We are excited to announce that we have partnered with The Lactation Network to bill some insurance companies directly for lactation visits.  They are currently billing the following insurance: Blue Cross and Blue Shield of Texas PPO, Anthem PPO Cigna Multiplan ONLY.  If you have any of the above insurance coverage please go to The Lactation Network and sign up to get pre approval before you schedule your appointment. All others, please be aware that our practice requires payment at the time of service.  We are not a provider on any insurance plan.  Clients will be provided with insurance codes and tax ID information to submit for reimbursement.

# BREASTFEEDING QUESTIONNAIRE

# Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mother’s Information**:

Name: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OB/Midwife: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_

**Baby’s Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: Age: \_\_\_\_\_\_\_\_\_\_\_

Gender: ­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gestational Age at Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Weight: \_\_\_\_\_\_\_\_\_\_\_\_ Lowest Weight: \_\_\_\_\_\_\_\_\_\_\_\_

Current Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where did you deliver? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR VISIT**

Baby always seems hungry   Baby crying excessively  Baby not interested   Breast pain

Cracked/bleeding nipples  Engorgement  Feeling that there is not enough milk  Latch-on difficulties

Preference for one breast  Sleepy baby   Sore nipples  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREGNANCY AND BIRTH HISTORY**

Planned  Surprise  Fertility

Was this your first pregnancy?  Yes  No

If no, how many pregnancies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many children? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you breastfeed your other children? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your baby have any known health problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your baby currently taking any medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of delivery did you have with this birth?

Vaginal  Forceps delivery  Vacuum extraction  Emergency C-Section  Planned C-Section

Are you taking any of the following?

Antacids  Antibiotics  Antihistamines  Aspirin  Birth Control Pills  Cold Remedies  Diet Pills Diuretics/Water Pills  Herbs  Iron  Laxatives  Pain Pills  Prenatal Vitamins  Other

Have you ever had any of the following breast procedures?

Biopsy  Breast Reduction Surgery  Implants  Lumps  Nipple Problems  Other

Do you presently have or do you have a history of any of the following?

Abnormal Pap Smear  Abortions  Alcohol  Allergies  Anemia Asthma  Cancer

Constipation  Depression  Diabetes  Diarrhea (chronic)  Eating Disorder  Heart Disease Hemorrhoids  Hepatitis  High Blood Pressure  Illegal Substances  Infertility

Kidney/Bladder Disease or Infection  Liver Disease  Miscarriages  Polycystic Ovarian Syndrome  Sexual Abuse  Smoker  Thyroid Disorders  Tuberculosis  Venereal Disease  Yeast Infections  Other

Did you have any of the following during this pregnancy?

Anemia  Fever  Gestational Diabetes  High Blood Pressure  Medications

Nausea/Vomiting-Severe  Premature Labor  Urinary Tract Infection  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have any of the following during this labor and delivery?

Antibiotics  Drugs to control high blood pressure  Drugs to control pain  Epidural  Fever  Hemorrhage - if so how much blood was lost        Premature rupture of membranes

Drugs to induce or speed labor-if so how long during labor were these drug administered?       Hours

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you experience any postpartum complications?

Excessive Bleeding/Hemorrhaging  High Blood Pressure  Low Blood Pressure  Seizures

Urinary/Other Infections  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the baby have any of the following after birth?

Breathing Difficulties  Low Blood Sugar  Meconium Aspiration  Jaundice (highest bili level      )

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was your bra size before pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast changes since delivery?  Hard/Engorged  Heavy  Leaking  Warm  No changes

**BREASTFEEDING HISTORY**

When did you start having breastfeeding difficulties? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you used any breastfeeding aids or pumps? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of pump \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your baby been supplemented?  No  Yes

If yes, what has your baby been supplemented with?  Expressed breast milk  Formula Type of formula \_\_\_\_\_\_\_

How was the baby supplemented?  Cup feeding  Feeding tube  Finger feeding  Bottle - type of bottle \_\_\_\_\_\_\_\_

If you are supplementing, how often did you supplement in the last 24 hours?\_\_\_\_\_\_\_\_\_\_\_\_\_ How much per feeding? \_\_\_\_\_\_\_\_\_\_\_\_

How many times have you breastfed your baby in the last 24 hours?

Less than 6 times  Less than 8 times  8-10 times  More than 12 times

Is the baby sleeping or content between feeds?  Often  Occasionally  Never

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 typically nurse at the breast?        One breast per feed  Both breasts per feed

How many months are you planning to breastfeed your baby?  1 month  2-3 months  3-6 months

6-9 months  12 months  12-18 months  18-24 months  longer than 24 months

Are you presently using a pacifier?  Yes  No How often

In the past 24 hours, how many? Wet diapers       Stools       Color of stool

Were the stools more than a tablespoon?  Yes   No

**FAMILY HISTORY**

Does anyone on either side of the baby’s family have any of the following?

Asthma  Breast Cancer  Diabetes  Eczema   Environmental Allergies

Food Allergies/Sensitivities  Genetic Disease  Thyroid Disease  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What age were you when you had your first menstrual period?         Regular  Irregular

Which method of family planning are you using or do you plan to use?

Barrier method  Birth control pills  Birth control shot  IUD Norplant

Planning/rhythm  Tubes tied  Vasectomy  None

Are you planning to return to work?  Yes  No When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Full-time  Part-time