The Lytle Center Breastfeeding Questionnaire

MOM:	Date of birth:	BABY:	Date of Birth:
Your OB/Midwife/Family Doctor:	Father/Partner :	Pediatrician/Family Doctor:	Baby's due date:

What are the main issues you would like to get help with today? (List in order of priority) Some issues may need to be addressed at a follow up appointment.

Mom Issues: 1. 2. 3.	Baby Issues: 1. 2. 3.
How long have these things been going on?	How long have these things been going on?
Who else has helped you with breastfeeding issues:	**Baby's weight:** Birth weight: lb oz or grams Discharge weight: lb oz or grams Lowest weight: lb oz or grams/date Recent weight: lb oz or grams/date
Who referred you to our clinic?	**In the past 24 hours, how many times has your baby:** Had a wet diaper? Had a soiled diaper? Stool color:
Milk Expression: **In the past 1-3 days, approximately how often have you:** **Hand expressed your breasts?_____times/day** **Pumped** your breasts?______times/day Aprox _____oz/ml/pump or ______oz/ml/day. Do you yield more milk from one side? ___R ___L Does pumping hurt?__N___less than bf___more than bf What kind of pump do you use? What size flanges are you using? __21__24___25___27___28___30___36 Do your nipples rub on the flange? __N__Y Are you using Hands-on Pumping techniques? __N__Y **Are you using a nipple ointment?** Type: **Are you taking any herbs or medications for milk supply?** __none __yes, please list Name and amount How are you adjusting to the new baby? ____Very well ____reasonably well ____poorly ____very poorly Do you feel supported? __Y __N Please describe:	**Feeding:** **In the past 1-3 days, how many times has your baby:** **Breastfed?** Times/24h ____________One side/feed ___both sides___ How long are your feedings? ___min/side ____total/min Can you tell when your baby is swallowing? __No __Yes How do you decide when to switch sides? Are you using a nipple shield? __N__Y; size: ___when started___ Has your baby been able to latch without the nipple shield?___N___Y Do you have nipple pain without the nipple shield? ___N___Y Had **expressed breastmilk ?** ___times/day ___oz/feed ___oz/day Had **formula?** ____times/day-Type: Oz/day ___oz/feed How are you giving the supplement? At-breast supplementer (SNS) ___type_____ Bottle: __________________type__________________ Nipple brand______/flow rate ____ Finger feeder___________________ Other: __________________________ When was supplementation started? ___in hospital? ___day of life ___at first pediatrician visit ___other:

Are you (MOM) experiencing any of the following?				Is your BABY experiencing any of the following? *(with breast or bottle)*	
Nipple Issues	Check	**Breast Issues**	Check	**Baby:**	Check
Nipple pain at Baseline (out of 10)	L___/10 R___/10	Breast pain at baseline (out of 10)	L___/10 R___/10	Difficulty latching	☐
				Shallow latch	☐
				Loses suction/pops off	☐
				Not opening wide	☐
Nipple pain at Worst	L___/10 R___/10	Nipple pain at Worst	L___/10 R___/10	Gets frustrated	☐
				Clicks	☐
				Gulps fast	☐
Pinching	☐	Shooting pain	☐	Gags	☐
Stinging	☐	Burning pain	☐	Chokes/coughs	☐
Cracks/ wounds	☐	Aching	☐	Breathes fast	☐
		Throbbing	☐	Falls asleep quickly	☐
Bleeding	☐	Plugged ducts/lumps	☐	Jaundice	☐
Blisters	☐			Weight loss	☐
Bleb (white spot)	☐	Swelling	☐	Slow weight gain	☐
Redness	☐	Hot	☐	Long feedings (most are more than an hour)	☐
Itching	☐	Red	☐		
Turns white	☐	Mastitis	☐	Fussy	☐
Thrush/yeast infection	☐	Milk supply: -Low -Normal -Oversupply	 ☐ ☐ ☐	Gassy	☐
				Frequent spit up	☐
Flat/lipstick shape after bf	☐			Difficult to wake up	☐
Back/neck/arm pain	☐	Forceful let down	☐	other	
Other:___					

Details/other issues?	Details/other issues?

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 or psychiatrist?

___Y ___N

___Diabetes

___Heart Disease

___High Blood Pressure

___Infertility

___Polycystic Ovarian Syndrome

___Irregular periods

___Liver Disease/Hepatitis

___Thyroid Disorders (hypo_ or hyper-)_________

___Physical abuse

___Emotional/sexual abuse

___Alcohol use

if yes-amount_________

___Smoking

if yes-amount_________

PREGNANCY and BREASTFEEDING HISTORY

Number of pregnancies:_____

Did you breastfeed other children?

__N__Y: How long?___

Any difficulties?

___Sore nipples

___Low milk supply

___Engorgement

___Mastitis/plugged ducts

___Thrush

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

___Fertility treatment

___Medications (describe)

___Fever

___Premature Labor

___Gestational Diabetes

___Tobacco/alcohol/drug use

___Bed rest

___High blood pressure

___Multiples

___Anemia

___Depression/anxiety

__Insomnia

___Severe nausea/vomiting

___Urinary tract infection

___Abnormal weight gain

___Other:

BREASTS:

Did your breasts change (get bigger, more tender, increase cup size, heavier) during pregnancy?

__N__Y

Surgeries ?

__N__Y

__Augmentation (implants) when ?___

__Reduction; when?

__Biopsy; when?

Which side?___

BIRTH HISTORY

Birth:

___Vaginal

___Vacuum assisted

___Forceps assisted

___Cesarean section; reason:

Labor:

___medications

___Epidural/spinal/antibiotics/narcotics/

Pitocin to speed up labor?

___Induced?

How long?____Pushing ?___

Was your baby placed skin-to-skin with you right after birth?

__Y __N

Did your baby latch on within the first hour after birth? ___Y ___N

During your hospital stay, did you have any difficulty with breastfeeding?

___None or:

___latch difficulty

___nipple pain

___breast refusal

___preference for one side

___supplemented with formula

___"not enough milk"

___Other:

Baby complications

___None or:

___meconium

___sleepy/not interested in feeding

___jaundiced

___low blood sugar

___transferred to NICU

___other

Mother complications

___None or:

___bleeding

___Fever

___infection

___other

What day after birth did your milk "come in?"

____ day