Name of Patient: _____ DOB: _____

Newborn Feeding Questionnaire
(Breast and/or Bottle)

1. Are feeding times stressful?	YES	NO
2. Does it take longer than 30 minutes to feed your baby?	YES	NO
3. Does your baby squirm or become irritable with feedings?	YES	NO
4. Does your baby lose liquid out the sides of his/her mouth when feeding?	YES	NO
5. Do you find you have to feed your baby more frequently than every 2 hours?	YES	NO
6. Does your baby gulp, cough, gag or choke during feedings?	YES	NO
7. Does your baby have trouble calming when using a pacifier?	YES	NO
8. Does your baby have difficulty sustaining a suck pattern with either a pacifier or nipple?	YES	NO
9. Does your baby tire before completing feedings?	YES	NO
10. Does your baby frequently turn his/her head away from the nipple?	YES	NO