

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 #2 _____ months #3 _____ months #4 _____ months

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 concerns

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

5. Metabolic health

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

BMI ≥ 30 ** Polycystic Ovarian Syndrome ** Pituitary disorders / surgery *

Gestational diabetes ** Pre-existing diabetes **

Thyroid disorder * If yes, the 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