The Breastfeeding Center of Chicago
Maternal Medical History Form

first name	last name	Birthdate	phone	email
OB/midwife	Pediatrician	Who is your OB/Gyn?		Who referred you to TBCC

How many pregnancies have you had?	How many children do you have?	
Did you breastfeed them?	Did you have challenges conceiving?	
How long did you breastfeed each one?		
Do you smoke?	Does anyone in the household smoke?	
Allergies		
Medications		
Herbs, Essential Oils		
Vitamin Supplements		
Do you have any of the following medical problems? If yes, please indicate with the word "yes". If not, leave fields blank:		
Auto-immune disorder		
PCOS	What medication are you on?	
MS		
Myastenia Gravis		
Diabetes	Type I /II?	Medications?
Untreated Thyroid problems		
Depression	What medicine are you taking?	
Anxiety	What medicine are you taking?	
Eating Disorders	Which one?	
Other Conditions		
History of injury to breasts. If yes, please indicate with the word "yes" and provide details. If not, leave fields blank		
Burns		
Radiation		
Chest Tube [even as an infant]		
Breast Surgery	Date	
Reduction		
Augmentation		
Biopsy		
Other		
Did you breastfeed before surgery?		
Did you breastfeed since the surgery?	Do you have sensation in your nipples?	
Other information we did not ask that you may think pertinent?		

Thank you for completing this form. Please print it and bring it to your first visit at The Breastfeeding Center of Chicago.