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MATERNAL HISTORY Date:_____ Client Name:_____

Baby's Name:_____

Date of Birth:_____

List Number of: ___Full-term babies delivered ___Premature babies delivered

___Miscarriages ___Household members besides children

___Number of pregnancies ___Pets

Other Children:

Name Current Age Breastfed Until Age Reason for Weaning Method of Weaning Living in Household?

_____
_____
_____
_____

FAMILIAL HISTORY (husband, baby's siblings, grandparents, aunts, uncles, cousins):

☐ High Blood Sugar ☐ Asthma ☐ Allergies (food, animals, pollen, wool, etc.)

☐ Low Blood Sugar ☐ Eczema ☐ Depression

If yes, what relation? _____

PERSONAL HISTORY

I am ☐ right handed ☐ left handed

☐ High Blood Sugar ☐ Thyroid Problems: if yes, describe_____

☐ Low Blood Sugar ☐ Asthma ☐ Eczema ☐ High Blood Pressure ☐ Low Blood Pressure

☐ Allergies: if yes, type _____

☐ Vaccinated: If yes, type (include COVID and FLU shots):_____

_____

and when:_____

☐ Polycystic Ovary Syndrome (PCOS) ☐ MTHFR ☐ Migraines ☐ Sinus Problems

☐ Hormone Imbalance/Therapy: if yes, describe _____

☐ Depression or Mental Illness: if yes, when and describe_____

☐ Breast Surgery/Trauma: if yes, describe_____

☐ Sensitive Skin (sun, creams, etc.) ☐ Infection in the last 6 months (yeast, ear, bladder, throat, etc.)

☐ Do you face any Cultural or other significant factors pertaining to breastfeeding or childrearing (e.g. acceptability of

breastfeeding in public) _____

PRENATAL HISTORY

☐ Yes ☐ No - This pregnancy was planned.

☐ Yes ☐ No - I became pregnant easily.

☐ Yes ☐ No - I attended childbirth education classes.

☐ Yes ☐ No - I attended prenatal breastfeeding classes.

☐ Yes ☐ No - I took a prenatal vitamin regularly throughout pregnancy.

☐ Yes ☐ No - I took other medications/supplements while pregnant. If yes, what? _____

☐ Yes ☐ No - I was on a special diet during pregnancy. If yes, what? _____

☐ Yes ☐ No - I "binged" on certain foods with this pregnancy. If yes, what?_____

☐ Yes ☐ No - I had complications with this pregnancy. If yes, describe_____

☐ Yes ☐ No - I had complications with previous pregnancies. If yes, describe_____

During this pregnancy, I drank and/or used: ☐ Tobacco ☐ Alcohol ☐ Caffeinated substances ☐ Other social drugs

During this pregnancy, I was under the care of a: ☐ Midwife ☐ OB/GYN ☐ Family Practice Doctor ☐ Other_____

During this pregnancy, I had _____ ultrasounds. Please list gestational age for each ultrasound _____

☐ Yes ☐ No - This healthcare provider discussed breastfeeding with me prior to birth

I weighed: ____lbs. at the beginning of pregnancy ____lbs. at the end of pregnancy ____lbs. gained

____lbs. is my present weight ____lbs. is my ideal weight ____is my present height

FOR OFFICE USE ONLY: (birth story)

BIRTH HISTORY

Due Date_____ Birth Date_____ Number of days / weeks: "Early" or "Late"_____

Baby was born in: __Hospital delivery room ___Birth center ___Home Other: _____

Which hospital/midwife did you deliver at?_____

My labor was _____ hours long. I pushed for _____ hours/mins.

Were you induced? ☐ Yes ☐ No If yes, for what reason? _____

☐ Yes ☐ No - I was given medications during labor. Please check all that apply.

☐ Antibiotics ☐ IV Fluids ☐ Pitocin ☐ Cytotec/Cervidil ☐ Epidural

☐ Narcotics (Nubain, Demerol, Stadol, etc.) ☐ Spinal ☐ General anesthesia

Other: _____

☐ Yes ☐ No - There were complications during labor. If yes, describe_____

Baby was born ☐ vaginally ☐ c section

During delivery, did any of the following occur? Please check all that apply. ☐ Use of vacuum ☐ Use of forceps

☐ Cord around baby's neck or body ☐ Episiotomy ☐ Tearing - If yes, to what degree? _____

☐ Compound presentation (baby's head presenting with another body part such as an arm)

Baby's Apgar score: ___At 1 minute ___At 5 minutes

Who attended the birth? (father, parent, doula, etc)_____

Overall, were you happy with the birth? ☐ Yes ☐ No ☐ Somewhat
Explain:_____

Were you given medications after delivery? ☐ Stool softeners ☐ Antibiotics ☐ Iron Other _____

☐ Pain medication If yes, which ones? _____

I was discharged from the hospital / birthing center when baby was _____ days old.

