Mosaic Dental
KELLY M. GIERA, DDS, PC

PREGNANCY/LABOR HISTORY

Were there any additional stressors with labor? Yes / No If yes, please circle below:

Long Labor/Excessive Pushing Breech Birth Unplanned C-Section Trauma from vacuum or forceps

Other: _____

Difficulty with latch after birth? Yes / No If yes, please explain: _____

MODE OF FEEDING

Is this your first time breastfeeding? Yes / No / N/A Other breastfed children/how long? _____

Are you using a nipple shield? Yes / No

Are you supplementing with pumped breastmilk? Yes / No

If yes, how many bottles/ounces per day? _____

How would you rate your milk supply? Oversupply Good Fair Poor

Are you supplementing with formula? Yes / No

If yes, how many bottles/ounces per day? _____

Have you done any pre/post-feeding weight checks? Yes / No

If so, how much was transferred? ____oz.

On average, how long does it take to breast feed your child? _____minutes

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BABYS SYMPTOMS

Does your infant pop on and off the breast/bottle while feeding?	Yes / No
Does your infant struggle to stay awake while nursing?	Yes / No
Does milk leak or spill out the side of the mouth while actively feeding?	Yes / No
Does your infant have a history or poor weight gain?	Yes / No
Does your infant chomp and gum on your nipples while feeding?	Yes / No
Does your infant become fussy or fight you at the breast?	Yes / No

(Continued)

Does your infant's upper lip remain tucked in while feeding? Yes / No

Is your infant very gassy? Yes / No

Does your infant cough/choke during or after feeding? Yes / No

Has your infant been diagnosed with GERD (reflux)? Yes / No

Do you hear a "clicking" noise while feeding? Yes / No

Does your infant use a pacifier? Yes / No

If yes, does it frequently pop out? Yes / No

MOTHERS SYMPTOMS

Please rate your level of discomfort while feeding or when you did breastfeed:

N/A None Very Low Low Medium High Very High

Please check any of the following that best describes your breasts or nipples after feeding. Also indicate which breast you are noticing the issues:

R=Right|L=Left|B=Both Creased: R|L|B Flattened: R|L|B Lipstick-Shaped: R|L|B

Blanched White: R|L|B Bruised: R|L|B Blistered: R|L|B Bleeding: R|L|B

Are you experiencing poor or incomplete breast drainage? Yes / No

Do you have history of, or currently have, mastitis? Yes / No

Do you have history of, or currently have, nipple/infant oral thrush? Yes / No

In a sentence or two, please share your breastfeeding/feeding goals or other concerns:

_____

_____

_____

Whom may we thank for referring you to our office? _____