Outpatient Lactation Consultation

Mother’s name: ____________________________ Baby’s name: ____________________________ Today’s Date: ____________

Breastfeeding Evaluation

How is breastfeeding going for you?________________________________________________________________________

What are your breastfeeding goals?__________________________________________________________________________

How many times in 24 hours does your baby breastfeed? ______ How many times midnight-6am? ______

Did you feel your milk “come in” after the birth of the baby? □ Yes □ No If yes, what day? ______

Did you experience extreme engorgement? □ Yes □ No How long? ______

Do you feel your milk letdown? □ Yes □ No

Describe your baby’s behavior at the start of a feeding:

☐ Waking on own /feeding cues ☐ Yes ☐ No
☐ Must wake for feedings ☐ Yes ☐ No
☐ Does your baby cry when offered the breast? ☐ Yes ☐ No
☐ Does the baby fall asleep at the start of the feeding? ☐ Yes ☐ No
☐ Are your baby’s eyes closed at the start of the feeding? ☐ Yes ☐ No

How long does your baby typically spend at each feeding? ______ Who ends the feedings? □ You □ Baby

Do you allow the baby to come off first breast before offering the second breast? □ Yes □ No

Do you alternate the breast on which you start a feeding? □ Yes □ No

Does your baby prefer one breast? ☐ Right ☐ Left ☐ No preference

Does your baby feed at one or both breasts at each feeding? ☐ One breast per feeding ☐ Both breasts at each feeding ☐ Varies

When your baby breastfeeds

☐ Do you hear swallowing? ☐ Yes ☐ No
☐ Do you hear loud gulping at the start of the feeding? ☐ Yes ☐ No
☐ Does your baby choke? ☐ Yes ☐ No
☐ Does your baby pull off the breast? ☐ Yes ☐ No
☐ Do you see milk squirting from your breasts when baby lets go? ☐ Yes ☐ No

Is the baby content after breastfeeding? ☐ Yes ☐ No

Are you experiencing any nipple pain? ☐ Yes ☐ No Breast pain? ☐ Yes ☐ No When did it start? ______

Is there any nipple damage? ☐ Yes ☐ No Type of damage ______________________

Are you using a breast pump? ☐ Yes ☐ No What type? ______________________ How often? ______________________

Are you using a nipple shield? ☐ Yes ☐ No If yes, are you pumping after each feeding? □ Yes □ No

Is the baby taking a pacifier? □ Yes □ No How often? ______________________

Is the baby receiving any formula now that the baby is home? □ Yes □ No How much in 24 hours? ________
Outpatient Lactation Consultation

Mother’s name: ______________________________  Baby’s name: ________________________________  Today’s Date: ____________

### Labor & Delivery

- Delivery Type: 
  - [ ] Vaginal
  - [ ] Vacuum assisted
  - [ ] Forceps assisted
  - [ ] Cesarean/planned
  - [ ] Cesarean/unplanned

- Due Date: ____________  Delivery Date: ____________

- Was your labor induced?  [ ] Yes  [ ] No

- What medicines did you receive during labor or postpartum while in the hospital?
  - [ ] Pitocin
  - [ ] Magnesium Sulfate
  - [ ] Antibiotics
  - [ ] Epidural
  - [ ] Pain Medicine (Type): ____________
  - [ ] Other: ____________

- How long was your labor? _____ hours  How long was your pushing stage? _______ minutes

- Was the baby suctioned after birth?  [ ] Yes  [ ] No

- Did you hold your baby skin-to-skin immediately after delivery?  [ ] Yes  [ ] No

- Did your baby breastfeed during the first hour after birth?  [ ] Yes  [ ] No

  - If no, how long after delivery did you get to hold and feed your baby? ____________

- Did your baby have low blood sugar?  [ ] Yes  [ ] No

- Did your baby have any bruising or birth trauma?  [ ] Yes  [ ] No

- Did you have major bleeding after the birth?  [ ] Yes  [ ] No

- Did you have high blood pressure with the pregnancy?  [ ] Yes  [ ] No

- Did it develop into preeclampsia during the pregnancy?  [ ] Yes  [ ] No

- Did you have the baby with you all the time in the hospital?  [ ] Yes  [ ] No

  - If no, why did your baby leave your room? ____________

- Did your baby spend any time in the Level 2 nursery?  [ ] Yes  [ ] No

  - If so, reason why: ____________

- Did your baby have any formula while in the hospital?  [ ] Yes  [ ] No

  - If so, reason why: ____________

- Did you receive assistance with breastfeeding in the hospital?  [ ] Yes  [ ] No

### Maternal History

- Height ______  Weight before pregnancy ________  Weight at end of pregnancy __________

- How many times have you been pregnant? _______  How many children do you have? (including this child) ________

