Maternal-Infant History Form

ANGEL KIDS PEDIATRICS
JACKSONVILLE BREASTFEEDING CENTER
13241 Bartram Park Blvd, Suite 217
Jacksonville, FL 32258
13770 Beach Blvd, Unit 6
Jacksonville, FL 32224

Mother's Name: **Date of Birth:**

Address:

City, State, Zip: **Phone:**

Baby's Name: **Baby's Date of Birth:**

Baby's Gestational Age: **Baby's Birth Weight:**

Occupation: **Back to Work Date:**

Do you have history of any of the following medical conditions?

☐ Depression	☐ Thyroid Disease	☐ PCOS
☐ Eczema	☐ Diabetes	☐ Asthma
☐ HIV	☐ Breast Cancer	☐ Heart Disease
☐ Hepatitis	☐ Other _____	

Please list the following that you are currently taking or have recently taken:

Prescription Medications: _____
(Pain Medications, Birth Control Pills, etc.)

Over the Counter Medications: _____
(Stool Softener, Tylenol, Motrin, Cold Relief, etc.)

Herbal Supplements or Vitamins: _____
(Fenugreek, Multivitamins, etc.)

Recreational Drugs: _____
(Marijuana, Amphetamines, etc.)

Do you drink caffeinated beverages? ☐ No ☐ Yes **Please explain:** _____
(Coffee, Tea, Soda, etc.)

Do you drink alcohol? ☐ No ☐ Yes **Please explain:** _____

Do you smoke cigarettes? ☐ No, I used to smoke ☐ Yes **Please explain:** _____
☐ No, never smoked

Do you use any other substance or device that contains nicotine? ☐ No ☐ Yes **Please explain:** _____

Do you have any allergies? ☐ No ☐ Yes **Please explain:** _____

Have you had any breast surgeries? ☐ No ☐ Yes **Please explain:** _____
(Augmentation, Reduction, Biopsy, etc.)

Did you notice any breast changes during pregnancy? ☐ No ☐ Yes **Please explain:** _____

Do you currently have any diet restrictions? ☐ No ☐ Yes **Please explain:** _____
(Vegetarian, Low Sodium, Cultural/Religious, etc.)

Please list any other children, if any, that you have:

Age	Breastfed?	How long?
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

What type of delivery? ☐ **Vaginal** ☐ **VBAC** ☐ **Ceserean** **Why?** _____

Please explain any complications:

Were forceps or the vacuum used?	☐ **No**	☐ **Yes**	
Were medications used during labor or delivery? (Epidural, Pitocin, etc.)	☐ **No**	☐ **Yes**	**Explain:** _____
Did baby receive any medications?	☐ **No**	☐ **Yes**	**Explain:** _____
Were there any issues for baby?	☐ **No**	☐ **Yes**	**Explain:** _____
Did baby have jaundice?	☐ **No**	☐ **Yes**	
Did baby require light therapy?	☐ **No**	☐ **Yes**	
If male baby, did you opt to circumcise?	☐ **No**	☐ **Yes**	☐ **Not Applicable**
Were you visited by Lactation?	☐ **No**	☐ **Yes**	
Did baby take to nursing easily?	☐ **No**	☐ **Yes**	
Do you offer both breasts at each feed?	☐ **No**	☐ **Yes**	
How often is baby feeding? (24 hours)	☐ **Every hour**	☐ **Every 1-2 hours**	☐ **Every 2-3 hour** ☐ **Other:** _____
Does your baby receive bottle feedings?	☐ **No**	☐ **Yes**	
Do you supplement with formula?	☐ **No**	☐ **Yes**	
Do you have a pump?	☐ **No**	☐ **Yes**	**Brand:** _____ **How often do you pump:** _____
Is your spouse/partner/family supportive of breastfeeding?	☐ **No**	☐ **Yes**	☐ **Maybe**

Have you experienced any of the following (check all that apply):

☐ Sore Nipples	☐ Breast Pain	☐ Breast Infection
☐ Plugged Ducts	☐ Latch Issues	☐ Supply Issues (Over/Under)
☐ Slow Weight Gain – Infant	☐ Engorgement	☐ Flat/Inverted Nipples
☐ Other _____		

What are your breastfeeding goals:

_____

_____

Please tell us about any questions, concerns, or information that you feel should be addressed at your visit today:

_____

_____

_____