



LACTATION ASSESSMENT FORM

Date:	
Lactation Consultant Name:	
LC Phone Number:	
LC Email:	

Lactating Parent's Name:	Phone:
Baby's Name:	Baby's Birth Date:
Parent's Doctor:	Phone:
Baby's Doctor:	Phone:

Health History ~ Lactating Parent

Have you breastfed any children previously? Did you meet your goals?

List any medical conditions or problems that you have experienced / been diagnosed with:

Do you have any history of chest or breast injury or surgery? **Y N** Please explain:

Do you smoke or vape? Y N	# per day:	Any cigarette smoke exposure? Y N
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Are you using marijuana? Y N	In what form?
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List any medications that you currently take (include OTC, prescribed, birth control, herbal supplements, lactation cookies or tinctures):

Drug Name	Dosage	Frequency Taken

Pregnancy / Birth Information

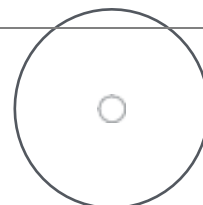
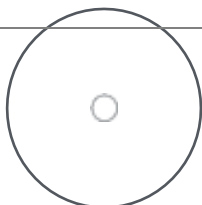
# of Pregnancies?	# of Births?	Fertility Treatments? Y N
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How was your menstrual cycle before this birth?
 Has your cycle returned? **Y N**

Breast/chest changes during *this* pregnancy? **Y N** Tenderness Fullness Size Other

Was labor induced? Y N	# Weeks Gest:	Length of Labor:	Pushing:
Pain Relief During Labor: <input type="checkbox"/> Epidural <input type="checkbox"/> IV Drugs: <input type="checkbox"/> Local <input type="checkbox"/> Other:			
Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section		Interventions:	
How soon after delivery did baby go to breast?			
How did the first feeding go?			
Birth Weight:	Discharge Weight:	Current Weight:	
First Week Postpartum			
Did the <i>baby</i> experience any of the following in the hospital?			
<input type="checkbox"/> Supplements <input type="checkbox"/> Separation from Mom <input type="checkbox"/> Pacifier <input type="checkbox"/> Jaundice <input type="checkbox"/> NICU <input type="checkbox"/> Procedures:			
Did <i>parent</i> experience any of the following in the hospital or first few days after delivery?			
<input type="checkbox"/> Hand Expression <input type="checkbox"/> Pumping <input type="checkbox"/> Nipple Pain <input type="checkbox"/> Nipple Damage <input type="checkbox"/> Procedures:			
<input type="checkbox"/> Engorgement Day:		Is this on-going? Y N	
Current Feeding Routine			
Feeding Methods (Check all that apply):			
<input type="checkbox"/> At Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Syringe <input type="checkbox"/> Cup <input type="checkbox"/> Spoon <input type="checkbox"/> SNS <input type="checkbox"/> Other:			
At breast	# / 24 hours:	Length of time:	Who ends feed?
Supplement name(s):		# / 24 hours:	Ounces / 24 hours:
Is baby waking to feed? Y N			
How do you know when your baby is ready to eat?			
Is baby eating any other food? Y N			
Is baby taking any medications? Y N			
Does baby use a pacifier? Y N	How often / when?		
Output: # BM diapers / 24 hrs.:	Color:	Size:	
# Wet diapers / 24 hrs.:	Color:		
Where does baby sleep?			
Baby Assessment			
Does the baby appear hydrated?			
Infant muscle tone: <input type="checkbox"/> tense <input type="checkbox"/> floppy <input type="checkbox"/> normal <input type="checkbox"/> other			
Infant demeanor: <input type="checkbox"/> calm <input type="checkbox"/> irritable <input type="checkbox"/> lethargic <input type="checkbox"/> agitated <input type="checkbox"/> other			
Head and body symmetry:			

Pumping			
Are you using a breast pump? Y N		What brand /model? <input type="checkbox"/> NEW <input type="checkbox"/> USED	
What size flanges are you using?		Is pumping comfortable? Y N	If no, explain:
How many times in 24 hrs. do you pump?		How many times overnight?	
How much milk are you collecting each time?		Total oz in 24 hrs.?	
What are you doing with your milk? <input type="checkbox"/> Feed Immediately <input type="checkbox"/> Store <input type="checkbox"/> Discard			Why?
Do you have concerns about pumping or milk storage? Y N			
Are you using any other products such as breast shields or supplemental nursing systems? Y N			
Are you returning to work / school? Y N		Start Date:	Will you pump while away? Y N
Concerns & Goals			
What are your short and long-term breastfeeding/chestfeeding goals?			
What concerns do you have today?			
Do you have help and support? Y N		Who?	
Feeding Observation & Breast Exam			
Breast: <input type="checkbox"/> Left <input type="checkbox"/> Right		Breast: <input type="checkbox"/> Left <input type="checkbox"/> Right	
Position Used:		Position Used:	
Time on breast:		Time on breast:	
Audible Swallows? Y N	Pain? Y N	Audible Swallows? Y N	Pain? Y N
Adjustments Made:		Adjustments Made:	
Resolved Y N		Resolved Y N	
Breast form, color, and shape:		Breast form, color, and shape:	
Notes:		Notes:	



Oral Exam
Tongue Placement (during suck) <input type="checkbox"/> Over gums <input type="checkbox"/> Over lip <input type="checkbox"/> Other:
Tongue Position (during suck) <input type="checkbox"/> Cupped <input type="checkbox"/> Humped <input type="checkbox"/> Other:
Resistance under tongue? Y N
Notes:

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1. **mail:**
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
2. **fax:**
(833) 256-1665 or (202) 690-7442; or
3. **email:**
program.intake@usda.gov

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