Your names: ________________________________________________________________

Your baby’s name (if chosen): ________________________________________________

Baby’s doctor: ______________________________________________________________

Does doctor have privileges at your hospital?  □ Yes  □ No

Baby’s insurance: ____________________________________________________________

How are you planning to feed your baby?  □ Breast  □ Bottle  □ Both

Is there anything that concerns you or appeals to you about either feeding method? ________________

_____________________________________________________________________________

_____________________________________________________________________________

Have you or will you be attending a breastfeeding class?  □ Yes  □ No

Which feeding method(s) have you used in the past?  □ Breast  □ Bottle  □ Both

Most important issues (Any concerns, fears or issues you would like us to know about?): __________________________

_____________________________________________________________________________

_____________________________________________________________________________

Educational needs (baby care, breastfeeding, etc.): ________________________________

_____________________________________________________________________________

Circumcision?  □ Yes  □ No

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