The Lytle Center for Pregnancy and Newborns
Breastfeeding Questionnaire for Follow-up Visits

Mom:	Date of Birth:
Baby:	Date of Birth:

● **What are the main issues you want to get help with today? (in order of priority)**
Mom issues: 1. 2.
Baby issues: 1. 2.
Any changes since last visit? Please describe:
Any new medications? □ No □ Yes, please list: ___________________________________ □ Herbs □ Reglan (metoclopramide) or Domperidone (motilium) How often:
Is baby latching? □ No □Yes □Sometimes Are you using a nipple shield? □ No □Yes Size: □ 20 mm (small) □24 mm (medium)
How many breastfeedings in the last 24 hours? Any feeds with bottle/finger feeder/syringe? How many in the last 24 hours? How long do the feedings last? # of wet diapers _______________ # of dirty diapers ______________
Have you pumped your breasts? □ No □Yes, and how often in the last 24 hours? _______ How much do you collect with pumping?
Are you supplementing? □ No □ Yes, with: □ expressed breast milk, how much in 24 hours? _______ □ donor human milk, how much in 24 hours?__________ □ formula, how much in 24 hours?________ □ after how many feedings in 24 hours?________
Pain with breastfeeding? □ No □ Yes, please describe: Pain with pumping? □ No □ Yes, please describe:
How has breastfeeding been in the past 24 hours?