Breastfeeding Questionnaire

Baby's Name: _____ **DOB:** _____

Mom's Name: _____ **Today's Date:** _____

Please answer each question with "Yes" or "No" or write brief notes as needed.
We will have time to discuss answers in our session.

- [ ] Was labor really long?
- [ ] Was labor really short?
- [ ] Did mom have IV fluids or an epidural during labor?
- [ ] Did mom have a C-section?
- [ ] Has milk been delayed coming in or low in supply?
- [ ] Are baby being fed with something other than mom's milk?
- [ ] Has baby had any jaundice?
- [ ] Any prior chest surgeries for mom?
- [ ] Are mom's nipples flat or inverted that you know of?
- [ ] Any history of thyroid health issues for mom?
- [ ] Is mom experiencing any nipple pain or damage?
- [ ] Is mom pumping?
- [ ] Is mom using a nipple shield?
- [ ] Does the nipple shield stay on well?
- [ ] Has mom breastfed babies prior to this?
- [ ] Did mom's breasts grow 1+ cup sizes during pregnancy?
- [ ] Is baby gaining weight/regained to birth weight?
- [ ] Can mom feel the milk letdown while nursing?
- [ ] Is mom's nipple drawn into the shield after unlatching?

Number of feedings per day? _____ How long does each feeding take? _____

Number of pee diapers per day? _____ Number of poopy diapers per day? _____

What color is the poop? _____

How long do you hope to breastfeed? _____

Anything else you think would be helpful to know _____

_____

_____

_____

Mom's Signature: _____