

**Lactation Consultation Intake Form – Follow Up**

Breastfeeding Parent Information:

Legal Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Chosen Name (if different) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Baby’s First and Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Baby’s DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Baby’s Current Age \_\_\_\_\_\_\_\_\_\_\_\_\_ weeks/months

Breastfeeding Parent’s Health History (please select all that apply)

Breastfeeding Parent’s Underlying Conditions:

* Anemia
* Anxiety
* Autoimmune disorder
* BMI >30
* Breast surgery (cosmetic or other)
* Cancer
* Depression
* Diabetes (Gestational or Other)
* Difficulty conceiving
* Eating disorder
* Heart Disease
* Hepatitis
* High Blood Pressure
* Infertility
* Irregular Periods
* Polycystic Ovarian Syndrome (PCOS)
* Sexually Transmitted Infection
* Thyroid Disorder: hypothyroid, hyperthyroid
* Vitamin D Deficiency
* Known contraindications for breastfeeding
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking (or noting for future use) any of the following?

* Prescription Drugs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Supplements \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Herbs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Encapsulated Placenta
* Topical Estrogen or Progesterone Cream
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* None

Are you currently using (or noting for future use) any of the following?

* Recreational Drugs
* Alcohol
* Cigarettes/Nicotine/Tobacco

Lactation: What questions/concerns would you like to address at your lactation consultation?