INTAKE-FIRST VISIT	Date_____ Name _____ __ Email_____ Phone_____

Thank you for coming to the Lactation Clinic. Please complete the following:

Your date of birth: _____ Your Primary Care Provider_____

Baby's name_____ Baby's date of birth_____ ☐ Boy ☐ Girl

Where was your baby born? ☐ UNC ☐ WBWC Other: _____

Baby's Primary Provider ☐ UNC ☐ WBWC Other: _____

Where did you get your prenatal care? ☐ UNC ☐ WBWC Other:

Race and Ethnicity

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific
☐ Asian
☐ Other

I am coming to lactation clinic for help with:

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

Have you seen anyone else for help with breastfeeding problems? ☐ no ☐ yes

Who?_____ Did this person refer you to our care? ☐ no ☐ yes

About your pregnancy and birth

How tall are you? _____ ft _____ inches

Weight prior to pregnancy _____ bs Weight gain during pregnancy _____ lbs

By how many bra cup sizes did your breasts increase during pregnancy? _____

Did you have any of these problems during your pregnancy or birth?

yes		yes	
☐	Pre-eclampsia	☐	Breech
☐	Gestational Diabetes	☐	Asynclitic (head turned during labor)
☐	High blood pressure in pregnancy	☐	Bruising or molding of baby's head
☐	Preterm birth	☐	Posterior presentation ('sunny side up')
☐	Multiple birth	☐	Compound presentation (hand by head)
☐	Other pregnancy complication_____	☐	Epidural
☐	Baby Re-hospitalized	☐	Narcotics in labor
☐	Baby in Intensive Care	☐	Antibiotics during labor
☐	Baby treated for jaundice	☐	Post-partum hemorrhage
		☐	Other:

What was your due date? _____

Labor Hours of labor _____ ☐ started naturally ☐ was induced ☐ scheduled C-section

Birth ☐ Vaginal ☐ Vacuum ☐ Forceps ☐ C-section

Baby's birth weight _____ lbs _____ oz Age when baby regained birth weight (days)_____

Most recent weight _____ lbs _____ oz Date of most recent weight_____

What is your goal for breastfeeding?_____

Number of pregnancies _____ Number of children _____ **If 1, → skip to "<u>About current feeding"</u>**

Ages of other children_____

How old was / were your other children when you stopped breastfeeding?_____

With one or more of my previous children, I had difficulty with:

☐ Low milk supply ☐ Yeast infection ☐ Other
☐ Mastitis ☐ Recurrent plugged ducts ☐ No problems
☐ Nipple pain ☐ Baby with tongue tie

Do you feel you were able to achieve your breastfeeding goals with your other children? ☐ no ☐ yes

<u>About current feeding</u>

Please write "0" if your child has not had a food in the past 24 hours

How many times in the past 24 hours has your child had…	**#**	**Type of supplement**	**Comments / how much per feed?**
…milk at the breast	_____		
…**YOUR pumped breast milk**	_____	☐Bottle ☐SNS	
… **DONATED pumped breast milk**	_____	☐Bottle ☐SNS	
…infant formula	_____	☐Bottle ☐SNS	
…**solid foods**	_____		

How many ounces **total** has your baby been supplemented with formula in the past 24 hours? _____ oz

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? ☐ No ☐ Yes → who? _____

In past 24 hours, how many: wet diapers (pees) _____ bowel movements (poops) _____

DOES YOUR BABY	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: ☐ 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 turns white during/after feeding or pumping?	☐	
…broken skin, blisters, or other lesions on your nipples?	☐	
HAVE YOU NOTICED		
…your breasts soften with feeding?	☐	
…your baby swallowing during the feeding?	☐	

Are you using a nipple shield? ☐ No ☐ Yes → size _____

Reason for using ☐ latch difficulty ☐ pain ☐ other: _____

Do you use any other type of breastfeeding equipment? _____

Are you currently working outside the home or in school? ☐ No ☐ Yes → How many hours/week? _____

Who cares for your child when you are at work / school?
☐ in home caregiver ☐ child care center ☐ partner ☐ family ☐ other_____

About Pumping

Do you pump? ☐ yes ☐ no → If **NO, skip to About Pain with Breastfeeding**

Type of breast pump _____ What size flange? _____

Age of baby when started pumping? _____ days OR _____ weeks

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

Amount of milk pumped each session: Left _____ Right _____

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

ABOUT BREAST AND NIPPLE PAIN

Do you have pain? ☐ yes ☐ no → If **NO, skip to <u>Treatments to increase milk production on page 6</u>**

Think about the **past 48 hours**. On a scale of 0 to 10where "0" is no pain and "10"is the "most intense pain imaginable", how much pain did you experience on each side…

	n/a	Left (0-10)	Right (0-10)
With latching…	[ ]		
In the nipple	[ ]		
In the breast	[ ]		
After the first 30 seconds of breastfeeding…	[ ]		
In the nipple	[ ]		
In the breast	[ ]		
While pumping…	[ ]		
In the nipple	[ ]		
In the breast	[ ]		
While not breastfeeding or pumping	[ ]		
In the nipple	[ ]		
In the breast	[ ]		

How would you describe your pain?

Coping Strategies Questionnaire

Persons who experience pain have developed a number of ways to cope or deal with it. Below is a list of thoughts or feelings that some patients have when they experience pain or medical symptoms. For each thought or feeling below, *please indicate how often you feel this way when you experience pain* using the scale from 0 (never think or feel that way) to 6 (always think or feel that way). *Remember you can use any point along the scale from 0 to 6.*

When I feel pain …	Never think or feel that			Sometimes think or feel that			Always think or feel that
1. It is terrible and I feel it's never going to get any better.	0	1	2	3	4	5	6
2. It is awful and I feel that it overwhelms me.	0	1	2	3	4	5	6
3. I feel my life isn't worth living.	0	1	2	3	4	5	6
4. I worry all the time about whether it will end.	0	1	2	3	4	5	6
5. I feel I can't stand it anymore.	0	1	2	3	4	5	6
6. I feel like I can't go on.	0	1	2	3	4	5	6

PAIN TREATMENTS
Below is a list of medications or treatments that you may have used **TO TREAT BREASTFEEDING OR PUMPING PAIN.** Please check "Used" if you have tried a treatment and then check **whether it helped.**

☐ I have not used anything for pain → **Skip to <u>Treatments to increase milk production on page 6</u>**

Treatment		**If used, did the treatment / medication help?**			**Comments**
	Used	**Yes**	**Some**	**No**	
Ointments and Creams					
All-purpose nipple ointment	☐	☐	☐	☐	
Medihoney *Type*	☐	☐	☐	☐	
Bactroban (Mupirocin) *# times/day*	☐	☐	☐	☐	
Steroid ointment *(Name)* *# times/day*	☐	☐	☐	☐	
Antifungal ointment *(Name)* *# times/day*	☐	☐	☐	☐	
Other *Details*	☐	☐	☐	☐	
Mechanical					
Nipple shields	☐	☐	☐	☐	
Nipple shells	☐	☐	☐	☐	
Changed pump flange	☐	☐	☐	☐	
Heat to breasts	☐	☐	☐	☐	
Ice to breasts	☐	☐	☐	☐	
Massage	☐	☐	☐	☐	
Frenotomy (tongue tie clipped)	☐	☐	☐	☐	
Physical therapy for baby	☐	☐	☐	☐	
Medications					
Ibuprofen (Motrin)	☐	☐	☐	☐	
Nifedipine	☐	☐	☐	☐	
Propanolol	☐	☐	☐	☐	
Mother antibiotic *Name*	☐	☐	☐	☐	
Mother antifungal (for yeast) *Name*	☐	☐	☐	☐	
Child antifungal (for yeast) *Name*	☐	☐	☐	☐	
Other	☐	☐	☐	☐	

