE THE BIRTH of BABY?
□ **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 PUMP? □ **YES** □ **NO**

WHY?____

TYPE of PUMP(s) ____

HAVE YOU USED OTHER BREAST FEEDING SUPPLIES? □ **Nipple Shield – size _____mm**
□ **Hydrogel pads** □ **Supplemental Nursing System** □ **Hot or Cold packs**

HAVE YOU USED ANY NIPPLE CREAMS OR OINTMENTS? □ **Lansinoh** □ **MotherLove Nipple Cream** □ **Medela Tender Care** □ **EarthMama Natural Nipple Butter** □ **Over-the-counter All Purpose Nipple Ointment Recipe** □ **Jack Newman Prescription-All Purpose Nipple Ointment Recipe**
Other____

HAS YOUR BABY BEEN SUPPLEMENTED WITH ANY OF THE FOLLOWING?
□ **expressed breastmilk** □ **donor breastmilk** □ **water** □ **formula**
IF FORMULA, NAME TYPE OF FORMULA ____

IF BABY RECEIVED SUPPLEMENT, HOW WAS THE BABY SUPPLEMENTED?
□ **feeding tube** □ **finger feeding** □ **cup feeding** □ **bottle** □ **IV fluids**
TYPE of BOTTLE ____

IF SUPPLEMENTS HAVE BEEN USED, HOW OFTEN IN PAST 24 HOURS?
____
HOW MUCH PER FEEDING? _____________ oz or ml
At what age was supplementation started?____________________

HOW MANY TIMES IN THE PAST 24 HOURS HAVE YOU BREASTFED YOUR BABY?
□ **less than 6 times** □ **less than 8 times** □ **8-10 times** □ **more than 12 times**

ARE YOU EXPERIENCING ANY OF THE FOLLOWING? □ **latch-on difficulties** □ **engorgement**
□ **sore nipples** □ **preference for one breast? -** □ **Right or** □ **Left** □ **baby not interested**
□ **cracked/bleeding nipples** □ **breast pain** □ **sleepy baby/hard to wake**
□ **feeling that there is not enough milk** □ **baby crying excessively** □ **baby always seems hungry**

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Other

IS THE BABY CONTENT and/or SLEEPING BETWEEN FEEDINGS?
□ occasionally □ often □ never

BABY'S DISPOSITION IS?
□ mostly content with some alert active wakeful periods □ mostly sleeping with few alert active wakeful periods □ sleeps but when awake is never content □ when awake displays frantic behavior

WHAT IS THE LONGEST TIME YOUR BABY HAS GONE BETWEEN FEEDINGS?
DAY: _____ hours NIGHT: _____ hours

WHO DECIDES WHEN THE FEEDING IS OVER? □ Mother or □ Baby

HOW LONG DOES BABY NURSE AT BREAST DURING A FEEDING SESSION? ____________ total minutes both breast

WHEN BABY FEEDS AT BREAST: □ ONE BREAST per feeding □ BOTH BREAST per feeding □ Mostly both breast per feeding □ About half feeds with one breast and half with 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 □ NO

HOW OFTEN IS PACIFIER USED? □ Less than one hour per 24 hours □ 2 - 4 hours per 24 hours □ Anytime baby is awake □ Anytime baby is sleeping

ARE FEEDINGS? □ Demand (as baby request) □ Scheduled
IF scheduled, what is the schedule like:
____

IN THE PAST 24 HOURS, HOW MANY?

WET DIAPERS _________________ STOOLS _______________________

WERE THE STOOLS BIGGER THAN A TABLESPOON? □ YES □ NO □ Some but not all IN YOUR OWN WORDS DESCRIBE ANY FEEDING PROBLEMS THAT CONCERN YOU:

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