

BREASTFEEDING SELF ASSESSMENT

Patient Name: _____ DOB: _____ Date: _____

Please fill out this questionnaire and give it to your provider. You may use the additional space below for any comments or concerns that you may have.

Questionnaire

1. How do you feel breastfeeding is going? well not well
2. Does your baby seem satisfied? yes no
3. Does your baby latch to breast easily? yes no
4. Can you feel rhythmic tugging, (not pain) on your nipple as you nurse? yes no
5. Can you hear your baby swallow with nursing? yes no
6. Is your milk in? Are your breasts full and heavy? yes no
7. Does your baby feed 8-10 times in 24 hours? yes no
8. Does your baby wake you up and demand to feed? yes no
9. Is your baby having at least 6-8 wet diapers in 24 hours? yes no
10. Is your baby having at least 1-2 stools in 24 hours? yes no
11. Are the color of the stools becoming a lighter brown? yes no
12. Do you enjoy each time you breastfeed? yes no
13. Are you getting support at home with breastfeeding? yes no
14. Will you be on medications while you are breastfeeding? yes no
15. Do you plan to use a pacifier? yes no
16. Do you have any soreness or pain in breasts or nipples? yes no

Comments/Concerns:

THANK YOU!

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