Eastside Total Health & Lactation

MOTHER'S MEDICAL HISTORY

NAME:	**AGE:**
What brings you here today?	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:**
List any previous breasteeding issues:			

Are you restricting your diet in any way? ☐ no ☐ yes What foods are you avoiding?	**Do you use alcohol or recreational drugs? ☐ Yes ☐ No If yes, please explain:**

MOTHER HEALTH HISTORY								
	RECENT	**PAST**		**RECENT**	**PAST**		**RECENT**	**PAST**
GENERAL:			**STRESS/MOOD:**			**ENDOCRINE:**		
Headaches /Migraine	☐	☐	Depressed	☐	☐	High Androgen Levels	☐	☐
SKIN:			Bipolar Disorder	☐	☐	Thyroid disorder	☐	☐
Rash/Eczema/Psoriasis	☐	☐	**OB/GYN**			**OTHER:**		
BREASTS:			Infertility	☐	☐	Substance Abuse	☐	☐
Surgery/Injury	☐	☐	PCOS	☐	☐	Physical/Sexual Abuse	☐	☐
Abnormal Development	☐	☐	Premature Labor	☐	☐	Emotional Abuse	☐	☐

PREGNANCY AND BIRTH HISTORY

During your pregnancy, did you experience any of the following:	
☐Fertility treatment ☐Medications	☐ Depression/anxiety ☐ Gestational Diabetes ☐Premature labor ☐ Domestic violence ☐ Breast Changes (size, tenderness, etc)

BIRTH

How was your baby's birth? Birth Weight?	**How long was your pregnancy?** weeks days
☐ vaginal ☐ vacuum assisted ☐ forceps assisted ☐ cesarean section: reason:	Where was your baby born? ☐ home ☐ birth center: ☐ hospital:
How did your labor begin?	**How long was your labor? _____** hrs **pushing? ____** hrs
Was your baby malpositioned at any point in your labor? **☐ no ☐ yes, describe:**	**Any complications for baby after the birth?** ☐ none
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

BABY'S MEDICAL HISTORY

BABY:	**DATE OF BIRTH:**

MOM: BABY: DATE:

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Medication allergies? □ none □ yes: Reaction:	**Current medications, vitamins, supplements:**

Has your baby experienced any of the following?								
	Past week	**Ever**		**Past week**	**Ever**		**Past week**	**Ever**
Meconium aspiration	☐	☐	Heart murmur	☐	☐	Abdominal pain	☐	☐
Fever	☐	☐	Heart defect	☐	☐	Excessive spit up	☐	☐
Seizures	☐	☐	Rash	☐	☐	Jaundice	☐	☐
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								

*To be as accurate as possible, Mom should fill this out herself, without discussing the answers with others
. 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

Score:
Reviewed by:

***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

MOM: BABY: DATE:

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