CHEAHA WOMEN'S HEALTH AND WELLNESS
Joshua Johannson M.D., FACOG – Obstetrics and Gynecology
office # 256-241-0885 – www.cheahawomen.com

Breastfeeding Questionnaire

Mother: _____ DOB: _____ Occupation: _____
Father: _____ DOB: _____ Occupation: _____
Infant: _____ DOB: _____ Physician: _____
What was YOUR weight before pregnancy? _____lbs. Final weight you gained: _____lbs.
How did your labor start? Went into labor / induced / planned C-Section
Where did you receive your prenatal care? _____
How many pregnancies have you had? _____ How many births? _____

Birth Weight: _____ Discharge Weight: _____ Lowest Weight: _____ Date: _____
Birth Place: _____ Gestational Age at Birth: _____Wks. Type of Delivery: _____
Baby gender: _____ Labor: _____ Hours Pushing time: _____ Apgar's: _____
Does your baby have any known health problems: _____ If yes, explain: _____
_____
Is your baby currently on any medications? _____ If yes, list medications: _____
_____

Are **YOU** taking any of the following? (Please circle all that apply)

Anti-acids	Herbal Medicines	Pain pills
Diuretics	Antihistamines	Cold remedies
Hormonal Birth Control	Laxatives	Prenatal vitamins
Antibiotics	Aspirin	Others: _____

How many days after birth did your milk come in? _____
In the last 24 hours, how many times have you breastfed baby? _____ times
In the last 24 hours, how many wet diapers? _____ Stools? _____
Is stool larger than table spoon? _____ What color is stool? _____
How often does baby have explosive stools? Always/ sometimes/ never/ rarely
How often does your baby spit- up? Always/ sometimes/ never/ rarely
Is baby being supplemented? Nothing/ water/ formula/ own pumped milk/ milk bank
If yes, what type of supplementer? Spoon/ cup/ bottle/ syringe/ supplemental nursing system
How much is baby in- taking? _____ How often? _____
Have you used any of the following? (If yes, circle)
nipple shield / hand expression / manual pump / electric pump, type _____
Are you using a pacifier? _____ If so, approximately how many hours per day? _____

Did you notice breast changes during pregnancy? _____ If yes, explain: _____
Have you ever had breast surgery? _____ If yes, explain: _____
Have you had prior breast feeding experience before? _____ ages at weaning: _____

Who initiated weaning? _____
Any past breastfeeding issues? _____ If yes, explain: _____

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Lactation Services

Do you breastfeed/ pump/ bottle formula/ or a mixture? _____
Has baby had: milk at breast/ pumped breast milk/ formula/ or solid foods? Circle all that apply
How often do you pump? _____ How often does baby get formula? _____
What type of breast pump do you use? _____ Standard flange? _____
How long does your baby nurse? _____minutes How many times a day? _____
How long is the range between the beginning of one feed to the next feeding? _____ hours
Does your baby cough or choke at the breast? _____ Is baby distressed at the breast? _____
Explain if yes for either: _____
Are you currently waking baby for feedings? _____ Does baby have difficulty latching? _____
How often does baby seem satisfied after feeding? Always/ sometimes/ never
How often does baby soften at least one breast during feeding? Always/ sometimes/ never
Can you hear baby swallowing during feeding? _____
How often do your nipples turn white during/ after feeding? Always/ sometimes/ never

Are YOU experiencing pain? _____ If no, please skip this section.
Is it painful for both breast, left breast, or right breast? Circle one please
Is pain worse on one side than the other? _____ Which side? _____
When is the pain more intense? Beginning, during, or after feeding/ with pumping/all the time?
Do you have nipple pain while: breastfeeding/expressing milk/not feeding or expressing milk?
Do you have breast pain while: breastfeeding/expressing milk/not feeding or expressing milk?
If yes to the two (2) above questions, explain: _____

Have you used any of the following to treat nursing or pumping pain?

1. Expressing milk onto nipples after feeding or pumping
2. All- purpose nipple ointment/ Jack Newman's Nipple Cream
3. Nipple shields
4. Nipple shell
5. Lanolin ointment
6. Changed size of Flange
7. Hydrogel dressings (Soothies)
8. Tylenol/ acetaminophen
9. Motrin/ ibuprofen
10. Heat to breast after feeding
11. Aquaphor/ Vaseline
12. Ice pack to breasts
13. Infant treated for yeast infection
14. Maternal antifungal pills (name)_____
15. Maternal Cream/ointment for yeast (name) _____
16. Maternal Antibiotic pills (name) _____
17. Maternal cream/ ointment for bacteria (name) _____
18. Steroid Cream/ ointment (name) _____

If yes, specify which number, used when, and if treatment/ medication worked or made worse.

_____
_____
_____
_____
_____

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For each of the following **BREASTFEEDING** statements, please describe how confident you are (VERY, NOT, SOMETIMES)

I can always determine that baby is getting enough milk. _____
I can always successfully cope with breastfeeding like I have with other challenging tasks. _____
I can always breastfeed my baby without using formula as a supplement._____
I can always ensure that my baby is properly latched on for the whole feeding. _____
I can always manage the breastfeeding situation to my satisfaction. _____
I can always manage to breastfeed even if baby is crying. _____
I can always keep wanting to breastfeed. _____
I can always breastfeed comfortably with family members present. _____
I can always be satisfied with my breastfeeding experience. _____
I can always deal with the fact that breastfeeding can be time consuming. _____
I can always finish feeding baby on one breast before switching to the other breast. _____
I can always continue to breastfeed my baby for every feeding. _____
I can always keep up with baby's breastfeeding demand. _____
I can always tell when baby is finished breastfeeding. _____

Signature: _____ Date: _____

Reviewed by: _____

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PEDIATRIC HISTORY FORM

INFANT'S NAME: _____ DOB: _____ DATE: _____

Birth Weight	**Birth Length**	**Discharge Weight**	**Sex**	**Apgars**
___ lbs ___ oz	___ inches	___ lbs ___ oz	F or M	___/___

Weeks of Gestation: _____
Birth Place: _____
Delivery Type: _____

Outcome: (please circle)

Full-term Premature Birth Abortion-Induced Abortion-Spontaneous
Ectopic Fetal Demise

Breastfeeding or Formula (Please circle)

Complications: _____
_____
_____
_____

_____ _____
Signature of Parent Date