TriHealth Breastfeeding Care Center--Breastfeeding and Lactation History

Please bring this completed form with you to your scheduled appointment:

Mother's Name______________________________________Age______Today's Date________

Baby's Name____Date of Birth_________

Baby's gestational age at birth_____Age Today______ Hospital where baby born_____________

Partner's Name___________________Name of Person with Mom and Baby today____________
(If other than partner)

Address____City______Zip_______________

Home Phone_____________________Work Phone_______________Cell Phone___________

Mother's OB/PCP____________________________OB/PCP phone:_______________________

Baby's Ped/PCP_____________________________Ped/PCP phone:______________________

Reason for Visit

Please check all that apply:

☐ Breastfeeding painful
☐ Breastfeeding difficult for baby
☐ Baby spitting up
☐ Mom engorged
☐ Mom has poor milk production
☐ Difficulty latching on
☐ Baby sleepy
☐ Baby tongue-tied
☐ Mom has nipple damage
☐ Baby has slow weight gain
☐ Baby fussy at breast
☐ Baby jaundiced
☐ Mom has pain when pumping
☐ Mom has mastitis
☐ Other, please describe:____

Breastfeeding History

Other children, ages, duration of breastfeeding____

Previous breastfeeding difficulties:____

Others in family who breastfed: ☐ Mother ☐ Sister(s)

Mother's Health History

Recent illness/injury/surgery other than birth ____

Chronic Ilnesses_______________Current Medications_________________________________

Breast surgery: ☐ No ☐ Yes If yes, explain____

Please check all that apply:

☐ Depression
☐ Hypothyroid
☐ Infertility
☐ Yeast infections
☐ Difficulty producing milk
☐ Hyperthyroid
☐ Excessive blood loss (during birth or any time)
☐ Polycystic Ovary Syndrome
☐ Eating Disorder
☐ Diabetes
☐ Bariatric Surgery
☐ High blood pressure

Use of: ☐ Tobacco ☐ Alcohol ☐ Recreational Drugs ☐ Caffeine
Allergies in family: ☐ Mother ☐ Father ☐ Siblings Please list allergies:______________________

Pregnancy/Birth History

Number of Pregnancies ______ Length of this pregnancy_____
Breast growth during pregnancy: ☐ Yes ☐ No

Type of birth ☐ Vaginal ☐ Cesarean ☐ Forceps ☐ Pre-eclampsia ☐ Induced
☐ Epidural Medications at birth:_______________________________________

Baby was: ☐ Full-term ☐ Preterm APGARs_______

Birth Weight_____ Lowest weight at hospital discharge_____

Weight at one week_____ Current weight_______

If your baby has had any surgeries, please describe______________________________________

If your baby is taking any medications, please list along with reasons for taking medications:
____

Current Pattern of Breastfeeding

Please check all that apply:
Exclusive Breastfeeding ☐ Yes ☐ No Number breastfeedings per day _________________

Average length of feeding ____Length of time between feedings ________Longest Sleep _______

Formula feedings ☐ Yes ☐ No If yes, number of feedings__________Amount given_______

Number of urines in 24 hours__________Number of stools in 24 hours __________________

Color of stools ________________ Medications Baby is taking/reason_______________________

Pacifier use: ☐ Yes ☐ No If yes, please describe type and frequency_______________

If you are pumping breast milk, what type of pump are you using?__________________________

If baby unable to breastfeed or if giving supplements, please check all that apply. Breast milk or formula given in:
☐ bottle ☐ syringe ☐ cup ☐ nursing supplementer (SNS) ☐ finger feeder

Mother's Breastfeeding Goals ____

Comments ____

Mother's Signature____

The Breastfeeding Care Center is located at:

Bethesda North Hospital
10500 Montgomery Road
2nd Floor Perinatal Programs
Cincinnati, OH 45242

To call the Breastfeeding Care Center/Helpline: 513-862-7867 option 3

Please call at least 24 hours in advance if you need to reschedule or cancel your appointment.