- Do you have previous breastfeeding experience?  [ ] Yes  [ ] No

  - If yes, how was your previous experience? ____________

- Did any relatives have difficulties with breastfeeding?  [ ] Yes  [ ] No

- Did your breasts enlarge during your pregnancy?  [ ] Yes  [ ] No

- Did you have problems getting pregnant?  [ ] Yes  [ ] No

### Medical Conditions:

- [ ] None
- [ ] Type 1 Diabetes
- [ ] Type 2 Diabetes
- [ ] Gestational Diabetes
- [ ] Insulin Resistance
- [ ] Hypothyroidism
- [ ] Hyperthyroidism
- [ ] Infertility
- [ ] Polycystic Ovarian Syndrome
- [ ] Anemia
- [ ] Depression
- [ ] Anxiety
- [ ] Allergies
- [ ] Eating Disorders
- [ ] Breast cancer
- [ ] Other: ____________

- Have you had any of the following surgical procedures?
  - [ ] Breast reduction/date: ____________
  - [ ] Implants/date: ____________
  - [ ] Breast biopsy/date: ____________
  - [ ] Nipple surgery/date: ____________
  - [ ] Gastric Bypass surgery/date: ____________

- Have you ever had any trauma to your breasts?  [ ] Yes  [ ] No

- Have you ever had radiation to your breasts?  [ ] Yes  [ ] No

---

The Birthplace Lactation Team 570-321-2092  lactationteam@susquehannahealth.org  IBCLC initials ____________
Source: Kay Hoover, MEd, IBLCE, RLC
### Outpatient Lactation Consultation

Mother's name: ___________________________ Baby's name: ___________________________ Today's Date: ____________

#### Maternal History cont.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>How is your appetite?</th>
<th>____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you on any special kind of a diet?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you on a vegan?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many cigarettes do you smoke daily?</td>
<td></td>
<td></td>
<td>Five</td>
<td>____________</td>
</tr>
<tr>
<td>What was the last time you used recreational drugs?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had any exposure to toxic chemicals?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What medications are you taking now?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What medications were you taking before you became pregnant?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What medications were you taking during this pregnancy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Are you using any kind of birth control now?

- [ ] Yes
- [ ] No

If yes, what type ___________________________ when was it started? ____________

#### Did you attend a breastfeeding class?

- [ ] Yes
- [ ] No

Where? ____________

#### Do you receive services from the following?

- [ ] WIC
- [ ] Healthy Beginnings
- [ ] Nurse Family Partnership
- [ ] N/A

#### Was this a planned pregnancy?

- [ ] Yes
- [ ] No

#### Do you feel you are under too much stress?

- [ ] Yes
- [ ] No

#### Are you able to sleep when there is an opportunity to sleep?

- [ ] Yes
- [ ] No

#### Do you have enough help with household chores?

- [ ] Yes
- [ ] No

#### Does your family support your wish to breastfeed your baby?

- [ ] Yes
- [ ] No

#### Do you feel pressured to breastfeed?

- [ ] Yes
- [ ] No

#### Are you enjoying breastfeeding?

- [ ] Yes
- [ ] No

### Baby History

#### Delivery Hospital ___________________________ Date of birth ___________________________ [ ] Boy [ ] Girl

- [ ] Term
- [ ] Preterm (how many wks early? _______)

Birth weight ____________ Discharge weight ____________

Your baby’s usual behavior:

- [ ] Regular active/alert/sleep times
- [ ] Sleepy all the time
- [ ] Fussy all the time

How many wet diapers does your baby have in 24 hours? ____________

What color is the baby’s urine? ____________

How many times in 24 hours does your baby have a bowel movement? ____________

What color are your baby’s bowel movements? ____________

#### Was your baby circumcised?

- [ ] Yes
- [ ] No [ ] N/A (girl)

Did your baby have any other procedures in hospital?

- [ ] Yes
- [ ] No

If yes, what was performed? ____________

#### Does your baby have any health problems/issues?

- [ ] Yes
- [ ] No

- [ ] Physical anomalies such as a heart problem, congenital abnormalities
- [ ] Central nervous system insult
- [ ] Congenital adrenal hyperplasia
- [ ] Hypotonic
- [ ] Neuromuscular disease such as CP
- [ ] Down syndrome
- [ ] Reflux
- [ ] Genetic impairment
- [ ] Hypertonic
- [ ] Other ____________

Is your baby on any medications? 

- [ ] Yes
- [ ] No

If so, what? ____________

Does your baby require any blood tests or follow-up procedures?

- [ ] Yes
- [ ] No

If yes, what? ____________

The Birthplace Lactation Team 570-321-2092 lactationteam@susquehannahealth.org IBCLC initials ____________

Source: Kay Hoover, MEd, IBCLC, RLC
Outpatient Lactation Consultation

Mother’s name: ______________________ Baby’s name: ______________________ Today’s Date: ________