

Mother History

Date: _____ Your name: _____ Your DOB: _____

Who referred you to our office? _____

Briefly state why you are here today. _____

THIS BIRTH

Where was baby born?

Delivery Type: Vaginal C/S VBAC

Induced? Y / N Epidural? Y / N

Any problems with your...

Pregnancy? _____

Labor/Delivery? _____

Postpartum? _____

Medications taken during pregnancy: _____

ALLERGIES

Medication _____

Foods/Other _____

FAMILY HISTORY

Your children	DOB	Breastfed how long?	General Health
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY/WORK LIFE

Who lives with you? Circle all that apply.

Spouse/Partner #__ Children Parent(s) Other _____

Work outside home? Yes *PT / FT* No

Occupation? _____

Date returning to work? _____

Marital Status? Single Married

Do you smoke? Yes No

Any household members smoke? Yes No

OTHER THINGS WE SHOULD KNOW ABOUT?

Medical & Pregnancy History

PAST AND CURRENT MEDICAL HISTORY

Number of pregnancies? _____

Any miscarriage/terminations? _____

Any history of the following (circle)?

Diabetes Infertility

Thyroid issues Hypertension

Polycystic Ovarian Syndrome Past breastfeeding problems

Mood issues (includes depression/anxiety/PPD) Personal or family history of breast cancer

Any other significant medical problems, conditions or hospitalization? _____

Medications/supplements taking now: _____

SURGICAL HISTORY

(Please include cesarean deliveries and breast surgeries)

Date	Surgery type
_____	_____
_____	_____

REVIEW OF SYMPTOMS

Recent/current problems with the following? (circle)

High blood pressure Shortness of breath

Abnormal blood sugar Headaches

Visual changes Fever or chills

Breast pain Nipple pain

Breast lump Swelling in legs/hands?

Concerns about your mood or emotions Joint/back muscle pain

Baby History

Feeding/Pumping

Date: _____ Baby's name: _____ Baby's DOB: _____

Briefly state why you are here today. _____

MEDICATIONS/SUPPLEMENTS

List any that baby is taking currently:

MEDICAL ISSUES

Low blood sugar? _____
 Jaundice? _____
 Reflux? _____
 Surgeries? _____
 Hospital readmission? _____
 NICU stay? _____
 Other _____

BABY'S BIRTH

Due Date: _____
 Birth weight: _____
 Discharge weight, if known: _____
 Baby's lowest wt and date: _____

REVIEW OF SYMPTOMS

wet diapers in 24 hours: _____
 # soiled diapers in 24 hours: _____
 Typical stool color: _____
 Extra sleepy/hard to wake? _____
 Fussy/crying a lot? _____
 Excessive spit up? _____
 Discomfort with spit up? _____

PREVIOUS THERAPIES

List any previous therapies/treatments received since baby's birth (physical therapy, chiropractic, frenotomy etc.)

Date	Treatment type
_____	_____
_____	_____
_____	_____
_____	_____

FEEDING/PUMPING HISTORY

Approximately how many times does your baby typically BREASTFEED in a 24-hour period?

Approximately how many ounces of EXPRESSED BREASTMILK does baby typically get in a 24-hour period?

Approximately how many ounces of FORMULA does baby typically get in a 24-hour period?

Approximately how many times do you typically PUMP OR HAND EXPRESS in a 24-hour period?

Approximately how many total ounces do you typically PUMP OR HAND EXPRESS in a 24-hour period?

Is your baby also eating solids? Yes / No

OTHER THINGS WE SHOULD KNOW ABOUT?

