REFERRED BY: ______________________ START TIME: __________

SimplyBreastfed

BIO

MOTHERS NAME: ______________________ AGE: ______ BIRTH DATE: ______________

ADDRESS: ______________________ HOME PHONE: ______________

EMAIL: ______________________ WORK OR CELL PHONE: ______________

OCCUPATION: ______________ RETURN TO WORK DATE: ______________

OB/MIDWIFE: ______________ PEDIATRICIAN: ______________

NUMBER OF OTHER CHILDREN: ________ NUMBER OF CHILDREN BREASTFED: ______________

PAST BREASTFEEDING PROBLEMS? ______________________

HEALTH HISTORY (circle): smoker thyroid problems breast surgery allergies diabetes depression infertility

Other: ______________________

Herbs and Medications: ______________________

BIRTH + BABY

BIRTH (circle): vaginal c-section antibiotics induction hemorrhage epidural pitocin

Other Information: ______________________

Medications Given During Birth: ______________________

BABY'S NAME: ______________________ BIRTH DATE: ______________

BIRTH WEIGHT: ______________ LOWEST WEIGHT: ______________

GESTATIONAL AGE AT BIRTH: ________ TODAY'S AGE: ______________

POOPY DIAPERS / 24 HOURS: ________ # WET DIAPERS / 24 HOURS: ________

MEDICATIONS OR SPECIAL MEDICAL INSTRUCTIONS:

BEFORE FEED WEIGHT: ______________ AFTER FEED WEIGHT: ______________

INTAKE AT BREAST: ______________ ADDITIONAL INTAKE: ______________

PARTNER

PARTNER'S NAME: ______________________ WORK OR CELL PHONE: ______________

ALLERGIES: ______________________

QUESTIONS OR CONCERNS:

Today I need help with: