The Milk Spot New Lactation Consultation Questionnaire Date _____

Mother Full Name _____ Date of Birth _____ Phone _____

Partner Full Name _____ Date of Birth _____ Phone _____

Baby Full Name _____ M / F Date of Birth _____ Weeks Gestation at Delivery_____

Address_____ City State Zip_____

Email address _____ Contact me by ❑ Phone ❑ Email ❑ Text

Maternity careprovider _____ City, State_____ Phone _____

Pediatrician _____ City, State _____ Phone _____

Insurance _____ Subscriber Name _____ Subscriber DOB _____

Emergency Contact _____ Phone _____ Relation _____

Mother's Health History

Pregnancies #	Miscarriage, Losses #	Births #
❑ Anemia	❑ Breast asymmetry	❑ Childbirth class
❑ High Blood Pressure	❑ Breast surgery, year _____	❑ Breastfeeding Class
❑ Hypothyroid	❑ Lumpectomy	❑ Vaginal birth
❑ Hyperthyroid	❑ Implants	❑ Epidural
❑ Diabetes/Gestational Diabetes	❑ Reduction	❑ Cesarean Birth
❑ PCOS	❑ Nipple Pain	❑ Breech
❑ Infertility	❑ Nipple damage	❑ Forceps/Vacuum
❑ GBS	❑ Infection, location	❑ Hemorrhage
❑ Depression	❑ Plugged Duct	❑ Doula
❑ Eating Disorder	❑ Breast pain	❑ Postpartum Doula
❑ Anxiety	❑ Mastitis	❑ Birth Control Pills, type _____
❑ Bipolar		
❑ OCD	Mother's profession	
❑ Abuse	Partner's profession	

Baby's Health History

Birth weight	Lowest weight on	Most recent weight on
❑ Jaundice	❑ Hypoglycemia	❑ NICU – How long?
❑ Other Complications		Total feedings
How many of each in the last 24 hours?		
Feedings At Breast #	With Bottle #	Other # (type)
Pee color	Stool color	
Pumping frequency	Quantity	

How has breastfeeding been going so far? _____

What are your main questions today? _____

_____

How did you hear about us? _____