



BREASTFEEDING SUCCESS TEST

This is a screening test for breastfeeding mothers. Please answer all questions. Questions 1-11 screen for a possible problem with breastfeeding. If you select any of the highlighted responses (1-11) then you might benefit from lactation support: Seek advice from your doctor or a lactation consultant.

	Yes	No
1 Are you happy when you are nursing your baby?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2 Do your breasts hurt or feel uncomfortably full?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3 Are your nipples cracked or sore?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4 Does your baby "need" formula?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5 Do you feel confident that your baby is growing and feeding well?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6 Does your baby fall asleep after nursing?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7 Does your baby seem satisfied after nursing?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8 Are your baby's stools yellow? (if over 4 days old)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9 Does your baby's skin look yellow?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10 Does your baby nurse at least 8 times a day?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11 Does your baby have at least 4 wet diapers a day? (if over 4 days)	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Questions 12-21 address high risk factors related to breastfeeding success. If you answer "yes" to any of these questions (12-22), then you should be extra careful when monitoring your breastfeeding success. Answering "yes" in this section does not automatically indicate the need to see a lactation specialist.

	Yes	No
12 Was your baby born at less than 38 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
13 Did you require fertility drugs to get pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
14 Did you have a difficult labor and delivery or require a C-section?	<input type="checkbox"/>	<input type="checkbox"/>
15 Do you have flat or inverted nipples?	<input type="checkbox"/>	<input type="checkbox"/>
16 Were you separated from the baby after delivery?	<input type="checkbox"/>	<input type="checkbox"/>
17 Do you have a history of thyroid or other hormone abnormalities?	<input type="checkbox"/>	<input type="checkbox"/>
18 Do you have polycystic ovary disease?	<input type="checkbox"/>	<input type="checkbox"/>
19 Are you overweight?	<input type="checkbox"/>	<input type="checkbox"/>
20 Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
21 Do you have a history of breast surgery?	<input type="checkbox"/>	<input type="checkbox"/>
22 Did you have trouble nursing a previous baby?	<input type="checkbox"/>	<input type="checkbox"/>