

Breastfeeding Screening

Patient's Name:	DOB:	Medical Record #:	Date:
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- Including this pregnancy, how many times have you been pregnant? / *Incluyendo este embarazo, ¿Cuántas veces ha estado embarazada? _____*
Live births? / *¿Cuántos nacidos vivos? _____*.
- Have you ever breastfed? / *¿Alguna vez ha dado pecho?*
 - Yes / *Sí*. In total, how long have you breastfed? / *En total, ¿Por cuánto tiempo ha dado pecho? _____ Weeks / months / years (circle one) / Semanas / meses / años (circule uno)*
 - No. (If answer is "No", skip section A) / *(Si la respuesta es "No", omitir la sección A)*

Please answer the following questions by marking a check (✓) in the boxes provided / *Conteste las siguientes preguntas marcando (✓) a las respuestas.*

A: During your past breastfeeding experience(s) did you have? (check all that apply) / <i>¿Durante su anterior experiencia al dar pecho, tenía usted? (marque las que apliquen):</i>	Yes/Sí	No
1. Sore Nipples / <i>Pezones adoloridos</i>	<input type="checkbox"/>	<input type="checkbox"/>
2. Latch-on Problems / <i>Dificultad en pegarse al pecho</i>	<input type="checkbox"/>	<input type="checkbox"/>
3. Not enough milk / <i>No suficiente leche</i>	<input type="checkbox"/>	<input type="checkbox"/>
4. C-Section / <i>Cesárea</i>	<input type="checkbox"/>	<input type="checkbox"/>
5. Jaundiced Infant / <i>Infante con bilirrubina alta</i>	<input type="checkbox"/>	<input type="checkbox"/>
6. Premature Baby / <i>Bebé Prematuro</i>	<input type="checkbox"/>	<input type="checkbox"/>
7. Twins/Multiple Babies / <i>Gemelos/Múltiples Bebés</i>	<input type="checkbox"/>	<input type="checkbox"/>
8. Breastfeeding Help / <i>Ayuda al lactar</i>	<input type="checkbox"/>	<input type="checkbox"/>
9. Other / <i>Otro: _____</i>	<input type="checkbox"/>	<input type="checkbox"/>
B: Have you had or currently have (check all that apply) / <i>¿Ha tenido o tiene actualmente? (marque las que apliquen):</i>	Yes/Sí	No
1. Breast Implants / <i>Implantes de seno</i>	<input type="checkbox"/>	<input type="checkbox"/>
2. Breast Surgery / <i>Cirugía de los senos</i>	<input type="checkbox"/>	<input type="checkbox"/>
3. Flat Nipples / <i>Pezones</i>	<input type="checkbox"/>	<input type="checkbox"/>
4. Inverted Nipples / <i>Pezones invertidos</i>	<input type="checkbox"/>	<input type="checkbox"/>
5. Hepatitis or HIV Positive / <i>Hepatitis o HIV Positivo</i>	<input type="checkbox"/>	<input type="checkbox"/>
6. Drug Use / <i>Uso de drogas</i>	<input type="checkbox"/>	<input type="checkbox"/>
7. Other / <i>Otro: _____</i>	<input type="checkbox"/>	<input type="checkbox"/>
C: Which of the following concerns do you have about breastfeeding? (Check all that apply) / <i>¿Qué le preocupa más al dar pecho? (marque las que apliquen)</i>		
<input type="checkbox"/> Not having enough milk / <i>No tiene suficiente leche</i>		
<input type="checkbox"/> Plan to work / <i>Planea trabajar</i>		
<input type="checkbox"/> Nobody to help / <i>Nadie me ayuda</i>		
<input type="checkbox"/> It seems hard / <i>Parece difícil</i>		
<input type="checkbox"/> It may hurt / <i>Podría doler</i>		
<input type="checkbox"/> Embarrassment/Shy / <i>Pena/Vergüenza</i>		
<input type="checkbox"/> C-Section / <i>Cesárea</i>		
<input type="checkbox"/> Poor eating habits / <i>Malos hábitos de comer</i>		
<input type="checkbox"/> None / <i>Ninguno</i>		
<input type="checkbox"/> My breasts may sag / <i>Mis senos podrían caerse</i>		
<input type="checkbox"/> Taking medications / <i>Tomando medicinas</i>		
<input type="checkbox"/> Other / <i>Otro: _____</i>		

For Provider / Clinician Use:
Breast Exam

- | | |
|---|---|
| <input type="checkbox"/> Symmetric | <input type="checkbox"/> No abnormal nipple discharge |
| <input type="checkbox"/> No skin changes | <input type="checkbox"/> No masses palpable |
| <input type="checkbox"/> Nipples normal (No dimpling or retraction) | <input type="checkbox"/> Non tender |
| <input type="checkbox"/> No engorgement | <input type="checkbox"/> No adenopathy |

Abnormal findings or comments:

- A:** Normal Breasts, No contraindications to Breastfeeding –or- Further evaluation –or- **Referral needed.**
 Limited knowledge regarding Breastfeeding
- P:** Literature regarding Breastfeeding
 Referral to Lactation Educator, if indicated
 Provide Education

Provider's Signature:

Provider's Printed Name:

Date:

Donated by - NEV - 176

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