BREASTFEEDING QUESTIONNAIRE

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? ______________

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?
□ 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? __________
Were breast same size before implants? □ YES □ NO Explain? ______________________________________________________________________________________
□ Breast REDUCTION SURGERY – If reduction, year done: __________ If reduction, areola relocated: □ YES □ NO
Other ______________________________________________________________________________________

NIPPLE CONCERNS: □ 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 □ constipation
□ autoimmune disease (describe below) □ depression □ sexual abuse □ abnormal pap smear □ eating disorder
□ kidney/bladder disease or infection □ Raynaud’s Phenomenon □ yeast infections □ polycystic ovarian syndrome
□ infertility – If infertility treatments were used, what treatments: ______________________________________________________________________________________
Other ______________________________________________________________________________________
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 □ high blood pressure □ fever □ 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
Other _______________________________________________________

LABOR - _______ hours active labor ________ hours pushing stage

WHAT TYPE OF DELIVERY DID YOU HAVE WITH THIS BIRTH? □ vaginal □ emergency c-section □ planned c-section

GESTATIONAL AGE OF BABY AT BIRTH? _____________ WEEKS

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

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 All Purpose Nipple Ointment Recipe
Other _______________________________________________________

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HAS YOUR BABY BEEN SUPPLEMENTED WITH ANY OF THE FOLLOWING? □ expressed breastmilk □ water □ formula □ type of formula ____________________________

IF BABY RECEIVED SUPPLEMENT, 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? □ 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 □ feeling that there is not enough milk □ baby crying excessively □ baby always seems hungry □ baby hard to wake

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? □ 3-6 MTHS □ 6-9 MTHS □ 12 MTHS □ LONGER THAN 12 MTHS

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

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

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: