**LYTLE CENTER FOR PREGNANCY AND NEWBORNS**
**NEW PATIENT BREASTFEEDING QUESTIONNAIRE**

**Mom: _____Date of Birth: _____**
**Baby: _____Date of Birth: _____ Gestational age: _____ weeks**
**OB/Midwife**:_____ **Baby's Pediatrician/Provider**:_____

**What are the main issues you want to get help with today, in order of priority?**
**Mom** issues:_____
_____
**Baby** issues: _____
_____

**Baby's birth weight: _____**
**Baby's last weight: _____ date:_____**

**How many breastfeedings in the past 24 hours? _____**
How long do the feedings last? _____
If your baby is not latching, how are you feeding your baby?_____

**Are you supplementing? Yes ___ No____**
How often in past 24 hours?_____
How much expressed breast milk in past 24 hours?_____
How much formula in past 24 hours?_____
How are you supplementing? Bottle ____ Tube and Syringe _____ Finger Feed _____
When did you start to supplement? _____

Are you using a **nipple shield**? Yes _____ No _____
If yes, when did you start?_____ Have you been able to attach your baby without the nipple shield?
Yes___ No___

**Have you been pumping your breasts? Yes___ No___**
If yes, how many times have you pumped in the past 24 hours? ____
How much do you collect with pumping? _____
Do you have pain with pumping? Yes _____ No _____
Type of pump? _____
**# of wet diapers in past 24 hours: _____**
**# of soiled diapers in past 24 hours: _____** Color: _____

**Do you have other children?** Yes _____ No_____. If yes, did you breastfeed them? Yes ____ No _____
Any difficulty with breasteeding the other children? Yes _____ No_____ If yes _____
_____
**Medications, including topical nipple treatments and any herbal supplements:**
_____
_____

**Turn page →**

**MATERNAL MEDICAL HISTORY:**

Have you ever had any of the following:

___Anemia
___Allergy/Asthma
___Cancer /Type?_____
___Depression/Anxiety If yes, are you in treatment with a psychologist/psychiatrist/therapist? ___Yes ___No
___Diabetes
___High Blood Pressure
___Infertility
___Polycystic Ovarian Syndrome
___Thyroid disorders (hypo- or hyper-)
___Physical/Emotional/Sexual Abuse
___Alcohol Use If yes, amount_____
___Smoking If yes, amount_____

**During this pregnancy, did you experience any of the following?**

___Gestational Diabetes
___High Blood Pressure
___Anemia
___Premature labor
___Severe nausea/vomiting
___ Infection, if yes, type_____
___Hospitalization
___Bed rest
___Depression/Anxiety
___Tobacco/Alcohol/Drug Use
___Other