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Breastfeeding Questionnaire

Date: _____

Personal Information

Mom's Name: First:_____Last: _____
Mom's Medical History:
Type of Delivery: ☐ Vaginal ☐ Vacuum ☐ Forceps ☐ C-Section
Medical Concerns: _____
Medications: (herbal &/or prescription) _____
Any breast surgery? ◯ YES ◯ NO If yes, explain _____
Any history of depression or anxiety?_____
Problems breastfeeding other children? ◯ YES ◯ NO
If yes, explain _____
Baby's Name: First:_____Last: _____
Baby's Medical History:
Baby's birth weight: _____
Date and value of last weight: _____
Medical concerns: _____
Was baby born prematurely? ◯ YES ◯ NO If yes, how early _____

Breastfeeding Information

Main breastfeeding concern: _____

_____

Things tried to date: _____

_____

Feeding History:
In 24 hours, how many times do you or the baby do the following:
Breastfeed ___☐___ How many minutes per breast _____
Pumping ___☐___ How many minutes per breast _____ Volume of pumped breastmilk per pump _____
Volume of expressed milk given per feed _____
Formula ___☐___ Volume of formula given per feed _____

If your baby gets formula or pumped milk, is this:
☐ After breastfeeding ☐ In place of breastfeeding ☐ Before breastfeeding

Goals for feeding:
◯ Breastfeeding only ◯ Breast & expressed milk ◯ Breast & formula ◯ Formula only

Baby's Output:

In 24 hours, how many times does the baby have:

Wet diapers _____ Stools _____

Check All That Apply

Latch:	**YES**	**NO**
Do you have inverted or flat nipples?	☐	☐
Do you have nipple pain?	☐	☐
Do your nipples hurt more at the beginning of feeds?	☐	☐
Are your nipples cracked or damaged?	☐	☐
Do you find it awkward to position your baby for feeds?	☐	☐
Yeast:		
Has the baby had any diaper rash?	☐	☐
Has the baby had thrush (yeast in the mouth)?	☐	☐
Have you or baby been on antibiotics?	☐	☐
Do your nipples hurt more at the end of feeds?	☐	☐
Do you have shooting pains in the breast after feeds?	☐	☐
Do you have any vaginal itching or unusual discharge?	☐	☐
Supply:		
Did you have significant blood loss after delivery?	☐	☐
Is the baby gaining weight well?	☐	☐
Does the baby feed vigorously?	☐	☐
Can you hear the baby swallow?	☐	☐
Does your baby seem satisfied after breastfeeding?	☐	☐
Are your breasts fuller before feeds?	☐	☐
Are your breasts softer after feeds?	☐	☐
Overactive Milk Ejection Reflex:		
Is your baby fussy and/or gassy?	☐	☐
Does your baby choke or sputter at the breast?	☐	☐
Does your baby pull on & off the breast?	☐	☐
Does your milk spray out or leak often?	☐	☐
Do your breasts often feel engorged?	☐	☐
Miscellaneous:		
Does your baby refuse the breast?	☐	☐
Are there any white spots in or on the nipple?	☐	☐
Do your nipples turn white after feeds?	☐	☐
Are there any painful lumps in the breast?	☐	☐