EVALUATION & MANAGEMENT POSTPARTUM/MATERNAL FORM Today's Date_____

MOTHER_____DOB_____ INFANT_____DOB_____
MATERNAL WEIGHT_____ B/P_____ INFANT AGE_____ MATERNAL AGE_____
KNOWN DRUG ALLERGIES_____

Please describe your current symptoms:_____

_____

_____

_____

Please check all boxes that apply to Mother, Birth, and Infant Risk Factors. Some issues have more of a negative impact on lactation than others. These issues have been set in bold.

Maternal Risk Factors

- ☐ No breast changes with pregnancy
- ☐ Thyroid or pituitary problems
- ☐ **Breast abnormalities e.g. wide angle, tubular, marked asymmetry, minimal glandular tissue**
- ☐ Prior lactation failure
- ☐ Family History of lactation failure
- ☐ Fibrocystic Breast/Dense Breast
- ☐ Flat or inverted or large nipples
- ☐ Diabetic mother
- ☐ Hypertension, eclampsia, or PIH
- ☐ Administration of betamethasone
- ☐ **PCOS/other infertility problems**
- ☐ **Maternal obesity (BMI > 29)**
- ☐ Adolescent mother < 18
- ☐ Advanced maternal age > 35
- ☐ First time mother
- ☐ Depression or anxiety
- ☐ Smoking
- ☐ **Breast surgery or trauma inc. radiation**
- ☐ States intention to both breast and bottle feed in 1st 4 weeks
- ☐ States early intention to return to work prior to 6 weeks

Birth Risk Factors

- ☐ Stressful labor or delivery
- ☐ Unscheduled C/section
- ☐ Separated from her infant
- ☐ Placenta previa or retained placenta
- ☐ **Delivery for multiples**
- ☐ **Sheehan's syndrome- massive hemorrhage**
- ☐ Edema of extremities
- ☐ Anemia
- ☐ **Blood transfusion**
- ☐ **No signs of milk "coming in" by 72 hours**
- ☐ **Breast pump dependent at the time of discharge**
- ☐ Epidural/Pitocin over 15 hours

List all prescriptions/ herbs/OTC meds taken during pregnancy/after birth below:

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Infant Risk Factors

- ☐ Male infant
- ☐ **Multiples**
- ☐ **Oral abnormalities e.g. Tongue/lip tie, cleft, large tongue, recessed jaw, high arched palate**
- ☐ **Neurological problems e.g. Down, Hypotonia, Hypertonia**
- ☐ **Born prior to 37 weeks gestation**
- ☐ Small or Large for Gestational Age
- ☐ Separated from mother e.g. jaundice, hypoglycemia, respiratory problems
- ☐ Using a pacifier
- ☐ **Using a feeding device e.g. nipple shield, SNS at the time of discharge**
- ☐ **Causing persistent sore or cracked nipples**
- ☐ **Weight loss of more than 10% by third day of life**
- ☐ **Inability/refusal to latch to breast and transfer breastmilk at the time of discharge**
- ☐ Supplemented with bottle nipple more than 3 times/day
- ☐ **Getting less than 10cc/pumping at 60 hours of life**
- ☐ Reflux requiring medication or cereal

TOTAL SCORE _____

EVALUATION & MANAGEMENT POSTPARTUM/MATERNAL FORM

Please check all boxes that apply to Mother and Family

Medical Health History

- ☐ Heart Disease
- ☐ Lupus
- ☐ Arthritis
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Blood Clots
- ☐ HIV
- ☐ Herpes
- ☐ Genital Warts
- ☐ Chlamydia or Gonorrhea
- ☐ Sickle Cell Disease or Trait
- ☐ Anemia
- ☐ Migraines
- ☐ Thyroid Disease
- ☐ Cancer
- ☐ Bleeding Tendencies
- ☐ Lung Disease
- ☐ GYN/Breast Conditions

Please indicate date, condition, and treatment:_____

_____
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Family Health History

Please indicate what family member:

- ☐ Heart Disease _____
- ☐ Stroke _____
- ☐ Arthritis _____
- ☐ Autoimmune Disease _____
- ☐ Genetic Disorder _____
- ☐ Diabetes _____
- ☐ Kidney Disease _____
- ☐ Blood Clots _____
- ☐ Sickle Cell Disease or Trait _____
- ☐ Anemia _____
- ☐ Migraines _____
- ☐ Thyroid Disease _____
- ☐ Cancer _____
- ☐ Bleeding Tendencies _____
- ☐ Lung Disease _____
- ☐ GYN/Breast Conditions _____

Pregnancy History

- How many times have you been pregnant?_____Children?_____
- Complications:_____

_____
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- List all medications you are currently taking:

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_____
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_____

- Do you feel unsafe at home? Y N
- Have you ever felt afraid of your partner? Y N
- Do you feel depressed? Y N
- Do you feel like hurting yourself or your baby? Y N

Progress Notes

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