## **History Information for Lactation Consultation**

	Baby's information (Baby A if tw	1110)	
Name:	Name:	(M / F)	
Date of birth:	Date of Birth:		
Address:		ght:	
City/St/Zip:			
Phone:	Where did you birth?		
Partner's name:	_		
Obstetrician / Midwife:	Baby's doctor / Pediatrician:		
Practice name:	Practice name:		
Fax#:	Fax #:		
Ni	Dahyla history		
Nursing parent's history:	Baby's history: Gestational age at birth:	Age today:	
Medical conditions/Illness:	Hospital/NICU stay due to illness?		
Ownersh was disable as			
Current medications:	Current medications:		
Plan to use hormonal contraceptives? Y/N	History of jaundice? Y/N	l evel·	
	# Feedings/24 hours:	Level:	
Allergies:		How often?	
Baby's mother:	# Diapers/24 hours: Wet:		
Baby's father:	Use of pacifier? Y/N	0.00.01	
	Use of pump? Y/N How of	ten:	
Vaginal, w/Epidural? Y/NLength of labor:	Use of other feeding devices?	Y/N	
Cesarean planned / unplanned	What type?		
How many other children do you have?	washington of Santa	- William - I - I - I - I - I - I - I - I - I -	
Were they breastfed? Y/N How long?	Date of next appointment with baby's doctor:		
History of breast or chest surgery or injury?			
al analysis of the anti-property and party at the transfer of the first of the firs	(If twins, complete Baby B info on page 2.)		
What are your feeding concerns or difficulties with this What other information would you like?	s baby?		
I understand that a lactation consultation usually	includes: (Please initial)		
I understand that a lactation consultation usually  Assessment of nursing parent's breasts.	includes: (Please initial)		
I understand that a lactation consultation usually  Assessment of nursing parent's breasts.  Assessment of baby related to feeding.	includes: (Please initial)		
I understand that a lactation consultation usually  Assessment of nursing parent's breasts.  Assessment of baby related to feeding.  Suck assessment.	includes: (Please initial)		
I understand that a lactation consultation usually Assessment of nursing parent's breasts. Assessment of baby related to feeding. Suck assessment. Observing a full feeding.	includes: (Please initial)		
I understand that a lactation consultation usually  Assessment of nursing parent's breasts.  Assessment of baby related to feeding.  Suck assessment.  Observing a full feeding.  Use of feeding equipment if needed.			
I understand that a lactation consultation usually Assessment of nursing parent's breasts. Assessment of baby related to feeding. Suck assessment. Observing a full feeding.		0.	
Assessment of nursing parent's breasts.  Assessment of baby related to feeding.  Suck assessment.  Observing a full feeding.  Use of feeding equipment if needed.  Offering the parents the help and information needs	ed to establish a satisfying feeding relationshi	0.	
Assessment of nursing parent's breasts.  Assessment of baby related to feeding.  Suck assessment.  Observing a full feeding.  Use of feeding equipment if needed.  Offering the parents the help and information needed.  I understand that all medical care is to be provided.	ed to establish a satisfying feeding relationship only by a licensed medical practitioner.		
Assessment of nursing parent's breasts. Assessment of baby related to feeding. Suck assessment. Observing a full feeding. Use of feeding equipment if needed. Offering the parents the help and information needed. I understand that all medical care is to be provided I give my permission for information about this const	ed to establish a satisfying feeding relationshiped only by a licensed medical practitioner. Sultation to be sent to the baby's and my medi	cal provider.	
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## History Information for Lactation Consultation, page 2

Nursing parent's information:		Baby's information (Baby B if twins)	
Name:		Name:	(M / F)
Date of birth:		Date of Birth:	A STATE OF THE STA
		Birth weight: Lowest weight:	
		Where did you birth?	
		Baby's doctor / Pediatrician:	
		Practice name:	
		Fax #:	- i
*'e		Baby's history:	
		Gestational age at birth: Age toda	A.
		Hospital/NICU stay due to illness?	
		How long? Reason:	N
		Current medications:	
		History of jaundice? Y/N Leve	d:
		# Feedings/24 hours: Lengtl	-
		Supplements? Y/N How often	
		# Diapers/24 hours: Wet: Stool	Name of the Owner, when the Owner, which the Owner, w
		Use of pacifier? Y/N	·
		Use of pump? Y/N How often:	
		Use of other feeding devices? Y/N	
		What type?	
		Date of next appointment with baby's doctor:	
		Date of flext appointment with baby's doctor.	
*			
What are your feeding concerns of	or difficulties with this b	paby?	
What are your reeding concerns o	difficulties with this t	, and the second	
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Nursing parent's signature:		Date:	