Hope Breastfeeding Support – Initial Information

Mom's Name: ____________________________Baby's Name: _____________________Dad's Name: ________________

Address: ____City: ________________State: ________Zip: __________

Phone: ____________________ Email: _______________________Maternity Provider: ___________________________

Delivery Site: ____________________________ Type of Delivery __________________NICU______________________

Delivery Complications: __________________________________Health Issues?__________________________________

Do you smoke? ___Thyroid Problems?___Diabetes (including Gestational) ___ PCOS___.Surgeries?_______________________

High blood pressure (including gestational)?__________Depression, Anxiety, Chronic Pain? ________________________

Any allergies? ____________________________Baby's Father?____

Medications: ____Vitamins/Herbs_________________________________

Did your breast size change during pregnancy?___Since delivery?___Have you experienced engorgement? _____

Have you had any breast or nipple surgery? Y ☐ N ☐ What type and when? ______________________________

Other Children: No. __________Breastfed No. ________ Any problems ______________________________________

Rate Breastfeeding Pain 1☐ 2 ☐ 3☐ 4 ☐ 5☐ 6 ☐7 ☐ 8 ☐ 9☐ 10 ☐ Pain Goal for Breastfeeding __________

Date of Delivery: ____________Baby's Birth Weight: ______ Discharge Weight _____Last Weight_______Date:_________

How many breastfeedings per day? ____ Do you use a nipple shield? Y_N_What size? ______How long?______________

Pumping: Y☐ N ☐ With what: _____________ How many times daily___How much per pump/per day: _____________

When did you start pumping? _________Are you using a pacifier? ______What kind and how often? _________________

Feeding baby with a bottle: Y ☐ N ☐ What kind of bottle? _______How much? _______ How often_________________

What do you put in the bottle? Expressed breast milk____Donor milk ____Formula: Type ________________________

What are your breastfeeding goals? ____

Any special issues you would like addressed during our consult? ____

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How long do you plan to breastfeed?_______________________ Returning to work?__________When?______________

Current Problems: ____

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How many wet diapers last 24 hours? ___How many dirty diapers?________Color? _______________________________

When was baby last fed? ____________Breastfed? Y_N_. If supplemented, amount, type and device _____________

Completed by ____ Date: ___________________________________

Client Signature