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INTERNATIONAL BOARD CERTIFIED LACTATION CONSULTANTS

INTAKE HISTORY

PAGE ONE

Mother's Name _____

Consultation Date _____

Problem: ❑ nipple pain ❑ latch ❑ breast refusal ❑ undersupply ❑ oversupply ❑ slow weight gain ❑ multiples ❑ other_____

Others consulted about this breastfeeding issue: ❑ LC ❑ doctor ❑ nurse ❑ LLL ❑ friend ❑ family ❑ doula ❑ other _____

Ultimate breastfeeding goal: ❑ breastfeed exclusively ❑ pump exclusively ❑ bf and pump ❑ bf and supplement ❑ unsure ❑ whatever happens

YOUR HEALTH HISTORY

Any history of: ❑ thyroid ❑ ovarian cyst ❑ Polycystic Ovarian Syndrome (PCOS) ❑ diabetes (type ❑ I ❑ II) ❑ other: _____

_____

Medications currently taking (including herbs and vitamins): _____

Breast or chest surgery or injury: ❑ none ❑ reduction ❑ mastopexy ❑ augmentation ❑ biopsy ❑ injury ❑ other Date:_____

Conceive easily: ❑yes ❑ no (how long: _____) ❑ IVF ❑ IUI (donated: ❑ sperm ❑ egg ❑ neither)

Abortion(s): ❑ no ❑ yes (#_____ year(s) _____) Miscarriage(s): ❑ no ❑ yes (#_____year(s) _____)

Miscarriage(s) reason(s): ❑ unknown ❑ _____

Number of other pregnancies: _____ Number of other children living: _____

BREASTFEEDING HISTORY

Number of other children breastfed: _____ How long other child(ren) breastfed: #1: ____ ❑ wks ❑ mos ❑ yrs

#2: ____ ❑ wks ❑ mos ❑ yrs | #3: ____ ❑ wks ❑ mos ❑ yrs | #4: ____ ❑ wks ❑ mos ❑ yrs | #5: ____ ❑ wks ❑ mos ❑ yrs

How did breastfeeding go with the older child(ren): ❑ easy ❑ difficult (describe): _____

_____

_____

THIS PREGNANCY

Breast changes: ❑ enlargement ❑ tenderness in first trimester ❑ leaking ❑ areola darkening Any complications: ❑ no ❑ yes: _____

_____

Bed Rest: ❑ no ❑ yes (start week: _____ until week_____) Reason: _____ Pregnancy length: _____ wks _____ day(s)

LABOR

How labor began: ❑ spontaneous ❑ induced (how: ❑ pitocin ❑ cervical gel ❑ membrane ruptured ❑ other:_____)

Where: ❑ home ❑ birth ctr ❑ hospital ❑ other Labor: ___ hrs Pushing: ____ min Delivery: ❑ vag (❑ VBAC) ❑ vacuum ❑ forceps ❑ C-sect

Medications during labor: ❑ pitocin ❑ epidural (#cm when started: _____) ❑ narcotic (demerol, nubain) ❑ other _____

Antibiotics: ❑ no ❑ yes (reason: ❑ strep B ❑ fever ❑ C-sect ❑ other _____) Hemorrhage: ❑ no ❑ yes (med to stop: _____)

LABOR EXPERIENCE: _____

_____

_____

HOSPITAL / POSTPARTUM

1st nursing: ____ min /hrs after birth ❑ easy ❑ difficult Sides: ❑ 1 ❑ 2 When milk came in: day ____ ❑ not noticed ❑ slight ❑ mod ❑ heavy

1st 24 hours frequency: every_____ hours 2nd 24 hours frequency: every_____ hours 3rd 24 hours frequency: every_____ hours

❑ Circumcision (Day _____) Pacifier: ❑ no ❑ yes (when began: day_____) Separation: ❑ none ❑ some ❑ night ❑ mostly nursery ❑ NICU

Baby complications: ❑ jaundice ❑ hypoglycemia ❑ other _____ How treated: _____

INPATIENT BREASTFEEDING EXPERIENCE: _____

_____

_____

_____

_____

INTAKE HISTORY

PAGE TWO

AT HOME

FEEDINGS: How often: ____ min/hrs LATCHING: ❑ easy ❑difficult ❑ impossible Who ends: ❑ me ❑ baby Avg length: ____ min

Nipple pain: ❑ none ❑ some ❑ moderate ❑ severe Which nipple(s): ❑ L ❑ R When began: _____ ❑ days ❑ weeks ❑ months

SUPPLEMENTING: ❑ no ❑ yes When began: ____ days How: ❑ bottle ❑ cup ❑ syringe ❑ dropper ❑ spoon ❑ finger-feeder ❑ tube

When: ❑ before nursing ❑ after How often: ❑ every feed ❑ _____ x/day How much: ____oz/cc /feeding What: ❑ formula ❑ pumped milk

PUMPING: ❑ no ❑ yes When began: ____ days How often: _____ x/day Avg amt: _____ Flange size (imprinted on side): _____

Pump condition: ❑ new ❑ used (how long: _____ mths/yrs) Pump Type: ❑ rental ❑ owned (brand: _____)

POST-DISCHARGE BREASTFEEDING EXPERIENCE:_____

_____

_____

_____

_____

_____

_____

_____

Vaginal bleeding now: ❑ light ❑ moderate ❑ heavy ❑ over Color: ❑ bright red ❑ dark red ❑ brown

WHERE BABY SLEEPS: ❑ in our room ❑ in her/his room ❑ other:_____ What baby sleeps in: ❑ our bed ❑ co-sleeper ❑ crib/bassinet

NUMBERS

BABY'S WEIGHT HISTORY

DATE	WHERE WEIGHED	WEIGHT
BIRTH		

DIAPER OUTPUT HISTORY

DAY	Last 24 Hours	Last 25-48 Hours	Last 49-72 Hours	Last 73-96 Hours	Last 97-120 Hours
No. of Stools					
Stool Qty	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful
Stool Color	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow

Attend breastfeeding mothers' group: ❑ no ❑ yes (Where: _____)

Ideally, want to breastfeed: _____ ❑ months ❑ years ❑ until baby weans self Returning to work (outside home): ❑ no ❑ yes (At ____ ❑ wks ❑ mos)