

BREASTFEEDING QUESTIONNAIRE



TODAY'S DATE _____

MOTHER'S NAME _____ DOB _____

INFANT'S NAME _____ DOB _____

IN YOUR OWN WORDS DESCRIBE ANY FEEDING PROBLEMS THAT CONCERN YOU:

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 thyroid disease
other _____

WHAT AGE WERE YOU WHEN YOU HAD YOUR FIRST MENSTRUAL PERIOD? _____ REG IRREG

WAS THIS YOUR FIRST PREGNANCY? Yes No If no, how many pregnancies? _____
How many children? _____ Did you breastfeed your other children? _____ How long? _____

WHICH OF THE FOLLOWING FAMILY PLANNING METHODS DO YOU PLAN TO USE? norplant
birth control shot barriers birth control pills vasectomy natural family planning tubes tied LAM none

WILL YOU BE RETURNING TO WORK? Yes No WHEN _____ FULL TIME _____ PART TIME _____

Anyone in your home smoke? Yes No Are you a vegetarian? Yes No Do you drink? Yes No

PREGNANCY AND BIRTH HISTORY

DOES YOUR BABY HAVE ANY KNOWN HEALTH PROBLEMS? _____

IS YOUR 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?
biopsy lumps implants breast reduction surgery nipple problems piercing
other _____

DO YOU PRESENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?
allergy/asthma heart disease anemia depression diabetes venereal disease high blood pressure
thyroid disorders miscarriages infertility abortions abnormal pap smear eating disorder
kidney/bladder infectio yeast tuberculosis polycystic ovarian syndrome sexual abuse
other _____

DID YOU HAVE ANY OF THE FOLLOWING DURING THIS PREGNANCY? premature labor gestational diabetes
high blood pressure nausea/vomiting-severe anemia urinary tract infection medications
other _____

DID YOU HAVE ANY OF THE FOLLOWING DURING THIS LABOR AND DELIVERY?
premature rupture of membranes drugs to control pain drugs to control high blood pressure epidural fever
antibiotics drugs to induce or speed labor-if so how long was this administered? _____ hours
Hemorrhage-if so how much blood was lost _____ pints,

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? total labor longer than 30 hours
episiotomy or tear pushing stage longer than 2 hours tear that involved the rectum (3rd or 4th degree laceration)
forceps delivery vacuum extraction breech presentation
other _____

DID YOU EXPERIENCE ANY POSTPARTUM COMPLICATIONS? urinary/other infections low blood pressure
high blood pressure excessive bleeding or hemorrhaging transfusion
other _____

DID YOUR BABY HAVE ANY OF THE FOLLOWING AFTER BIRTH? breathing difficulties high hematocrit
low blood sugar meconium aspiration jaundice (highest bili level) _____
other _____

WHAT WAS YOUR BRA SIZE? BEFORE PREGNANCY _____ NOW _____
CHANGES SINCE THE BIRTH? hard/engorged 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 SUPPLIES? _____ PUMPS _____ TYPE OF PUMP _____

HAS YOUR BABY BEEN SUPPLEMENTED WITH ANY OF THE FOLLOWING? artificial milk expressed breastmilk
TYPE OF ARTIFICIAL INFANT MILK (FORMULA): _____

IF SO, HOW WAS THE BABY SUPPLEMENTED? SNS finger feeding cup feeding bottle haberman p-syringe
TYPE OF BOTTLE NIPPLE _____

IF SUPPLEMENTS HAVE BEEN USED, HOW OFTEN IN PAST 24 HOURS? _____
HOW MUCH PER FEEDING? _____

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

ARE YOU EXPERIENCING ANY OF THE FOLLOWING? latch-on difficulties engorgement sleepy baby
sore nipples preference for one breast baby not interested cracked/bleeding nipples breast pain
feeling that there is not enough milk baby crying excessively baby always seems hungry
other _____

IS THE BABY CONTENT OR SLEEPING BETWEEN FEEDINGS? never occasionally often

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

WHO DECIDES WHEN THE FEEDING IS OVER? Mother Baby

HOW LONG DOES BABY NURSE AT BREAST? _____ ONE BREAST BOTH BREASTS

ARE YOU PRESENTLY USING A PACIFIER? Yes No HOW OFTEN? _____

IN THE PAST 24 HOURS, HOW MANY? WET DIAPERS _____ STOOLS _____
WERE THE STOOLS BIGGER THAN A TABLESPOON? Yes No

HOW LONG DO YOU WISH TO BREASTFEED YOUR BABY?
3-6 MONTHS 6-9 MONTHS 12 MONTHS LONGER THAN 12 MONTHS