Eastside Women's Health & Lactation

MOTHER'S MEDICAL HISTORY

NAME:	**AGE:**
Are you in general good health? ☐ yes ☐ no explain:	Please list **medications, vitamins, herbs, supplements** that **YOU** are currently taking:

ALLERGIES: ☐ **none** ☐ **medications** ☐ **foods**			
Medications you are allergic to:	**Reaction:**	**Foods you are allergic to:**	**Reaction:**

PREGNANCY HISTORY			
Number of pregnancies:	**Miscarriages, losses, stillbirths or terminations:**	**Adoptions:**	**Number of children:**

Information about your other children:

Name:	**Age:**	**Treatment needed to conceive?**	**Length of pregnancy**	**Breastfeeding issues:**
		☐Yes ☐No		☐ Pain ☐ Latch issues ☐ Slow weight gain ☐ Low milk supply Other:
		☐Yes ☐No		☐ Pain ☐ Latch issues ☐ Slow weight gain ☐ Low milk supply Other:

DIET AND HEALTH BEHAVIORS					
Are you restricting your diet in any way? ☐ no ☐ yes What foods are you avoiding? Reason: Result:	**How often do you experience**:	Daily	Weekly	Monthly	Rarely/Never
	Exercise	☐	☐	☐	☐
	Caffeine	☐	☐	☐	☐
	Alcohol	☐	☐	☐	☐
	Tobacco	☐	☐	☐	☐
	Recreational drugs	☐	☐	☐	☐

MOTHER HEALTH HISTORY								
	RECENT	**PAST**		**RECENT**	**PAST**		**RECENT**	**PAST**
General:								
Fatigue/exhaustion	☐	☐	**Stress/Mood:**			**Endocrine:**		
Headaches (not migraine)	☐	☐	Overwhelmed	☐	☐	Diabetes - Adult	☐	☐
Migraines	☐	☐	Stressed	☐	☐	Gestational Diabetes	☐	☐
			Depressed	☐	☐	Insulin resistance	☐	☐
Skin:			Anxiety/Panic attacks	☐	☐	Thyroid disorder	☐	☐
Rashes	☐	☐	Bad dreams	☐	☐	Too hot or cold	☐	☐
Eczema	☐	☐	Bipolar disorder	☐	☐	Nipple discharge	☐	☐
Psoriasis	☐	☐	Persist neg thoughts	☐	☐	High androgen levels	☐	☐
Cold sores	☐	☐						
Heavy body hair	☐	☐				**Other:**		
-on breast/back/abdomen	☐	☐	**OB/GYN:**	☐	☐	Sexual abuse	☐	☐
Nipple piercings	☐	☐	Irregular periods	☐	☐	Emotional abuse	☐	☐
Nipple wounds/injury	☐	☐	PMS	☐	☐	Physical abuse	☐	☐

MOM: BABY: DATE:

			PCOS	☐	☐	Substance abuse	☐	☐
Breasts:			Premature labor	☐	☐			
Surgery	☐	☐	Infertility	☐	☐	**Details/other issues:**		
Injury	☐	☐	-Reason:	☐	☐	Tongue-tie	☐	☐
Abnormal develop.	☐	☐				Speech therapy	☐	☐
Breast lump	☐	☐				Autoimmune disorders	☐	☐
Pain prior to bf	☐	☐				Raynaud's syndrome	☐	☐
						Allergy to ibuprofen/asprin/ NSAIDS	☐	☐

PSYCHOLOGICAL WELL-BEING

*To be as accurate as possible, Mom should fill this out herself, without discussing the answers with others
As you have recently had a baby, we would like to know how you are feeling. Please check the answer which comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

1. I have been able to laugh and see the funny side of things
☐ As much as I always could
☐ Not quite so much now
☐ Definitely not so much now
☐ Not at all

2. I have looked forward with enjoyment to things
☐ As much as I ever did
☐ Rather less than I used to
☐ Definitely less than I used to
☐ Hardly at all

*3 .I have blamed myself unnecessarily when things went wrong
☐ Yes, most of the time
☐ Yes, some of the time
☐ Not very often
☐ No, never

4. I have been anxious or worried for no good reason
☐ No, not at all
☐ Hardly ever
☐ Yes, sometimes
☐ Yes, very often

*5. I have felt scared or panicky for no very good reason
☐ Yes, quite a lot
☐ Yes, sometimes
☐ No, not much
☐ No, not at all

*6. Things have been getting on top of me
☐ Yes, most of the time I haven't been able to cope at all
☐ Yes, sometimes I haven't been coping as well as usual
☐ No, most of the time I have coped quite well
☐ No, have been coping as well as ever

*7. I have been so unhappy that I have had difficulty sleeping
☐ Yes, most of the time
☐ Yes, sometimes
☐ Not very often
☐ No, not at all

*8. I have felt sad or miserable
☐ Yes, most of the time
☐ Yes, quite often
☐ Not very often
☐ No, not at all

*9. I have been so unhappy that I have been crying
☐ Yes, most of the time
☐ Yes, quite often
☐ Only occasionally
☐ No, never

*10. The thought of harming myself has occurred to me
☐ Yes, quite often
☐ Sometimes
☐ Hardly ever
☐ Never

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS), J. L. Cox, J.M. Holden, R. Sagovsky, From: British Journal of Psychiatry (1987), 150, 782-786.

