

MOTHER/INFANT ASSESSMENT

Patient's Name _____ Birth date _____ Today's Date _____

Medical problems: _____ Heart disease _____ Bleeding disorders _____ Other _____

_____ Male _____ Female Birth Weight _____ Present Weight _____ Birth Hospital _____

_____ Vaginal birth _____ C-Section Birth Any birth complications? _____

Are you presently breastfeeding ____ Yes ____ No If no, how long since you stopped breastfeeding _____

Medical History:

1. Infants are usually given vitamin K at birth. Did your child receive the vitamin K shot? ____ yes ____ no
2. Was your infant premature? ____ Yes ____ No If yes, how many weeks? _____
3. Does your infant have any heart disease ____ Yes ____ No
4. Has your infant had any surgery? ____ Yes ____ No

5. Has your infant experienced any of the following? Please check / circle / elaborate as needed.

- | | |
|--|---|
| <input type="checkbox"/> Shallow latch at breast or bottle | <input type="checkbox"/> Gumming or chewing your nipple when nursing |
| <input type="checkbox"/> Falls asleep while eating | <input type="checkbox"/> Pacifier falls out easily, doesn't like, won't stay in |
| <input type="checkbox"/> Slides or pops on and off the nipple | <input type="checkbox"/> Milk dribbles out of mouth when nursing/bottle |
| <input type="checkbox"/> Colic symptoms / Cries a lot | <input type="checkbox"/> Short sleeping requiring feedings every 1-2hrs |
| <input type="checkbox"/> Reflux symptoms | <input type="checkbox"/> Snoring, noisy breathing or mouth breathing |
| <input type="checkbox"/> Clicking or smacking noises when eating | <input type="checkbox"/> Feels like a full time job just to feed baby |
| <input type="checkbox"/> Spits up often? Amount / Frequency _____ | <input type="checkbox"/> Nose congested often |
| <input type="checkbox"/> Gagging, choking, coughing when eating | <input type="checkbox"/> Baby is frustrated at the breast or bottle |
| <input type="checkbox"/> Gassy (toots a lot) / Fussy often | How long does baby take to eat? _____ |
| <input type="checkbox"/> Poor weight gain | How often does baby eat? _____ |
| <input type="checkbox"/> Hiccups often | |
| <input type="checkbox"/> Lip curls under when nursing or taking bottle | |

6. Is your infant taking any medications? ____ Reflux ____ Thrush Name of medication: _____

7. Has your infant had a prior surgery to correct the tongue or lip tie? If yes, when, where, and by whom?

8. Do you have any of the following signs or symptoms? Please check / circle / elaborate as needed.

- | | |
|---|--|
| <input type="checkbox"/> Creased, flattened or blanched nipples | <input type="checkbox"/> Poor or incomplete breast drainage |
| <input type="checkbox"/> Lipstick shaped nipples | <input type="checkbox"/> Infected nipples or breasts |
| <input type="checkbox"/> Blistered or cut nipples | <input type="checkbox"/> Plugged ducts / engorgement / mastitis |
| <input type="checkbox"/> Bleeding nipples | <input type="checkbox"/> Nipple thrush |
| Pain on a scale of 1-10 when first latching _____ | <input type="checkbox"/> Using a nipple shield |
| Pain (1-10) during nursing: _____ | <input type="checkbox"/> Baby prefers one side over other ____ (R/L) |

Pediatrician _____ Phone number: _____

Lactation Consultant _____ Phone number: _____

Who referred you to us? _____

Doctor's Signature _____

