Name _____

RETURN VISIT

Email_____

Phone_____

Thank you for coming to the Lactation Clinic.
Please update us on how breastfeeding has been going since your last visit.

Today's date_____ **Child's Name**_____ **Child's Age**_____

I am returning for more help with:

☐ Painful nursing ☐ Baby is not gaining weight well ☐ Low milk production ☐ Latch issues ☐ Other_____

How has breastfeeding been going since your last visit?_____

_____

_____

Since last LC visit	**Circle** M = mother, C= child, B = both	
☐	M C B	Thyroid medication (name & dose) →
☐	M C B	Antidepressant OR Anti-anxiety (name & dose)→
☐	M C B	Reflux medication (name & dose)→
☐	M C B	Vitamins, supplements or probiotics (name & dose)→
☐	M C B	Herbs or medications to increase milk production (please fill out '**GALACTOGOGUES'** page 6)
☐	M C B	Medications / treatments for breast pain (please fill out '**PAIN TREATMENTS'** page 5)
☐	M C B	Other (name & dose) →

Has your child been weighed since the last visit? ☐yes ☐ no

If YES:

Baby's most recent weight_____lbs Date of most recent weight_____

Have you or your baby seen another health care provider about breastfeeding since your last visit? ☐yes ☐ no

IF YES:

☐ Ob/Gyn ☐ Midwife ☐ Family Physician ☐ Pediatrician ☐ Chiropractor ☐ Speech Pathologist ☐ Cranio-Sacral Therapist ☐ ENT ☐ Other

Comments:

RETURN VISIT

What has your child eaten?		# feedings in the last 24 hours	Type of supplementer	Comments / Type of Supplementer
Has your child had **milk at the breast**	☐yes ☐no	_____		
Has your child had **YOUR pumped breast milk**	☐yes ☐no	_____	☐Bottle ☐Other(specify)	
Has your child had **DONATED pumped breast milk**	☐yes ☐no	_____	☐Bottle ☐Other(specify)	
Has your child had **infant formula**	☐yes ☐no	_____	☐Bottle ☐Other(specify)	
Has your child had **solid foods**	☐yes ☐no	_____		

Average length of feeding _____minutes

Time between feedings (from beginning to beginning) _____minutes

Number of times you **wake** at night to nurse? _____ Does anyone else feed the baby at night (specify)_____

DOES YOUR BABY **CURRENTLY** HAVE	YES	COMMENTS / DESCRIPTION
…have difficulty latching?	☐	
…spit up more than 4 times a day?	☐	
…seem to be in pain with spitting up?	☐	
…have stools that are (Circle) green mucousy bloody	☐	
…cry at the end of a feeding?	☐	
…cough / choke or sound out of breath at the breast	☐	
…have to be woken for feeds	☐	
…use a pacifier	☐	
…come on and off the breast during feeding	☐	
DO YOU HAVE		
…nipples that turn white during/after feeding or pumping?	☐	
…broken skin, blisters, or other lesions on your nipples?	☐	describe
HAVE YOU NOTICED		
…your breasts soften with feeding?	☐	
…your baby swallowing during the feeding?	☐	

RETURN VISIT

Have you been pumping since your last visit? ☐yes ☐ no → If **NO, skip to 'Nipple Shields/Equipment'**

About Pumping Milk

Type of breast pump _____ What size flange?_____

Number of pumps in 24 hours? _____ Typical number of minutes pumped per session? _____

Amount of milk pumped each session: Left_____ Right_____

Amount of milk pumped in 24 hours?_____ Total amount of milk stored? _____

Nipple Shields/Equipment

Have you used nipple shields since your last visit? ☐yes ☐ no If yes size_____

Comments_____

Did you use any other type of breastfeeding equipment?_____

About Pain with Breastfeeding

Do you have pain?

☐ yes ☐ no → If **NO, skip to 'Galactogogues'**

Currently, is your pain worse on one side than the other?

☐ Worse on left ☐ Worse on right ☐ Same pain on both sides

When is the pain most intense?