Score: _____ Reviewed by: _____

Patient Signature: _____
I certify this information provided is true and accurate

MOM: BABY: DATE:

Eastside Women's Health & Lactation

PREGNANCY AND BIRTH HISTORY

Mom:	**DOB:** **Age:**	**Baby:**	**DOB:** **Age:**

During your pregnancy, did you experience any of the following:

☐ Fertility treatment ☐ Medications ☐ Premature labor ☐ Gestational diabetes ☐ Tobacco/alcohol/drug use ☐ Bed rest ☐ High blood pressure ☐ Multiples ☐ low / high amniotic fluid	☐ Depression/anxiety ☐ Domestic violence ☐ Other:

Did you experience Breast changes:	**During this pregnancy?**	**After birth?**
Tenderness	☐	☐
Heavier	☐	☐
Increase cup sizes	☐	☐
Firm	☐	☐
Engorged	☐	☐
Painful	☐	☐

BIRTH

How was your baby's birth? _____

☐ vaginal ☐ vacuum assisted ☐ forceps assisted
☐ cesarean section: reason:

How long was your pregnancy? _____ weeks _____ days

Where was your baby born?
☐ home ☐ birth center: ☐ hospital:

How did your labor begin?

How long was your labor? _____ hrs **pushing?** _____

Was your labor induced? ☐ no ☐ yes (check all that apply)
Reason for induction:

Were you given medications during your labor (ie: to induce labor, pain relief, etc)?
☐ yes ☐ no

Was your baby malpositioned at any point in your labor?
☐ **no** ☐ **yes,**
describe:

Any complications for baby after the birth? ☐ none

Was your baby separated from you after birth? ☐ no,
☐ yes, reason:

Did your baby breastfeed soon after birth? ☐ no,
☐ yes
describe:

Did your baby have any **bruising on his/her head** or **asymmetry** after the birth? ☐ no ☐ yes, describe:

What day after birth did your milk "come in"? day _____
Was it a dramatic increase? ☐ yes ☐ no

Did your baby receive vitamin K after birth?
☐ Injection ☐ Oral ☐ none

Details/other issues:

Patient Signature: _____
I certify this information provided is true and accurate

MOM: BABY: DATE:

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BABY'S MEDICAL HISTORY

BABY:	**DATE OF BIRTH:**
Medication allergies? ☐ **none** ☐ **yes:** **Reaction:**	**Current medications, vitamins, supplements:**
Does your baby have any health issues? ☐ none ☐ yes, describe:	Were there any concerns/abnormalities in the results of baby's newborn screening? ☐None ☐yes; explain:

Has your baby experienced any of the following?

	Past week	**Ever**		**Past week**	**Ever**	Rash	**Past week**	**Ever**
Meconium aspiration	☐	☐	Heart murmur	☐	☐	Abdominal pain	☐	☐
Fever	☐	☐	Heart defect	☐	☐	Excessive spit up	☐	☐
Hypoglycemia	☐	☐	Blue baby	☐	☐	Diarrhea	☐	☐
NICU stay	☐	☐	Breathing problems	☐	☐	Breath odor	☐	☐
Birth injuries	☐	☐	Periods of not breathing	☐	☐	Colic	☐	☐
Cerebral palsy	☐	☐	Blue around mouth	☐	☐	Reflux/ GERD	☐	☐
High hematocrit	☐	☐	Nasal congestion	☐	☐	Feeding tube	☐	☐
Seizures	☐	☐	Readmitted to hospital	☐	☐	Jaundice @_____days old	☐	☐
Lethargy	☐	☐	Explain:			Require blood test?	☐	☐
Medications	☐	☐				Require phototherapy?	☐	☐
Other:			Circumcision: ☐ no ☐ yes - ☐complications? ☐ none ☐ yes: _____					

Does anyone in the home smoke? ☐no ☐yes
Does anyone who sleeps with the baby use alcohol, drugs, or sleep aid medications? ☐no ☐yes

Parent/Gardian Signature: _____

I certify this information provided is true and accurate

Parent/Gardian Name: _____

MOM: BABY: DATE: