Newport Beach Milk Company

www.nbmilkco.com
949-246-8343

Client Questionnaire

Mother's Name: _____

Mother's Date of Birth: _____Age: _____

Address:_____

City/State/Zip Code: _____

Phone: Home _____Cell_____

Email: _____

Preferred method of communication: Call home / Call cell / Email / Text

Mother's OB/Midwife: _____

Medical Group Name:_____

OB Phone: _____

Baby's Name: _____

Baby's Date of Birth: _____ Birth weight: _____

Gestational age at birth: _____ Age today: _____

Birth hospital/location _____

Date of last pediatric visit: _____Weight: _____

Date of next scheduled pediatric visit: _____

Baby's Father's Name:_____

Baby's Pediatrician: _____

Phone: _____

Breastfeeding Concerns/Problems:

_____
_____
_____
_

Mother's Medical History

1. Do you have any allergies?
   _____
   _____

2. Do you have diabetes?_____

3. Are you anemic?_____

4. Are you depressed?_____

5. Do you have an eating disorder? _____

6. Have you ever had weight loss surgery?_____

3. Do you have thyroid disease? _____

4. Any genetic diseases in your (or your partner's history)?

_____

5. Do you smoke?_____

6. Is this your first pregnancy?_____ If no, how many pregnancies have you had?_____

7. How many children?_____

8. Have you breast fed before?_____How long?_____

9. Did you have difficulty getting pregnant?_____

10. Did you ever have breast surgeries?_____

11. Are you returning to work? _____

12. What is your occupation?_____

13. Are you taking any medications (Birth control, antibiotics, pain killers, prenatal vitamins,
etc)_____
_____

14. Any complications during pregnancy? (high blood pressure, diabetes, bed rest)_____
_____

15. Did you have an epidural? _____

16. What type of delivery? (vaginal, planned c-section, emergency c-section)-CIRCLE

17. Any complications with delivery? (hemorrhage or excessive blood loss)-
_____
_____

18. What was your due date?_____

19. What is baby's birthdate?_____

20. What was baby's apgar scores?_____

21. Any time spent in NICU? WHY?
_____

_____
_____

22. Did your baby have any difficulties after birth (jaundice, low blood sugar, breathing difficulties, meconium aspiration)?

_____
_____
_____

23. Does your child have any known health problems?

_____
_____

24. Is baby taking medication? What?

_____
_____

25. Are you using a bottle? (with formula? with expressed milk? How often?)_____
_____

26. Are you using a pacifier?_____

27. How many wet diapers in the past 24 hours?_____

28. How many stools in the past 24 hours?_____ What is the color/ consistency?

_____

29. Are your nipples sore?

_____

30. How many times a day do you feed your baby?

_____
_____

31. Do you have a pump?_____ Are you using it?_____ What kind of pump?

32. Have you ever had any breast surgery?_____

32. Anything else I should know?

_____
_____
_____