# PATIENT HISTORY FORM

Today's Date:_____ Your Name: _____

Baby's name: _____

**Past Medical History:** ***Do you have now or ever had?***

| | | | |
|---|---|---|---|
| □High Blood Pressure | □Liver Disease | □Headaches | □Stomach Ulcer |
| □Heart Disease | □Kidney Stones | □Asthma/COPD | □Blood Clots |
| □Heart Surgery | □Kidney Disease | □Stroke/CVA/TIA | □Seizures |
| □High Cholesterol | □Cancer | Diabetes: □Gestational | □Insulin Dependant |

**A Review Of Systems:** ***Do you have now?***

***Constitutional:*** □Weight loss □Fevers □Chills □Poor appetite □Fatigue □Insomnia □None

***Skin:*** □Rash □Pups Rash □Hives □Hair loss □Skin sores or ulcers □ Itching □ None

***Musculoskeletal:*** □Joint pain □Muscle aches □ Leg or arm cramps □Back pain □Muscle weakness □Bone pain □ Joint swelling □ None

***Psychiatric:*** □Anxiety □ Depression □ Baby Blues □Panic Attacks □Suicidal thoughts □Use of anti-depressants □Alcohol or drug dependence □ None

***Endocrine:*** □Thyroid Issues □Use of Thyroid Meds □Reynaud's □Cold intolerance □PCOS □Infertility □None

***Allergic/Immunology***: □Allergic reactions □ Yeast infection □Hepatitis □HIV positive □None
□Other Infections If so, please explain: _____

***Breast Conditions:*** □Fibrocystic □Breast Asymmetry □Breast Implants □Breast Reduction □Past Chest Surgery/Trauma □None

***Other Surgeries***: _____

Please list any current Medications/Vitamins:
_____ □ None

**Are you allergic to any medications?** □ NO □ YES If yes, explain:_____

Any Dietary Concerns?:_____ □ None

Use any Natural or Alternative Therapies such as chiropractic, magnets, massage, over-the-counter preparations, etc.?_____ □ None

Any additional Health Conditions? _____ □ None

**Social History:** □Spouse □ Partner □Single □Non-Smoker □Ex-Smoker □Current Smoker
Alcohol consumption: □Never □Occasional □Frequent

Mother's Initials_____ Provider's Initials_____

# Breastfeeding Resource Center

## ACKNOWLEDGEMENT OF PRIVACY PRACTICES AND PAYMENT

PLEASE READ AND SIGN

Printed name _____

### PRIVACY PRACTICES

- I give permission for information about this consultation and all additional consultations to be sent to my healthcare provider(s).
- I understand that all medical care is to be provided by my own healthcare providers.
- I give permission for the information from this consultation to be used to further the knowledge of breastfeeding. I understand that my name and the name of my family members will not be used.
- A copy of the Notice of Privacy Practices has been made available to me, and I have been provided an opportunity to review it.

Mother's signature _____Date _____

### INSURED OR AUTHORIZED PERSON'S SIGNATURE

- I authorize the release of any medical or other information necessary to process an insurance claim.
- I authorize payment of medical benefits to the Breastfeeding Resource Center.
- I agree to be responsible for any payment for lactation services received at the Breastfeeding Resource Center if my insurance company claim is denied.
- If the Breastfeeding Resource Center is out-of-network with my insurance company, I will pay for services received and will submit receipts to my insurance company for reimbursements.

Mother's signature _____Date _____