

# KIDS FIRST PEDIATRICS, PC

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## PATIENT DATA:

Patient Name		Date of Birth		Age	
Phone	H / W	Phone	H / W		

ALLERGIES:  NKMA

Date of Encounter \_\_\_\_\_

HISTORIAN:  mom  dad  other \_\_\_\_\_

## Lactation Consult

Patient Name: \_\_\_\_\_

Mother Name: \_\_\_\_\_

DOB: \_\_\_\_\_

DOB: \_\_\_\_\_

Birth weight \_\_\_\_\_

### Maternal History:

1) Do you have any medical problems? \_\_\_\_\_

2) Were there problems during your pregnancy? \_\_\_\_\_

3) Were there problems at the delivery? \_\_\_\_\_

4) Are you taking any medications? (including over the counter medications) \_\_\_\_\_

5) Previous experience breastfeeding \_\_\_\_\_

6) Are you pumping? If yes, how often \_\_\_\_\_

Breastfeeding my baby is

Easy

Difficult

My baby latches well

yes

no

I have pain when I nurse

yes

no

My nipples are sore

yes

no

I have breast pain

yes

no

I feel I don't make enough milk

yes

no

Reason for today's visit \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional Questions \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_