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Breastfeeding with Grace
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INTAKE FORM

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 _____TYPEOF 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