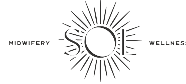


Mother's MEDICAL HISTORY

NAME:	AGE:

Are you in general good health? ☐ yes ☐ no Explain:	Please list **medications, vitamins, herbs, supplements** that **YOU** are currently taking:

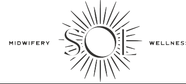
ALLERGIES: ☐ none ☐ medications ☐ foods			
Medications you are allergic to:	**Reaction:**	**Foods you are allergic to:**	**Reaction:**

PREGNANCY HISTORY				
Number of pregnancies:	**Miscarriages, losses, stillbirths or terminations:**	**Adoptions:**	**Number of children:**	
Information about your other children:				
Name:	**Age:**	**Treatment needed to conceive?**	**Length of pregnancy**	**Breastfeeding issues:**
		☐Yes ☐No		☐ Pain ☐ Latch issues ☐ Slow weight gain ☐ Low milk supply Other:
		☐Yes ☐No		☐ Pain ☐ Latch issues ☐ Slow weight gain ☐ Low milk supply Other:

DIET AND HEALTH BEHAVIORS/LIVING SITUATION					
Are you restricting your diet in any way? ☐ no ☐ yes What foods are you avoiding? Reason: Result: Who do you live with? ________________________ Do you feel safe in your home? ________________ Do you and your family have enough to eat? __________________ Do you have a gun in your home? Have you been physically, sexually or verbally abused? _________________________	**How often do you experience**:	Daily	Weekly	Monthly	Rarely/Never
	Exercise	☐	☐	☐	☐
	Caffeine	☐	☐	☐	☐
	Alcohol	☐	☐	☐	☐
	Tobacco	☐	☐	☐	☐
	Recreational drugs	☐	☐	☐	☐

PARENT HEALTH HISTORY								
	RECENT	PAST		RECENT	PAST		RECENT	PAST
General:			**Stress/Mood:**			**Endocrine:**		
Fatigue/exhaustion	☐	☐	Overwhelmed	☐	☐	Diabetes/Gestational	☐	☐
Headaches (not migraine)	☐	☐	Depressed	☐	☐	High Androgen Levels	☐	☐
Migraines	☐	☐	Anxiety/Panic Attacks	☐	☐	Nipple Discharge	☐	☐
Skin:			Bipolar Disorder	☐	☐	Thyroid disorder	☐	☐
Rashes	☐	☐	Persistent neg thought	☐	☐	Too hot or cold	☐	☐
Eczema	☐	☐	Bad Dreams	☐	☐	Insulin Resistance	☐	☐
Psoriasis	☐	☐	**OB/GYN**			**Other:**		
Cold sores	☐	☐	Irregular periods	☐	☐	Tongue-tie	☐	☐
Heavy body hair	☐	☐	PMS	☐	☐	Speech therapy	☐	☐

MOM: BABY: DATE:



-on breast/back/abdomen	☐	☐	PCOS	☐	☐	Raynaud's syndrome	☐	☐
Nipple piercings	☐	☐	Premature Labor	☐	☐	**Breasts:**		
Nipple wounds/injury	☐	☐	Infertility	☐	☐	Surgery/Injury	☐	☐
Abuse:				☐	☐	Abnormal Development	☐	☐
Substance Abuse				☐	☐			
Physical/Sexual Abuse				☐	☐			
Emotional Abuse				☐	☐		☐	☐
							☐	☐

PSYCHOLOGICAL WELL-BEING

*To be as accurate as possible, BREASTFEEDING PARENT should fill this out herself, without discussing the answers with others . Please check the answer which comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

1. I have been able to laugh and see the funny side of things
- ☐ As much as I always could
- ☐ Not quite so much now
- ☐ Definitely not so much now
- ☐ Not at all

2. I have looked forward with enjoyment to things
- ☐ As much as I ever did
- ☐ Rather less than I used to
- ☐ Definitely less than I used to
- ☐ Hardly at all

*3 .I have blamed myself unnecessarily when things went wrong
- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ Not very often
- ☐ No, never

4. I have been anxious or worried for no good reason
- ☐ No, not at all
- ☐ Hardly ever
- ☐ Yes, sometimes
- ☐ Yes, very often

*5. I have felt scared or panicky for no very good reason
- ☐ Yes, quite a lot
- ☐ Yes, sometimes
- ☐ No, not much
- ☐ No, not at all

*6. Things have been getting on top of me
- ☐ Yes, most of the time I haven't been able to cope at all
- ☐ Yes, sometimes I haven't been coping as well as usual
- ☐ No, most of the time I have coped quite well
- ☐ No, have been coping as well as ever

