HOLACTIC HEALTH LLC

INFANT HISTORY FORM

Is your baby in good health? ☐ yes ☐ no

Any medical problems? ☐ yes ☐ no

If yes, please explain: ______________________________

Was your baby jaundice? If yes, highest bilirubin?: ☐ yes ☐ no ______________

What was the day jaundice was discovered? ______________ *Treatment?* ____________

Is your baby taking any medication? ______________________________

Any medical complications post delivery? ☐ yes ☐ no

How soon after birth did you baby go to the breast? ______________

Any difficulty with latching the baby onto the breast in the hospital or birthing center? ☐yes ☐ no *Any neurological problems discovered?* ☐ yes ☐ no

If yes, please explain: ______________________________

Any oral/facial anomalies? *If so, please specify* ______________________

- *Clefts (palate, lip or both)*
- *Nasal Obstructions*
- *Tight Lingual Frenum (tongue-tied)*

Was it corrected? ☐ yes ☐ no

Number of Breastfeedings per day? ____________

How long on each breast? ____________

One or Two breasts per feeding? ____________

Bowel movements per day? ____________

Urination (wet diapers) per day? ____________

When is your baby's next pediatrician's appt? *Date* ______________ *Time* ______________

Is your baby getting any supplemental feedings? ☐ no ☐ yes If yes, check off which supplement:

☐ Breastmilk # of times per day______________ ☐ Formula # of times per day______________

If so, how is the supplement given? ☐ Bottle ☐ Tube ☐ Cup ☐ Syringe ☐ Spoon