

Breastfeeding Questionnaire



Today's Date: _____

Mother's Name: _____ DOB: _____

Father/Partner's name: _____ DOB: _____

Infant's Name: _____ DOB: _____

Home Address: _____

City: _____ Zip Code: _____

Telephone: _____ Email: _____

Obstetrician: _____ Telephone: _____

Pediatrician: _____ Telephone: _____

Midwife: _____ Telephone: _____

Doula: _____ Telephone: _____

Hospital/Birthing Center: _____

Family History

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

Food allergies Asthma Eczema Hay fever Breast cancer Diabetes Genetic disease
Thyroid disease other _____

Was this your first pregnancy? Yes No If no, how many pregnancies? _____ living children? _____
Losses: _____ Did you meet previous breastfeeding goals? _____

Which of the following family planning methods are you using or do you plan to use?

Norplant Injection Barriers Birth control pills Vasectomy Natural family planning/rhythm
Tubes tied None

Will you be returning to work? Yes No If yes, what type of work: _____

Date of return: _____ Full time? _____ Part time? _____

Do you have a location and time to be able to pump at work? Yes No

Pregnancy & Birth History

Does your baby have any known health problems? _____

Is the baby currently on any medications? _____

Are you taking any of the following? Prenatal vitamin-minerals Iron Antihistamines
Cold remedies Antibiotics Aspirin Laxatives Diuretics/water pills Antacids Pain pills
Diet pills Herbs Essential Oils Other _____



Have you ever had any of the following procedures related to your breasts? Biopsy Lumpectomy
 Implants Breast reduction Nipple correction Nipple piercings Injuries Breast lift
 Chest tube as infant or adult Other _____

Do you presently have or have you ever had any of the following? Anemia Allergy/Asthma
 Diarrhea(chronic) Heart disease Diabetes Hepatitis Sexually transmitted disease
 High blood pressure Liver disease Cancer Thyroid disorders Miscarriages
 Hemorrhoids Infertility Depression Sexual abuse or assault Constipation
 Eating disorder Kidney/Bladder disease or infection Hormonal disorder Yeast Infections
 Tuberculosis PCOS (polycystic ovarian syndrome) Hormonal disorders/Imbalances
 Other _____

Did you have any of the following during this pregnancy? Premature labor Gestational diabetes
 High blood pressure Nausea/Vomiting-severe Anemia Fever Urinary tract infections
 Medications Hormones Other _____

Did you have any of the following during this labor and delivery? Premature rupture of membranes
 Drugs to control pain Drugs to control high blood pressure Epidural Spinal
 Pudendal block Fever Antibiotics Drugs to induce or speed labor - If so then how long was this
 drug administered ? _____ Hours of hemorrhage-If so how much blood was lost _____
 Where you given blood? how many times were you given? _____
 Other _____

What type of delivery did you have with this birth?

Vaginal Emergency c-section Planned c-section VBAC

Gestational age of baby at birth? _____ weeks

Baby's birth weight: _____ lb. _____ oz. **Weight at discharge from hospital:** _____ lbs. _____ oz.
Most recent weight: _____ lb. _____ oz. **On what date?** _____ **at what location?** _____

Did you have any of the following with this birth? Total labor longer than 30 hrs Episiotomy or tear
 Pushing stage longer than 2 hrs Breech presentation Delivery or pushing stage less than 1 hr
 Tear that involved the rectum or urethra (3rd or 4th degree laceration) Forceps delivery
 Vacuum extraction Group Beta Strep positive Other _____

Did you experience any postpartum complications? Infections - what and where? _____
 Fever Low blood pressure High blood pressure Excessive bleeding or hemorrhaging
 Antibiotic treatment Other _____

Did the baby have any of the following after birth? Breathing difficulties Low blood sugar
 Antibiotics Meconium aspiration Jaundice (highest bili level _____) Phototherapy
 NICU Admission Hospitalization past the time of your discharge Other _____

What was your bra size: Before pregnancy _____ now _____

Changes during pregnancy?

Tenderness Enlargement Darkening of nipple/areola Leaking No changes

Changes since the birth?

Hard/engorged Heavy Warm Leaking Increase in blue veins No changes



Breastfeeding History

Have you used any breastfeeding supplies or pumps? Syringe Nipple shield Bottle Pump
Tube feeding Type of pump: _____

Has your baby been supplemented with any of the following? None Water Formula
Expressed breastmilk Donor milk Type of formula: _____

If so, how was the baby supplemented? Feeding tube at breast Finger-feeding Cup-feeding
Spoon Bottle Paced feeding using bottle? Yes No Type of bottle _____

If supplements have been used, how often in past 24 hours? _____ How much per feeding? _____

How many times in the past 24 hours have you breastfed your baby?
None 1-3 times 3-6 times 6-8 times 8-10 times more than 12 times

How frequently are you keeping baby in skin-to-skin care? _____ for _____ mins

Are you experiencing any of the following?
Latch difficulties Engorgement Sleepy baby Sore nipples Preference for one breast
Baby not interested Cracked/bleeding nipples Breast pain
Feeling that there is not enough milk Baby crying excessively Baby always seems hungry
Clogged milk ducts Nipple blebs/plugs Other _____

Is the baby content and/or sleeping between feedings?
Never Occasionally Frequently All the time

What is the longest time your baby has gone between feedings? Day: _____ Night: _____

Who decides when the feeding is over? Mother or Baby

How long does baby nurse at breast? _____ One breast or both breasts? _____

What's your breastfeeding goal?
Exclusively Pumping and breastfeeding Only pumping to give breastmilk
Breastfeeding and formula feeding For how many months? _____ Years _____

Are you presently using a pacifier? Yes No When did the pacifier use begin? _____
How often? _____ What type? _____

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

Were the stools bigger than a tablespoon? Yes No

Do you have any concerns about your baby's wet or poopy diapers? _____

Do you have any other concerns?

