Healthy Babies Happy Families
Breastfeeding Consultation Initial Visit Intake Form

Date:

Mother's Name: _____ Age: _____ # of Pregnancy ____ # of children / ages _____

Previous Breastfeeding: NA / Yes / No Duration:_____ Complications (if any):

Pregnancy History: ☐Normal ☐Complications Specify_____:

Breast changes during pregnancy ☐Yes ☐ No Pre pregnancy Bra size _____ Current Bra size _____

Any breast surgery? ☐Yes ☐No Specify _____ Year_____

Labor:☐Normal ☐Prolonged ☐Induction Epidural: Yes / No Delivery: ☐Vaginal ☐C/S Reason:

Place of Delivery:

Postpartum:☐Normal ☐Complications Specify:

Any Health Issues:☐No ☐Yes Specify:
☐Diabetes ☐High Blood Pressure ☐Hypothyroidism ☐Infertility ☐PCOS

Allergies: ☐No ☐Yes Specify:

Current Medications:

Baby's Name:_____DOB: _____ Pregnancy weeks _____ M / F Birth Weight: _____

Neonatal Complications:☐No ☐Yes Specify:

Baby's Date of Discharge: _____ Discharge Weight: _____ (% weight loss____)

Baby's Follow up Weight _____ Date _____ Weight _____ Date _____

Breastfeeding History: Initial feeding:☐Breast ☐Bottle ☐Other (specify)

Explain BF experience in the Hospital: ☐exclusively breastfed ☐mostly breastfed ☐some breastfeeding ☐unable to breastfeed
Complications If any:

Pumping:☐No ☐Yes Type of Pump: Amount expressed / session:
How many pumping sessions /24 hours?

Reason for Consultation: (check all that apply)

☐ Supervision of Lactation (Z391)
☐ Sore Nipples (O9213)
☐ Engorgement (O9229)
☐ Flat Nipple (O9203)
☐ Inverted Nipples (N6451)
☐Yeast infection (B3789)
☐ Breast Abscess (O9112)
☐ Low Milk supply (O925)
☐Breast/Nipple Infection (O9102)
☐ Mastitis (O9123)
☐ Induration of Breast (N6451)
☐Plugged Ducts
☐ Latch on Difficulty (P929)
☐ Weight gain problem (P926)
☐ Abnormal stool (R195)
☐Fussy baby (R6812)
☐Gassy / Colicky (R1083)
☐Tongue tie (Q381)
☐Other Feeding Problem (P928)
☐Spit up / Vomiting (P9209)
☐ Crying (R6811)
☐Other (specify)

Infant Feeding History:
# of feeding past 24 hrs: Directly at Breast _____ Wet diapers/24hrs: _____
Stools/24hrs: _____

Supplements: Expressed breastmilk: amount each feeds: _____ How many /24 hours_____

Formula: amount each feeds: _____ How many /24 hours _____