☐ Beginning of feed ☐ During feeding ☐ After feeding ☐ With pumping ☐ All the time

Think about your **last visit** and the **past 48 hours** when filling out this table**.**

	No change	Improved	Worse
If you had **nipple pain while breastfeeding** last visit, has it	☐	☐	☐
…**nipple pain while expressing** milk last visit, has it	☐	☐	☐
…**nipple pain even while not feeding** or expressing milk last , has it	☐	☐	☐
…**breast pain while breastfeeding** last visit, has it	☐	☐	☐
…**breast pain while expressing** milk last visit, has it	☐	☐	☐
…**breast pain even while not feeding or expressing** milk last visit, has it	☐	☐	☐

Since your last visit, how would you describe your pain?_____

_____

Pain Treatments ONLY THOSE YOU HAVE USED SINCE THE LAST VISIT
Below is a list of medications or treatments that you may have used **TO TREAT BREASTFEEDING OR PUMPING PAIN.**
Put anything you have **used for pain** on the left side of the table and **whether it worked** on the right side of the table.

☐ I have not used anything for breastfeeding pain since my last visit

Treatment of pain since last visit		**Did it help?**				**Comments**
	Yes		**Yes**	**Some**	**No**	
All-purpose nipple ointment	☐	**If YES**	☐	☐	☐	
Medihoney *Type*	☐	**If YES**	☐	☐	☐	
Bactroban (Mupirocin) *# times/day*	☐	**If YES**	☐	☐	☐	
Steroid ointment (name) *# times/day*	☐	**If YES**	☐	☐	☐	
Other topical (name) *# times/day*	☐	**If YES**	☐	☐	☐	
Nipple shields	☐	**If YES**	☐	☐	☐	
Nipple shells	☐	**If YES**	☐	☐	☐	
Changed pump flange	☐	**If YES**	☐	☐	☐	
Heat to breasts	☐	**If YES**	☐	☐	☐	
Ice to breasts	☐	**If YES**	☐	☐	☐	
Nifedipine	☐	**If YES**	☐	☐	☐	
Propanolol	☐	**If YES**	☐	☐	☐	
Ibuprofen (Motrin)	☐	**If YES**	☐	☐	☐	
Mother antibacterial *Name*	☐	**If YES**	☐	☐	☐	
Mother antifungal (for yeast) *Name*	☐	**If YES**	☐	☐	☐	
Child antifungal (for yeast) *Name*	☐	**If YES**	☐	☐	☐	
Other *Details*	☐	**If YES**	☐	☐	☐	

Galactogogues ONLY THOSE YOU HAVE USED SINCE THE LAST VISIT
Below is a list of medications or treatments that you may have used **TO INCREASE MILK PRODUCTION.**
Put anything you have used to **increase milk production** on the left side of the table and **whether it worked** on the right side of the table.

☐ I have not used anything to increase my milk production since my last visit

Treatment to increase milk	**Since last visit**	**Did the it help?**				
	Yes		**Yes**	**Some**	**No**	**Comments**
Diet changes (specify)	☐	**If YES**	☐	☐	☐	
Fenugreek *Dose*	☐	**If YES**	☐	☐	☐	
Alfalfa pills *Dose*	☐	**If YES**	☐	☐	☐	
Mulanggay/Go-Lacta *Dose*	☐	**If YES**	☐	☐	☐	
Blessed Thistle *Dose*	☐	**If YES**	☐	☐	☐	
Goat's Rue *Dose*	☐	**If YES**	☐	☐	☐	
More Milk tincture *Dose*	☐	**If YES**	☐	☐	☐	
Other herb_____ *Dose*	☐	**If YES**	☐	☐	☐	
Other herb_____ *Dose*	☐	**If YES**	☐	☐	☐	
Pumping after nursing	☐	**If YES**	☐	☐	☐	
Power pumping # *times/day*	☐	**If YES**	☐	☐	☐	
Supplemental Nursing System	☐	**If YES**	☐	☐	☐	
Other *Details*	☐	**If YES**	☐	☐	☐	