Mahala
Lactation and Perinatal Services, LLC

Medical History Form

Please complete ALL relevant fields

Your Name: _____ Date: _____

Reason for Seeking Care/Chief Complaint: ☐Nipple Pain | ☐Breast Pain | ☐Latching Difficulties | ☐Undersupply | ☐Oversupply | ☐Slow weight gain | ☐Tongue tie | ☐Diaper output/concerns about stool | ☐Difficulty sleeping | ☐Bottle feeding difficulty | ☐Fussiness/colic | ☐Spit-up/vomiting | ☐Weaning | ☐Other (explain): _____

YOUR HEALTH HISTORY

Any history of:

☐thyroid ☐ovarian cyst ☐PCOS ☐diabetes (type ☐I ☐II ☐gestational) ☐depression or anxiety

Details/other:_____

List any allergies:_____

Pertinent family health history (first degree relatives – diabetes, cancer, etc):

_____

List any medications (including vitamins): _____

Breast or chest surgery or injury: ☐none ☐reduction ☐augmentation ☐mastopexy ☐biopsy ☐injury year:_____

Conceive easily: ☐yes ☐no (how long:_____) ☐induced ovulation ☐IVF ☐IUI (donated: ☐sperm ☐egg ☐neither)

Number of other pregnancies: _____ Miscarriages: _____ (Year/s: _____) Number of other children living: _____

Smoker: ☐no ☐yes ☐former (quit date: _____) Surgical history (include year of procedure/s): _____

_____

Alcohol or drug use: ☐no ☐yes ☐former (date: _____) Frequency: ☐daily ☐weekly ☐amount: _____

PAST BREASTFEEDING

Number of other children breastfed: _____ How long: #1: _____ #2: _____ #3: _____ #4: _____

Describe your experience:

_____

_____

_____

_____

PREGNANCY

Breast changes: ☐enlargement ☐tenderness in first trimester ☐leaking ☐areola darkening

Complications: ☐no ☐yes Describe: _____

_____

Bed rest: ☐no ☐yes (start week: _____ until week: _____ Reason: _____ Pregnancy length: _____wk _____d

LABOR & DELIVERY

How labor began: ☐spontaneous ☐induced (how: ☐pitocin ☐cervical gel ☐membrane ruptured ☐sched c-sect ☐other: _____)

Where: ☐hospital ☐birth center ☐home Labor: _____ hrs Pushing: _____ hrs Delivery: ☐vag ☐VBAC ☐vacuum ☐forceps ☐c-sect

Meds: ☐pitocin ☐epidural (#cm when started: _____) ☐narcotic (demerol, nubain) ☐other:_____

Antibiotics: ☐no ☐yes (reason: ☐strep B ☐fever ☐c-sect ☐other: _____) Hemorrhage: ☐no ☐yes

Labor experience (describe): _____

_____

HOSPITAL

1st nursing: _____min/hrs after birth ☐easy ☐difficult When milk came in: day: _____ ☐not noticed ☐slight ☐mod ☐heavy

Circumcision: day _____ Pacifier: ☐no ☐yes (when began: day _____) Separation: ☐none ☐some ☐a lot ☐night ☐NICU

Baby complications: ☐jaundice ☐hypoglycemia ☐other: _____ How treated: _____

Inpatient breastfeeding experience:

_____

_____

HOME

FEEDING: How often: _____ min/hrs Latching ☐easy ☐difficult ☐impossible Who ends: ☐me ☐baby Avg length: _____ min

Nipple pain: ☐none ☐some ☐moderate ☐severe Side: ☐L ☐R When began: _____ ☐days ☐weeks ☐months

SUPPLEMENTING: ☐no ☐yes began: _____ days How: ☐bottle ☐cup ☐syringe ☐dropper ☐spoon ☐tube ☐other _____

When: ☐before nursing ☐after ☐during How often: ☐every feed ☐_____x/day How much:_____oz/cc ☐pumped milk ☐formula

PUMPING: ☐no ☐yes When began: _____ days How often: _____ x/day Avg amt: _____ Flange size: _____

Pump: ☐new ☐used (how old: _____) Pump type: ☐rental ☐owned (brand: _____)

Post-discharge breastfeeding experience:

_____

_____

_____

_____

Vaginal bleeding now: ☐over ☐light ☐moderate ☐heavy Color: ☐bright red ☐dark red ☐brown ☐spotting