*7. I have been so unhappy that I have had difficulty sleeping
- ☐ Yes, most of the time
- ☐ Yes, sometimes
- ☐ Not very often
- ☐ No, not at all

*8. I have felt sad or miserable
- ☐ Yes, most of the time
- ☐ Yes, quite often
- ☐ Not very often
- ☐ No, not at all

*9. I have been so unhappy that I have been crying
- ☐ Yes, most of the time
- ☐ Yes, quite often
- ☐ Only occasionally
- ☐ No, never

*10. The thought of harming myself has occurred to me
- ☐ Yes, quite often
- ☐ Sometimes
- ☐ Hardly ever
- ☐ Never

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS), J. L. Cox, J.M. Holden, R. Sagovsky, From: British Journal of Psychiatry (1987), 150, 782-786.

Score: Reviewed by:

PREGNANCY AND BIRTH HISTORY

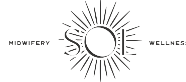
Parent:	**DOB:** **Age:**	**Baby:** **Birth Weight:**	**DOB:** **Age:**

During your pregnancy, did you experience any of the following:

☐ Fertility treatment	☐ Depression/anxiety	☐ low / high amniotic fluid	☐ Gestational Diabetes
☐ Medications	☐ Domestic violence	☐ Breast Changes (size, tenderness, etc)	☐ Bed Rest
☐ Premature labor	☐ High Blood Pressure	☐ Tobacco/alcohol/drug use	☐ Multiples

BIRTH

MOM: BABY: DATE:



How was your baby's birth? _____	**How long was your pregnancy?** _____ weeks _____ days
☐ vaginal ☐ vacuum assisted ☐ forceps assisted ☐ cesarean section: reason:	Where was your baby born? ☐ home ☐ birth center: ☐ hospital:
How did your labor begin?	**How long was your labor?** ______ hrs **pushing?** _____
Was your labor induced? ☐no ☐yes (check all that apply) Reason for induction:	Were you given medications during your labor (ie: to induce labor, pain relief, etc)? ☐ yes ☐ no
Was your baby malpositioned at any point in your labor? ☐ **no** ☐ **yes,** **describe:**	**Any complications for baby after the birth?** ☐ none
Was your baby separated from you after birth? ☐ no, ☐ yes, reason: — **Did your baby breastfeed soon after birth?** ☐ no, ☐ yes	Did your baby have any **bruising on his/her head** or **asymmetry** after the birth? ☐ no ☐ yes, describe:
What day after birth did your milk "come in"? day _____ **Was it a dramatic increase?** ☐ yes ☐ no	**Did your baby receive vitamin K after birth?** ☐ Injection ☐ Oral ☐ none **Has your baby had formula since birth?** ☐no ☐yes
Details/other issues:	

BABY'S MEDICAL HISTORY

BABY:	**DATE OF BIRTH:**
Medication allergies? ☐ **none** ☐ **yes:** **Reaction:**	**Current medications, vitamins, supplements:**
Does your baby have any health issues? ☐ none ☐ yes, describe:	Were there any concerns/abnormalities in the results of baby's newborn screening? None ☐yes; explain:

Has your baby experienced any of the following?

	Past week	Ever		Past week	Ever	Rash	Past week	Ever
Meconium aspiration	☐	☐	Heart murmur	☐	☐	Abdominal pain	☐	☐
Fever	☐	☐	Heart defect	☐	☐	Excessive spit up	☐	☐
Hypoglycemia	☐	☐	Blue baby	☐	☐	Diarrhea	☐	☐
NICU stay	☐	☐	Breathing problems	☐	☐	Breath odor	☐	☐
Birth injuries	☐	☐	Periods of not breathing	☐	☐	Colic	☐	☐
Cerebral palsy	☐	☐	Blue around mouth	☐	☐	Reflux/ GERD	☐	☐
High hematocrit	☐	☐	Nasal congestion	☐	☐	Feeding tube	☐	☐
Seizures	☐	☐	Readmitted to hospital	☐	☐	Jaundice @_____days old	☐	☐
Lethargy	☐	☐	Explain:			Require blood test?	☐	☐
Medications	☐	☐				Require phototherapy?	☐	☐
Other:			Circumcision: ☐ no ☐ yes - ☐complications? ☐ none ☐ yes: _____					

Does anyone in the home smoke? ☐no ☐yes Does anyone who sleeps with the baby use alcohol, drugs, or sleep aid medications? ☐no ☐yes

Parent/Guardian Signature: ______________________________________

I certify this information provided is true and accurate

MOM: BABY: DATE: