BREASTFEEDING & BOTTLE FEEDING INTAKE FORM

PATIENT INFORMATION *Referred by:* _____

Infant's Name: _____ DOB: _____ Age: _____ **M / F**

Parent/Caregiver 1 NAME_____ DOB_____ Occupation _____

Parent/Caregiver 2 NAME_____ DOB_____ Occupation _____

Address: _____ Address (if different):_____

City/State/Zip: _____ City/State/Zip: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Email Address: _____

OB/GYN:_____ Phone_____

Primary Care Physician/Pediatrician: _____ Phone_____

Please list any other specialists who are treating your child:

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

Language(s) Spoken at Home: _____ Preferred Language: _____

AREA OF CONCERN(S)

What is your major breast/bottle feeding concern? Please describe in your own words: _____

_____

MATERNAL HISTORY

Allergies to medications/foods: **Y / N** *(explain)* _____

Indicate any maternal health problems:

☐ High Blood Pressure	☐ PCOS	☐ Hyperthyroidism	☐Hypothyroidism	☐ Anxiety/Depression
☐Yeast Infection	☐ Anemia	☐ Eczema	☐ Diabetes	☐ Smoker
☐No breast change	☐ Breast Abnormalities		☐ Breast Surgery	☐ Breast Reduction
☐Breast Augmentation	☐Flat/Inverted Nipples		☐ Other (explain) _____	

How many pregnancies? _____ How many Children? _____

Did you breastfeed your other children? **Y / N / NA**

- if no, what caused you to not breastfeed: _____

- if yes, how long did you nurse them?_____

Drugs/Alcohol consumed during pregnancy? **Y / N** (*circle) - If Yes, explain:*_____

List **ALL** medication(s) you took during pregnancy and now (including over-the-counter/herbs/supplements) _____

_____

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BIRTH HISTORY

Adopted? **Y / N** (*circle) - If Yes, at what age? From where?* _____ Foster? **Y / N** *(circle)*

Full Term / Premature (# weeks early: _____) Delivery Type: Vaginal / C-Section Birth Weight: _____

NICU Stay **Y/ N** (if yes, how long?): _____ Ventilator: **Y / N** Feeding Tube: **Y / N**

Indicate any of the following complications during labor/delivery:

☐ Ruptured Membranes over 24 hrs
☐Epidural over 10 hrs
☐ Vacuum Extraction
☐3rd/4th Degree Tear
☐Labor over 30 hours
☐Stressful Delivery
☐Separated from infant at birth
☐ Magnesium for PIH
☐ Fever
☐ Emergency C-Section
☐ Spinal Headache
☐ Push over 2 hours
☐ Twins / Multiples
☐ Drugs to control pain
☐ Retained Placenta
☐ Blood Transfusion
☐ Postpartum Hemorrhage / Infection
☐ Forceps
☐ Swelling
☐ Antibiotics
☐ Meconium
☐ Hemorrhage
☐ Breech
☐ Other / Explain: _____

INFANT'S MEDICAl HISTORY: Gestational Age At Birth: _____

Indicate any known health problems:
☐ Jaundice
☐Recessed Chin
☐ Low Blood Sugars
☐ Respiratory Distress
☐ Diaper Rash
☐ NICU Admission
☐ Lip / Tongue-Tie

☐ Other: _____

Baby's Highest Bilirubin level (JAUNDICE) _____ How Old Was Baby for Last Bill Check? _____

Is baby currently on any medication(s)? **Y / N** (explain) _____

Baby's Discharge Weight: _____ Current Weight: _____ (Age: _____)

Surgeries/Hospitalizations (date/reason): _____

_____

Daily # of Wet Diapers: _____ Daily # of Stools: _____ Spit Ups/ Emesis **Y / N** frequency: _____

BREAST FEEDING HISTORY

Indicate any of the following difficulties you are experiencing:

☐_Latch-on difficulties
☐ Preference for one breast
☐Cracked/Bleeding Nipples
☐Baby always seems hungry
☐Other:
☐ Engorgement
☐ Baby refuses to nurse
☐ Low Milk Supply
☐ Milk Never "Came In"
☐ Sleepy Baby
☐Breast Pain
☐ Over Supply of Milk
☐ Pump Dependent
☐ Sore Nipples
☐ Excessive Crying (baby)
☐ Slow Weight Gain (baby)

What did the Lactation Consultant do in the hospital to assist with breastfeeding? _____

_____

Has your baby been supplemented with any of the following: **WATER / FORMULA / EXPRESSED BREASTMILK / NONE**

- *Type of formula:* _____

- *How was baby supplemented?* **feeding tube/ finger feeding / cup feeding / bottle** (bottle: _____)

- *How many times have you given a supplement?* _____ *How much per feeding?* _____

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How many times have you breastfed your baby? _____

How often does baby appear content between feedings? (circle) **OFTEN / OCCASIONALLY / NEVER**

What is the longest time your baby has gone between feedings? **DAY:** _____ **NIGHT:** _____

Who decides when the feeding is over? (Circle) **MOTHER / BABY**

How long does your baby nurse at the breast? _____ (circle) **ONE BREAST / BOTH BREASTS**

Position: _____

Have you used any breastfeeding supplies and/or pump? **Y / N** (explain) _____

- what type of pump do you use? _____

- When did you begin pumping? _____ How often do you pump? _____

- **NIPPLE/BREAST PAIN** ***(only complete this section if you are having pain)*** **YES / NO**

Nipple Pain: **LEFT / RIGHT / BOTH** — Indicate when the pain occurs: (check all that apply):

☐As baby latches on ☐ during entire feed ☐ starts out OK, then hurts more
☐Hurts on/ off ☐ Hurts after the feed ☐ unrelated to a feeding - hurts all the time

☐ other: _____

Describe the pain (check all that apply):

☐Tugging ☐ Tingling ☐ Irritating ☐ Rubbing ☐ Scraping
☐ Aching ☐ Throbbing ☐ Itching ☐ Pinching ☐ Sharp
☐ Biting ☐ Stinging ☐ Shooting ☐ Burning

☐ Other: _____

What is your nipple shape when baby comes off the breast?

☐Normal ☐ Elongated ☐ Creased ☐ Ridged ☐ Pinched
☐Lipstick Tube ☐ Peaked ☐ Smashed ☐ Pointed ☐ Stepped on
☐Flattened ☐ Squished ☐ Other: _____

Does your nipple turn white at the end of a feeding? **Y / N** Does your nipple turn white any other time? **Y / N**

Is your nipple a different color than usual? **NO /LIGHT PINK /DEEP PINK /RED /PURPLE /BLANCHED WHITE /WHITE STRIPE**

Is there any nipple damage? **NO / ABRASION / CRACK / BLISTER / SCAB / PIECE MISSING / BLEEDING /** Other: _____

Does your nipple(s) hurt when using a pump? **Y / N**

Breast Pain: **LEFT / RIGHT / BOTH** — Indicate how/when the pain occurs: (check all that apply):

☐Aching all over ☐ Tingling Sensation ☐ Shooting ☐ Burning
☐Radiates down my arm ☐ Radiates to my back
☐ After feedings ☐ During Feedings ☐ All the Time ☐ At times
☐ Not related to feedings ☐Other: _____

What are you doing to deal with nipple/breast pain? _____

BOTTLE FEEDING INTAKE / HISTORY:

CIRCLE: Breastmilk / Formula (current: _____) / Other: _____

- Formula type: Powder / Ready-to-feed / Concentrate
- Previous Formulas? **What kind /Describe tolerance:**_____

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Current bottle/nipple (brand/type/level): _____

List Bottles/Nipples Trialed: _____

Who primarily bottle feeds? _____

Please describe bottle feeding schedule, volume offered, volume (typically) accepted, etc: _____

_____

_____

Average amount per feeding: _____ Average Length of Feeding (minutes): _____

Position during Feeding:

☐Supine with head elevated	☐ Prone	☐ Side lying	☐ Reclined / Elevated
☐Sitting unsupported	☐ Head support required	☐ Seating Device	☐ Other: _____

Indicate any problems you have noticed during bottle feeding (check all that apply):

☐"Chomping" on bottle	☐ Fluid leaking from mouth	☐ Shallow Latch to Bottle
☐ Difficulty with flanging lips to bottle	☐ Falling asleep during feeding	☐ Crying during feeding
☐ Becoming uncomfortable during feeding	☐ Difficulty awakening/alerting for feedings	
☐Other:		

Patterns observed during bottle feeding: **STEADY DECLINE / RAPID DECLINE**

PACIFIERS:

Does your child currently take a pacifier? **YES / NO** How often? _____

If yes: current brand/type of pacifier: _____

What brands have you tried? _____

Does the pacifier seem to offer relief / soothing qualities? **Y / N**

Is there any other information that you would like to share that you feel would be beneficial? _____

_____

_____

Thank you for taking the time to complete your baby's history form. We look forward to working with your family, and thank you for choosing Holly Springs Feeding and Speech to help meet your baby's needs.

Parent/Guardian Signature: _____ Date: _____