Intake Medical History **Date:** **Start time:** **Referred by:**

Mother's Information

Mother's Name _____ Birth Date _____ Age _____

Address _____ Number of other children _____

_____ Number of children breastfed _____

Home phone _____ Past breastfeeding problems?

Work or Cell phone _____ _____

Health History- Please circle:

Occupation _____ Smoker Diabetes

Return to work date _____ Thyroid problems Depression

Breast surgery Infertility

Ob/Midwife & Practice _____ Allergies Other _____

_____ _____

Pediatrician & Practice _____ Herbs/Medications

_____ _____

Hospital or Birthing Center Name _____

Birth notes- Please Circle: Vaginal Antibiotics Epidural

C-section Induction Hemorrhaging

Other information_____

Medications Given During Birth _____

Baby's Information

Baby's name _____ Gestational age _____

Please circle M F Today's age _____

Birth Date _____ # poopy diapers/ 24 hrs. _____

Birth weight _____ # wet diapers/ 24 hrs _____

Lowest weight _____ Medications or special medical instructions

_____

Before feed weight: **After feed weight:** **Intake at breast:** **Addn'l intake:**

Dad's Information

Dad's Name _____

Dad's Allergies _____ Dad's concerns _____

Dad's cell or work # _____ _____

Today I need help with: _____

_____

1. I consent to a report of this lactation consultation being sent to my physicians.
2. I give my consent for information and any photographs from this consultation to be used, for educational purposes, and to promote breastfeeding, no names will be used.
3. I agree to release information needed by my insurance company to process a claim for reimbursement.
4. I understand that this consultation will include physical examination of the mother's breasts, the baby's suck, and the observation of a breastfeeding session. It may include use of equipment to maintain lactation.
5. Consultation rates are $75.00 per hour. One additional follow-up call will be at no charge. Additional consultation will be billed at $18.75 per 15 minutes. Travel fee applies at $35.00.

Signature_____ Date_____

Email address_____ (all reports and receipts will be emailed)

Susan Sullivan, IBCLC 2010

Fees: **Products:**

Intake Medical History Form
Susan Sullivan, IBCLC

Date:

Notes:

Date:

Notes:

Date:

Notes: