ROCKYVIEW
MATERNITY & FAMILY PRACTICE
Suite 258, 1011 Glenmore Trail S.W., Calgary, AB T2V 4R6
(P) 403-640-0600 (F) 403-253-0124
www.rockyviewmaternity.ca
Formerly South Maternity & Family Practice Group

Breastfeeding Questionnaire

Date: _____

Personal Information

Mom's Name: First:_____Last: _____

Mom's Medical History:

Type of Delivery: ☐ Vaginal ☐ Vacuum ☐ Forceps ☐ C-Section

Medical Concerns: _____

Medications: (herbal &/or prescription) _____

Any breast surgery? YES NO If yes, explain _____

Any history of depression or anxiety? _____

Problems breastfeeding other children? YES NO IF yes, explain _____

Baby's Name: First:_____Last: _____

Baby's Medical History:

Baby's birth weight: _____

Date and value of last weight: _____

Medical concerns: _____

Was baby born prematurely? YES NO If yes, how early _____

Breastfeeding Information

Main breastfeeding concern: _____

_____

Things tried to date: _____

_____

Feeding History:

In 24 hours, how many times do you or the baby do the following:

Breastfeed _____ How many minutes per breast _____

Pumping _____ How many minutes per breast _____ Volume of pumped breastmilk per pump _____

Volume of expressed milk given per feed _____

Formula _____ Volume of formula given per feed _____

If your baby gets formula or pumped milk, is this:

☐ After breastfeeding ☐ In place of breastfeeding ☐ Before breastfeeding

Goals for feeding:

☐ Breastfeeding only ☐ Breast & expressed milk ☐ Breast & formula ☐ Formula only

Baby's Output:

In 24 hours, how many times does the baby have:

Wet diapers _____ Stools _____

Check All That Apply		
Latch:	**YES**	**NO**
Do you have inverted or flat nipples?	☐	☐
Do you have nipple pain?	☐	☐
Do your nipples hurt more at the beginning of feeds?	☐	☐
Are your nipples cracked or damaged?	☐	☐
Do you find it awkward to position your baby for feeds?	☐	☐
Yeast:		
Has the baby had any diaper rash?	☐	☐
Has the baby had thrush (yeast in the mouth)?	☐	☐
Have you or baby been on antibiotics?	☐	☐
Do your nipples hurt more at the end of feeds?	☐	☐
Do you have shooting pains in the breast after feeds?	☐	☐
Do you have any vaginal itching or unusual discharge?	☐	☐
Supply:		
Did you have significant blood loss after delivery?	☐	☐
Is the baby gaining weight well?	☐	☐
Does the baby feed vigorously?	☐	☐
Can you hear the baby swallow?	☐	☐
Does your baby seem satisfied after breastfeeding?	☐	☐
Are your breasts fuller before feeds?	☐	☐
Are your breasts softer after feeds?	☐	☐
Overactive Milk Ejection Reflex:		
Is your baby fussy and/or gassy?	☐	☐
Does your baby choke or sputter at the breast?	☐	☐
Does your baby pull on & off the breast?	☐	☐
Does your milk spray out or leak often?	☐	☐
Do your breasts often feel engorged?	☐	☐
Miscellaneous:		
Does your baby refuse the breast?	☐	☐
Are there any white spots in or on the nipple?	☐	☐
Do your nipples turn white after feeds?	☐	☐
Are there any painful lumps in the breast?	☐	☐