Antenatal Breastfeeding Screening

1. What are your plans for feeding this baby?

☐ Breastfeeding ☐ Breastfeeding and infant formula ☐ Formula feeding

(If formula feeding only, you do not need to complete the rest of this questionnaire)

2. How long do you plan to breastfeed your baby? _____ months *or* _____ years

3. Breastfeeding history

How long did you breastfeed your older child/ren? ☐ N/A

#1 _____ months _____ years #2 _____ months _____ years

#3 _____ months _____ years #4 _____ months _____ years

Any previous preterm births? ☐ Yes * ☐ No

Previous breastfeeding difficulties:

☐ Nipple pain ☐ Breast pain ☐ Mastitis ☐ Abscess ☐ Low milk supply **

☐ Oversupply **

Other: _____

4. Breast anatomy and changes

Bra size pre-pregnancy: _____ now: _____ at _____ weeks

☐ No breast changes ** ☐ Breast hypoplasia **

Breast/nipple surgery: ☐ Augmentation * ☐ Reduction ** ☐ Other: _____

Nipples: ☐ Large ☐ Short ☐ Flat ☐ Inverted * ☐ No conerns

Nipple piercing: * ☐ No piercing ☐ Left ☐ Right ☐ Piercing was infected **

5. Metabolic health

Pre-pregnancy weight: _____ Height: _____ Pre-pregnancy BMI: _____

☐ BMI ≥ 30.0 **

☐ Polycystic Ovarian Syndrome **

☐ Gestational diabetes **

☐ Pre-existing diabetes **

☐ Pituitary disorders/surgery *

☐ Thyroid disorder * If yes, last TSH result: _____ Date: _____

6. Mental Health

History of: ☐ Anxiety ☐ Depression ☐ Other mental health difficulties

Details: _____

OUTCOME OF SCREENING

☐ **RED: breastfeeding class and antenatal lactation consultation with postpartum follow-up advised

☐ *ORANGE: breastfeeding class and postpartum lactation follow-up advised

☐ GREEN: no risk identified, breastfeeding class advised