Breastfeeding Assessment

Date: _____

Parent's Name: _____ Name of Baby: _____

Name of Support Person: _____ DOB Baby: _____ Age Today: _____

Parent DOB: _____ Gestational Age at Birth: _____

Gravida ___ Para ___ Birth Wt.: _____ Discharge Wt: _____

Feeding Concern: Today's Wt.: _____ Post Feed Wt.:_____

Wet Diapers/day: _____

Description of Current Feedings: Stools/day: _____ color& consistency: _____

Last Feeding & Type of Feeding: Any Supplementation:

Parent's History:

_____Birth Story:
_____Breastfeeding History:
_____Breast Changes during pregnancy, injuries, surgeries:
_____Milk volume increased how many days PP :
_____Milk Production now:
_____Medications, vitamins, supplements, birth control:
_____Postpartum bleeding – amount, color, clots, menses returned:
_____Menstrual cycle, fertility problems, miscarriages:

Infant's History:

_____ Birth Issues/Trauma:

_____ Medical Issues:

Parent's Assessment:

_____Breast:
_____Nipples, type, shape after feedings:
_____Pain with feedings
_____Milk Expression

Assessment of a Feeding:

Baby's Assessment:

_____Position and Latch
_____Behavior at the breast
_____Suck/Swallow Pattern:
_____Body evaluation of baby:
_____Facial features: Symmetry
_____Skin color, tone, hydration, fat pads:
_____Oral features- rooting, lips, tongue, roof of mouth:
_____Ability and desire to suck:

Assessment/Analysis of Issue:

Plan - Create a Feeding Plan that addresses:

1. Feed the Baby
2. Protect the Milk Supply
3. Seek a Solution