Where baby sleeps: ☐our room ☐baby's room ☐other: _____ In: ☐our bed ☐co-sleeper ☐bassinet/crib

BABY'S WEIGHT HISTORY		
DATE	WHERE WEIGHED	WEIGHT
BIRTH		

DIAPER OUTPUT HISTORY					
DAY	Last 24 Hours	Last 25-48 Hours	Last 49-72 Hours	Last 73-96 Hours	Last 97-120 Hours
# of stools*					
color					

*only count stools bigger than the size of a quarter

Since you are either pregnant or have recently had a baby, we want to know how you feel. Please place a CHECK MARK (✓) on the blank by the answer that comes closest to how you have felt IN THE PAST 7 DAYS—not just how you feel today. Complete all 10 items. This is a screening test; not a medical diagnosis.

1. I have been able to laugh and see the funny side of things:
- As much as I always could ☐ (0)
- Not quite so much now ☐ (1)
- Definitely not so much now ☐ (2)
- Not at all ☐ (3)

2. I have looked forward with enjoyment to things
- As much as I ever did ☐ (0)
- Rather less than I used to ☐ (1)
- Definitely less than I used to ☐ (2)
- Not at all ☐ (3)

3. I have blamed myself unnecessarily when things have gone wrong:
- Yes, most of the time ☐ (3)
- Yes, some of the time ☐ (2)
- Not very often ☐ (1)
- No, never ☐ (0)

4. I have been anxious or worried for no good reason:
- No, never ☐ (0)
- Hardly ever ☐ (1)
- Yes, sometimes ☐ (2)
- Yes, very often ☐ (3)

5. I have felt scared or panicky for no good reason:
- Yes, quite a lot ☐ (3)
- Yes, some of the time ☐ (2)
- Not very often ☐ (1)
- No, never ☐ (0)

6. Things have been getting to me:
- Most of the time I have a hard time coping ☐(3)
- Sometimes I haven't been coping as well ☐ (2)
- Most of the time I can cope well ☐ (1)
- No, I have been coping as well as ever ☐ (0)

7. I have been so unhappy that I have had difficulty sleeping:
- Yes, most of the time ☐ (3)
- Yes, some of the time ☐ (2)
- Not very often ☐ (1)
- No, never ☐ (0)

8. I have felt sad or miserable:
- Yes, most of the time ☐ (3)
- Yes, some of the time ☐ (2)
- Not very often ☐ (1)
- No, never ☐ (0)

9. I have been so unhappy that I have been crying:
- Yes, most of the time ☐ (3)
- Yes, some of the time ☐ (2)
- Not very often ☐ (1)
- No, never ☐ (0)

10. Thoughts of harming myself or my baby have occurred to me:*
- Yes, quite often ☐ (3)
- Sometimes ☐ (2)
- Hardly ever ☐ (1)
- No, never ☐ (0)

Total score here: _____

*If you scored a 1,2, or 3 on question 10, PLEASE CALL YOUR HEALTHCARE PROVIDER (OB/Gyn, family doctor or nurse-midwife) or GO TO THE EMERGENCY ROOM NOW to ensure your safety and the safety of your baby.

If your score is 11 or more, you could be experiencing postpartum depression (PPD). Please call your healthcare provider (OB/Gyn, family doctor or nurse-midwife) now to keep you and your baby safe.

If your total score is 9-10, we suggest you repeat this test in one week or call your healthcare provider (OB/Gyn, family doctor or nurse-midwife).

If your total score is 1-8, new mothers often experience mood swings that can make them cry or get angry easily. Your feelings may be a product of normal postpartum hormones. However, if they worsen or sontu=inue for more than a week or two, call your healthcare provider (OB/Gyn, family doctor or nurse-midwife). Take care of yourself by:

- ♥ Getting some sleep – try to nap when baby is napping
- ♥ Asking friends and family for help
- ♥ Drinking plenty of fluids
- ♥ Eating a good diet
- ♥ Getting exercise, even if it's just walking outside

**Please note: The Edinburgh Postnatal Depression Scale (EPDS) is a screening tool that does not diagnose postpartum depression (PPD) or anxiety.

Edingurgh Postnatal Depression Scale (EPDS). Adapted from the *British Journal of Psychiatry*, June, 1987, vol. 150 by J.L. Cox,J.M. Holden, R. Sekovsky