GBMC Healthcare
6701 North Charles Street
Baltimore, MD 21204

Patient Name: _____
DOB: _____
MRN: _____ CSN: _____

Today's Date: _____

## LACTATION CONSULTATION INTAKE – Page 1 of 2

*What is the reason for your visit today? What do you wish to accomplish at today's visit?*

_____

_____

| | | | |
|---|---|---|---|
| | Sore/Cracked/Bleeding Nipples/Nipple Pain | | Flat or Inverted Nipples |
| | Low Milk Supply | | Excess Weight Loss or Slow Weight Gain |
| | Feeling Not Enough Milk | | Returning to Work |
| | Thrush | | Refusing Bottle |
| | Latching Difficulties | | Excessive Spitting and/or vomiting |
| | Refusal to Feed | | Preference for One Breast |
| | Engorgement | | Weaning |
| | Maintaining Milk Supply | | Other |

**Preferred Name**: _____

**Current Medications, Supplements, or Herbs**

_____

_____

**Do you have any medical issues we need to be aware of?**

___ No ___ Yes (explain) ie. PCOS, hypertension, etc**.**

_____

_____

**History of Breast Surgery**: ___ Yes ____ No

___ Augmentation ___ Reduction ___ Other

**Is this your first child**? ___ Yes ___ No

Ages(s) other children_____

**Did you breastfeed your other children**? ___ Yes ___ No

How long? _____

**Describe your previous breastfeeding experience**:

_____

_____

**Infant's Name**: _____**M/F (circle)**

**Gestational Age/Weeks at Birth:** _____

**Current Age:** _____ **Date of Birth:** _____

**Birth Weight**: _____ pounds _____ ounces

**Last Weight: _____ lbs. _____ounces Date: _____**

**Lowest Weight/Discharge Weight**: ____ lbs. _____ ounces

**Does the infant have any known health concerns?**

___ No ___ Yes (explain)_____

_____

Infant **is Feeding By:**

____ Breast Milk Only ____ Bottle ____ Both

**Feeding Method(s):** _____ Breast _____ Syringe ____ Bottle

Bottle type: _____ Nipple type/level_____

**Volume of Supplements**: _____

**Number of feedings in 24 hours** _____

**Does the infant take both breasts at each feeding?**

____ Yes ____ No ____ So

* L A C T A T I O N *

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**LACTATION CONSULTATION INTAKE – Page 2 of 2**

**Patient Information**

**Breast changes during most recent pregnancy?**

___ Tenderness ___ Breast growth ___ No change

**Type of Delivery**: ____ Vaginal ____ VBAC

___ Cesarean (planned or urgent) _____

**Breast changes since birth: ____** No change

___ Heavy ___ Warm ___Leaking ___ Hard/engorged

**When did your milk come in**? _____

**What is your breastfeeding goal?** _____

_____

**Infant Information**

**Number of feedings in 24 hours?** _____

**How long does the infant stay on the breast at each feeding?**

_____

**Does the infant take both breasts at each feeding?**

___ Yes ___ No ___ Sometimes

**Number of diapers in the past 24 hours? ____ wet ___ dirty**

**Is the infant content/sleeping after feedings**?

___ Often ____ Occasionally ____ Never

**Does the infant use a pacifier?**

___ Yes ___ No ____ Sometimes

**Pumping Information**

Do you have a breast pump? Yes ____ No __

If yes, what kind of pump _____

How often do you pump? _____

When did you begin pumping? _____

What volume do you collect at each pump session? _____

Have you used any of these breastfeeding supplies? ___ Nipple Shield (Size: _____)

___ Haberman ___ Supplemental Nursing System (SNS)

**Comments**:

_____

_____

_____

_____

Patient's Signature: _____ Date: _____ Time: _____

Lactation Consultant: _____ Date: _____ Time: _____