Baby was discharged from hospital when he/she was _____ days / weeks old.

☐ Yes ☐ No - Did you have a postpartum hemorrhage? If yes, how much blood did you lose? _____

☐ Yes ☐ No – Has your vaginal bleeding stopped? If yes, when did bleeding stop? _____

If no, describe (color, flow, clots?)_____

Did you have retained placenta? If yes, how was it treated?_____

Baby's Weight - _____At birth _____At discharge _____Lowest weight; when _____

NUTRITION

Since baby was born, my appetite has: __Significantly increased __Significantly decreased __Stayed the same

I eat _____ meals each day. I eat _____ snacks each day.

What foods do you typically eat? _____

_____

☐ Yes ☐ No – My urine is a pale yellow color by noon

I am taking vitamins/supplements, check all that apply - ☐ Prenatal vitamin ☐ Calcium ☐ Iron ☐ Magnesium ☐ Probiotics

Other_____

☐ Yes ☐ No - I take herbal supplements or drink herbal teas. If yes, what? _____

Reason: _____

☐ Yes ☐ No - I am taking my encapsulated placenta.

☐ Yes ☐ No - I currently take medications. If yes, please list _____

☐ Yes ☐ No - I drink / eat dairy products. If yes, please list types._____

How much? _____

☐ Yes ☐ No - I am on a special diet. (Weight loss, gluten free, low sodium, vegetarian, vegan,

dairy free, etc.)If yes, what? _____

☐ Yes ☐ No - I am losing weight or would like to lose weight.

I drink or use: ☐ Tobacco ☐ Alcohol ☐ Caffeinated substances ☐ Other social drugs

☐ Yes ☐ No - Is there a smoker in the home? If yes, who?_____

Baby is around people who smoke: ☐ Never ☐ Rarely ☐ Occasionally ☐ Often

LIFESTYLE

Overall, my health is _____

I feel: ☐ Exhausted ☐ Slightly tired ☐ Like I am getting enough rest

My sleeping pattern currently looks like: _____

How are you coping with change in sleeping pattern? _____

Who is your breastfeeding support person(s)? _____

☐ Yes ☐ No - I have help at home. (housework, meal prep, errands, etc.)

☐ Yes ☐ No - I feel like my healthcare provider is supportive of breastfeeding.

☐ Yes ☐ No - Is there anyone close to you who feels you should not breastfeed? Whom? _____

☐ Yes ☐ No - I have a special place where I like to breastfeed.

If yes, please describe. _____

☐ Yes ☐ No - I plan to go back to work. When? _____

Who will care for your baby? _____

☐ Yes ☐ No - I plan on pumping.

☐ Yes ☐ No - I have experience with pumping.

I express ____ ml/oz from the R breast and ____ ml/oz from the L breast at each pumping session. Or a **total** of ____ ml/oz in a 24 hour period.

☐ Yes ☐ No - I own a pump. ☐ Electric ☐ Manual Brand/Model _____

☐ Yes ☐ No - I have experience with manual/hand expression.

BREASTFEEDING HISTORY (of previous child(ren) and current baby)

☐ Yes ☐ No - I successfully breastfed a child(ren) before this baby. If yes, how long?_____

With this baby, I have experienced:

☐ Mastitis	☐ Right Breast	☐ Left Breast
☐ Breast infection	☐ Right Breast	☐ Left Breast
☐ Engorgement	☐ Right Breast	☐ Left Breast
☐ Sore/cracked nipples	☐ Right Breast	☐ Left Breast
☐ Thrush	☐ Right Breast	☐ Left Breast
☐ Plugged ducts	☐ Right Breast	☐ Left Breast
☐ Abscesses	☐ Right Breast	☐ Left Breast
☐ Blebs (Milk Blisters)	☐ Right Breast	☐ Left Breast

On a scale of 1-10 (with 1 being little to no pain and 10 being excruciating pain), how would you rate your nipple/breast pain:

R nipple/breast (circle one): 1 2 3 4 5 6 7 8 9 10

L nipple/breast (circle one): 1 2 3 4 5 6 7 8 9 10

☐ Yes ☐ No ☐ Not Sure - I feel like I make enough milk to feed my baby.

☐ Yes ☐ No - I have a noticeable milk ejection reflex (let down). What does it feel like to you?_____

FIRST WEEK OF BREASTFEEDING HISTORY

☐ Yes ☐ No - My baby was given to me immediately after birth. If not, we were separated for:_____

Reason:_____

☐ Yes ☐ No - I breastfed within the first hour after delivery

☐ Yes ☐ No - The baby breastfed well at the first feeding

My milk "came in" on the _____ day.

☐ Yes ☐ No - I had sore nipples the first week.

☐ Yes ☐ No – I was engorged - Defined as swelling of breasts in the first 4-5 days causing pain, throbbing &/or swelling. If yes, for _____ days. Treatment:_____

☐ Yes ☐ No - Did you pump the first week? If yes, why? _____