TREATMENTS TO INCREASE MILK PRODUCTION
Below is a list of medications or treatments that you may have used **TO INCREASE MILK PRODUCTION.** Check 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 → **Skip to <u>About your medical history</u>**

Treatments		**If used, did the treatment / medication help?**			**Comments**
	Used	**Yes**	**Some**	**No**	
Diet changes (specify)	☐	☐	☐	☐	
Herbs / medications					
Alfalfa pills *Dose*	☐	☐	☐	☐	
Blessed Thistle *Dose*	☐	☐	☐	☐	
Fenugreek *Dose*	☐	☐	☐	☐	
Goat's Rue *Dose*	☐	☐	☐	☐	
More Milk tincture *Dose*	☐	☐	☐	☐	
Mulanggay/Go-Lacta *Dose*	☐	☐	☐	☐	
Other herb_____ *Dose*	☐	☐	☐	☐	
Reglan (metoclopramide)	☐	☐	☐	☐	
Domperidone	☐	☐	☐	☐	
Mechanical					
Pumping after nursing *Details*	☐	☐	☐	☐	
Power pumping # *times/day*	☐	☐	☐	☐	
Supplemental Nursing System	☐	☐	☐	☐	
Frenotomy (tongue tie clipped)	☐	☐	☐	☐	
Other *Details*	☐	☐	☐	☐	

ABOUT YOUR MEDICAL HISTORY

How old were you when you first got your period? _____

Were you overweight when you got your period? ☐ no ☐ yes

Have you had any of the following medical problems or procedures?

☐ Panic attacks
☐ Depression
☐ Post-partum depression
☐ Anxiety disorder
☐ Seasonal allergies
☐ Food sensitivities
☐ Diabetes
☐ Hypertension
☐ Hyperthyroid
☐ Hypothyroid
☐ Other thyroid problems

☐ Breast augmentation
☐ Breast reduction
☐ Other breast surgery
☐ Gastric bypass
☐ Irregular periods
☐ Polycystic Ovarian Syndrome (PCOS)
☐ Infertility treatment

☐ Ever smoked
☐ Current smoker

☐ Fingers turn white/blue in cold
☐ Breasts are painful in the cold
☐ Raynaud's syndrome

☐ Migraines
☐ Bowel pain
☐ Extreme pain with periods
☐ Pain with sex
☐ Low back pain
☐ Other pain

Do you have any allergies to medications?
☐ None ☐ Yes, I am allergic to:

What medications are you and your baby currently taking?

Taking Now		Type and dose
	Mother	
☐	Thyroid medication	
☐	Antidepressant or Anti-anxiety	
☐	Birth control	
☐	Vitamins, supplements or probiotics,	
☐	Other medications	
	Baby	
☐	Reflux medication	
☐	Vitamins, supplements or probiotics	
☐	Other medication	

What else would you like us to know about your health?

DMER

Some mothers experience negative emotions such as anxiety, unpleasantness or dread during milk let down. Have you experienced this?

☐ No ☐ Yes if you answered "No", please skip to **How are you feeling?** on the next page

To what extent do you experience the following sensations during milk let down?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
A sensation of a pit/hollowness or sinking in the stomach	☐	☐	☐	☐	☐
Sadness	☐	☐	☐	☐	☐
Feelings of being hopeless	☐	☐	☐	☐	☐
Feelings of being apprehensive	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Dread	☐	☐	☐	☐	☐
Agitation	☐	☐	☐	☐	☐
Tension	☐	☐	☐	☐	☐
Feeling paranoid	☐	☐	☐	☐	☐

If you experience different sensations, please write each of them and let us know to what extent you feel that way

Other sensations you feel	Not at all	A little bit	Moderately	Quite a bit	Extremely
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

Adapted from:
http://www.d-mer.org/Spectrum_and_Intensities.html

HOW ARE YOU FEELING?

We would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

☐ Yes, all the time
☒ Yes, most of the time
☐ No, not very often
☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

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 copied quite well
☐ No, I 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