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