STS Initial Lactation Form

Contact Information:

Mother’s Name: _______________ Baby’s Name’s __________________ Baby’s DOB _________

Baby's sex: ___________ Baby’s Due Date:_____________ Gestational age at birth:_________

Do you give consent for the lactation consultant to work with you during this consultation?

Yes / No

Photo/Recording Consent: Do you consent to you, or your baby being recorded or have photos taken? Yes/No

Your & Your Baby’s Medical History

Please list any medications, supplements, or herbs you or baby are currently taking:

____

Please describe any food or environmental allergies (include sensitivities and intolerances if applicable) for yourself or baby:

____

Initial: ___

Please indicate here if you have a current or chronic condition in any of the following categories

Please place X if it applies to you:

Diabetes___ Gestational Diabetes___ PCOS___ Endometriosis___ Breast Cancer

Breast Augmentation Breast Reduction Sheehan's Syndrome Raynaud's Syndrome

Celiac Disease Hashimoto's Disease Grave's Disease Hyperemesis Gravidem

Hyperthyroidism Hypothyroidism Bariatric Surgery Fertility Treatment Other

Please explain Other:____

Pregnancy - skip if not applicable

How many weeks are you:_________________ When is your due date:_________________

Have you noticed any size changes in your breasts:____________________________________

Do you have any complications or conditions:____

Labor and birth

What type of birth did you have:_____________________ How long was labor:____________

Where did you birth to your baby:______________ How long was the pushing:______________

What interventions did you have:____

Initial: ___

Baby Medical History

Did baby have any conditions at birth: ____

Did baby have any interventions/ medical procedures at the hospital: ____________________

Please provide the names of any health care providers other than your pediatrician involved in your baby's care: ____

Anything else you'd like me to know about your baby: _________________________________

Feeding history

Please tell me about any issues or concerns you're currently having related to breastfeeding: (supply, pumping, latching, routines, returning to work, etc.)

____

Please tell me about any issues or concerns you're currently having related to your baby:

____

Initial: ___

Diapering Information

Wet Diapers per day: __________ Stools per day: ________ Color of stools__________

Consistency of stool: ________

Feeding Information:

Does your baby do any cluster feeding, and If so, when: ________________________________

How often does your baby spit up: _________________________________

If your baby has any digestive issues, please describe: _____________________________

Breastfeeding

How many times does your baby feed in 24 hours: ______ Length of a typical feeding: ______

Rate your breast pain 1-10: ________ Any other breast-feeding issues: ____________________

Initial: ___

Supplementation

Supplementation If not using a bottle or supplementing please leave blank. (Please mark an X)

What are you giving to your baby:

breast milk ____ liquid ready to feed formula____ powdered formula______

How many times in 24 hours: _____ Average amount each time: ________

What brand & type of formula are you using (if applicable) ___________________________

Pumping

Do you have concerns about pumping: ____

Flange size: ___________ How many times a day do you pump: ______________________

What is the average amount you are expressing each time: _______________________

What pump(s) are you using: __________________________________

What is the total amount you are pumping each day: __________________

How many minutes is each pumping session: ________________

Please list any weights recorded for your baby since birth, such as discharge weight and any pediatrician visits, along with dates: ____

Parent Signature: ____

Initial: ___