Patient's Name:___________________ Date of Birth:________________

Today's Date:____________Birth Weight:_________ Present Weight:___________

Medical History: Has your child experienced any of the following problems or treatments?

1. Received vitamin K injections? Yes__ No__
2. Was your infant born premature? Yes__ No__
3. Does your infant have any heart disease? Yes__ No__
4. Has your infant had any surgery? Yes__ No__
5. Is your infant taking any medications? Yes__ No__
   ____

6. Has your infant experienced any of the following?
   a. ___Poor latch
   b. ___Falls asleep while attempting to nurse
   c. ___Slides off the nipple when attempting to latch
   d. ___Colic symptoms
   e. ___Reflux symptoms
   f. ___Poor weight gain
   g. ___Gumming or chewing of your nipple while nursing
   h. ___Unable to hold pacifier in mouth
   i. ___Short sleep episodes requiring feeding every 2-3 hours
   j. ___Thrush
7. Has your infant received any pain medication today? Yes__ No__
8. Has your infant received any cranial-sacral therapy? Yes__ No__
9. Has your infant had a prior surgery to correct the tongue or lip-tie? Yes__ No__
   If yes please indicate when and where:

   ____

10. Have you had any of the following signs or symptoms?
    a. ___Creased, flattened or blanched nipples after nursing
    b. ___Cracked, bruised or blistered nipples
    c. ___Bleeding nipples
    d. ___Severe pain when your infant attempts to latch
    e. ___Poor or incomplete breast drainage
    f. ___Infected nipples or breasts
    g. ___Plugged ducts
    h. ___Mastitis or nipple thrush

11. Have you seen a lactation consultant regarding your breastfeeding concerns? Yes__ No__

Pediatrician:_______________________ Phone Number:______________ Fax:_______________
Address:__________________________ City:________________________ Province/State:____
Lactation Consultant:_______________ Phone Number:______________ Fax:_______________
Referred by:_______________________

Additional Comments: ____
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