

◎ Fill out the following by writing strong pressure due to carbon copy.

Date of Checkup: / /

Guide Book No.						Sex	Date of Birth	Born on / /		
Furigana						Male	生年月日	Completed -Year-and- Month-Old		
Name of Child						Female	Birth Order	Child		
Address						TEL				
Family Structure 家族構成	Relationship 続柄	Name	Age 年齢	Occupation 職業	Condition of Health 健康状態	Relationship 続柄	Name	Age 年齢	Occupation 職業	Condition of Health 健康状態
Main Care Giver in Daytime 日中の主な保育者		Mother 母/ Father 父/ Grandmother 祖母/ Grandfather 祖父/( ) Nursery School 保育園/ Others その他( )								
Filled out by 健診票を記入した人		Mother 母/ Father 父/ Grandmother 祖母/ Grandfather 祖父/ Others その他( )								
Accompanied by 相談と一緒に来た人		Mother 母/ Father 父/ Grandmother 祖母/ Grandfather 祖父/ Older Brother 兄/ Older Sister 姉/ Younger Brother 弟/ Younger Sister 妹/ Others その他( )								

I. We will ask you some questions regarding the condition of your infant's health.

1. Condition of Birth 生まれた時の状態: Weight ( ) g Weeks of Pregnancy ( ) weeks Name of Facility for Childbirth 出産施設名( )
2. Was you feeling all right regarding your pregnancy/childbirth? 妊娠・出産は順調でしたか。Yes / No
3. Has your infant ever suffered from any serious illness? 今までにかかった大きな病気はありますか。No / Yes Name of Illness 病名 ( )
4. Is your infant suffering from any illness and currently being treated? 現在治療中の病気はありますか。 No / Yes Name of Illness 病名 ( )
5. Does your infant any family doctor? かかりつけ医はいますか。 Yes Name of Medical Institution 医療機関名 ( ) / No
6. Type of having already got a vaccination 今までに受けた予防接種 Hib (①②③ Addition) Pediatric pneumococcal vaccine(①②③ Addition)小児用肺炎球菌 DPT-IPV (①②③ Addition) MR (①) Chicken pox 水痘 (①②) Others ( )

II. We will ask you some questions regarding the condition of your infant's nutrition and teeth.

1. Does your infant have three meals every day at almost same hour? 食事はほぼ決まった時間に3回食べていますか。Yes / No ( )
2. Does your infant have a meal with any principal food and main/side dish?*1 食事は、主食、主菜、副菜がそろっていますか。 Yes, every time 毎食そろえている。/ Yes, at least twice every day. 1日2回はそろえている / Yes, at least once every day 1日1回はそろえている。/ No, almost. ほとんどそろわない
3. Does the guardian have a meal with your infant ?*2 保護者はお子さまと一緒に食事をとるようにしていますか。 Yes, almost every time. ほぼ毎食/ Yes, at least twice every day. 1日2回/ Yes, at least once every day. 1日1回/ No, almost. ほとんどない
4. Does your infant eat any vegetables at each mealtime every day? Yes / No (at least twice every day 2食/日/ at least once every day 1食/日/ No 食べない) 1日3食野菜料理を食べていますか。
5. How many times does infants have any snack every day? Once or twice 1~2回/ Three times or more 3回以上/ Never has any snack. 食べない 間食(おやつ)は、1日何回食べていますか。
6. What does your infant often eat for snacks? Circle any of the applicable items as follows: 間食(おやつ)は何を食べていますか。よく食べているものに○をつけてください。 a. Candy / Gummi candy / Caramel candy, etc. あめ・グミ・キャラメル類 b. Chocolate, etc. チョコレート類 c. Cookie, etc. クッキー類 d. Junk food スナック菓子 e. Ice cream アイスクリーム f. Dairy foods 乳製品 g. Juice, etc. ジュース類 h. Fruit 果物 i. Rice, etc. ご飯類 j. Bread, etc. パン類 k. Japanese cookie (Senbei) せんべい l. Gum ガム m. Others その他( )
7. What does your infant often drink? (In the case of drinking 5 times or more per week, write the amount of each time and the number of drinking. In other cases, circle any of the applicable items as follows.) 飲み物は何を飲んでいますか。(週5回以上の場合は1回量と回数を数字で記入し、それ以外は該当する内容に○をつけてください) a. Milk 牛乳 5 times or more per week 週5回以上: ( ) ml x ( ) times per day 回/日/ 2-3 times per week 週2~3回/ Rarely drink ほとんど飲まない b. Milk for child-care (including "Follow-up milk") 育児用ミルク(フォローアップ含む) 5 times or more per week: ( ) ml x ( ) times per day / 2-3 times per week / Rarely drink c. Juice, etc.*3 ジュース類 5 times or more per week: ( ) ml x ( ) times per day / 2-3 times per week / Rarely drink.
8. Does your infant has a habit of drinking tea and water? お茶や水を飲む習慣がありますか。 Yes / No ( )
9. Does your infant try to use a spoon, etc. to eat something? スプーンなどを持って食べようとしていますか。 Yes / No ( )
10. Is your infant good at using a cup.? コップを上手に使えますか。 Yes / No ( )
11. Do you give your infant breast milk? 母乳を与えていますか。 No / Yes: When do you give him/her it? どんな時( )
12. Does your infant use a baby bottle? 哺乳びんを使用していますか。 No / Yes : When does your infant use it? どんな時( ) What is in the bottle? 中身は( )
13. Does your infant suck his/her thumb or use a pacifier? 指しゃぶりやおしゃぶりをしますか。 No / Yes: When does your infant suck his/her thumb, etc.? どんな時( )
14. Does your infant brush his/her teeth (by himself/herself)? お子さまは、歯みがきをしていますか。(自分自身で) Yes / No
15. Do you brush your infant's teeth as finishing? 保護者による仕上げみがきは行われていますか。 Yes, at least three times. 1日3回/ Yes, at least twice every day. 1日2回/ Yes, at least once every day. 1日1回/ No.

16. Has your infant ever received any treatment at a dental clinic? 歯科医院を受診したことはありますか。Yes (due to any health checkup 健診/ dental treatment 治療) / No	
17. Do you ask a dentist regularly to paint fluoride on your infant's teeth? フッ化物(フッ素)を定期的に塗っていますか。	Yes / No
18. Does your infant use any toothpaste including fluoride? フッ化物(フッ素)入りの歯みがき剤を使用していますか。	Yes/ No
19. Write something about your infant's nutrition and teeth, if any: その他お子さまの栄養や歯について、気になることがあればご記入ください。	

III. We will ask you some questions regarding your infant.

1. We will ask you about your infant's life-style. *Add your infant's time schedule to the following list (regarding eating snacks, playing, taking a bath, sleeping(taking a nap), etc.)お子さまの1日を教えてください。*下の表に、間食(おやつ)、遊び、お風呂、睡眠(ひるね)などの時間も追加してください。 ---Getting up---Having a breakfast ----- Having lunch ----- Having dinner ----- Going to bed ----- (Time: ) (Time: ) (Time: ) (Time: ) (Time: ) <b>起床 朝食 昼食 夕食 就寝</b>	
2. Do you adjust the rhythm of day/night and sleeping for your infant? お子さまの昼夜の生活リズムや、睡眠リズムは整っていますか。	Yes / No
3. Do you usually use any municipal facility (Child Support Center (Kosodate-Shien-Center), Child Center (Jido-kan), disparting a garden of each nursery school, etc.)?市の施設(子育て支援センター・児童館・園庭開放など)を利用していますか。 Yes, often uses. / Yes, sometimes uses. / Never uses although knowing. / Never know. <b>よく利用する 時々利用する 知ってるが利用したことがない 知らない</b>	
4. Does your infant speak some meaningful words such as "Mama (mother)" and "Wan-wan (dog)" <b>「ママ」「ワンワン」などの意味のあることばをいくつか話しますか。</b> In the case of "Yes," number of words: approximately ( ) 語くらい details of words ( ) どんなことば	Yes / No
5. If you ask your infant about something to know ("What is a dog (Wan-wan)?" etc.) while reading any picture book, does your infant point out the things? <b>絵本などを見て、「ワンワンはどれ?」など知っているものを聞くと指差しますか。</b>	Yes / No
6. Does your infant understand some of easy words said by adults ("Come here" "Give me" etc.)? <b>大人の言う簡単なことばがわかりますか。(おいで、ちょうだいなど)</b>	Yes / No
7. If someone calls your infant from behind, does your infant turn back? <b>うしろから名前を呼んだ時、振り向きますか。</b>	Yes / No
8. In the time of talking, do you have any worries about your infant's line of sight, etc.? <b>話をする時、視線が合わないなどの心配がありますか。</b>	No / Yes
9. Does your infant imitate any behavior by someone in TVs or adults? <b>テレビや大人のしぐさをマネたりしますか。</b>	Yes / No
10. Is your infant interested in another child (ex. getting closer to another child)? <b>他の子どもに近寄るなど関心を示しますか。</b>	Yes / No
11. Do you have any worries about your infant's walking? Walking while holding on to something: approximately ( ) months <b>つたい歩き( )か月</b> Walking by himself/herself: approximately ( ) months <b>ひとり歩き( )か月</b>	No/Yes
12. Do you have any worries about your infant's eye movement, etc.? <b>目について気になることはありますか。</b> Irises are out of the inside/outside / With the eyes half-closed / Tilting the head or looking sideways / Iris looks whitish / Others ( ) <b>黒目が内や外にずれる 目を細める 頭を傾けて横目で見る 黒目が白っぽく見える</b>	No / Yes
13. Do you have any worries about your infant's hearing? <b>耳の聞こえについて気になることはありますか。</b> No-replying even if someone calls your infant many times <b>何度呼んでも返事をしない</b> / Often asking someone to repeat what to say <b>聞き返しが多い</b> /Larger sound of TVs <b>テレビの音を大きくする</b> / Bad hearing <b>聞こえが悪い</b> / Often suffering tympanitis: ( ) times <b>中耳炎を繰り返す( )回</b> /Others ( )	No / Yes
14. (*Only for boys) Can you recognize when you touch your infant's testicle in scrotums? <b>(※男の子のみ)陰のうの中に睾丸(タマタマ)が左右触れますか。</b>	Yes / No / Sometimes shakes <b>時々</b>
15. Write something to be worried about your infant, if any: その他お子さまのことで、気になることがあればご記入ください。	

IV. We will ask you some questions regarding yourself (person who fills out the form).

1. Circle the most applicable item as follows:	
a. Do you often enjoy child-raising?	<b>育児が楽しいと思える時間がよくありますか。</b> Yes / No
b. Do you think child-raising for your infant suits you?	<b>自分はこの子の育児に向いていますか。</b> Yes / No
c. Does any of your health conditions affect child-raising now?	<b>あなたは現在、健康上の問題で育児に何か影響がありますか。</b> No / Yes
d. How many hours do you show your infant any video such as TVs, DVDs or Smartphones? <b>テレビやDVD、スマートフォンなどの動画をどのくらい見せていますか。</b>	Approximately ( ) hour(s) per day <b>1日( )時間くらい</b>
e. Do you often read any picture book to your infant?	<b>絵本の読み聞かせをよくしていますか。</b> Yes / No
f. Do you have someone to talk to about child-raising?	<b>育児の相談相手はいますか。</b> Yes / No
g. Has your infant had a medical examination at any medical institution for a recent half year due to any accident or injury, etc.? <b>ここ半年間で、事故やケガなどで医療機関を受診したことがありますか。</b>	No / Yes
1. Swallow (eat) food by mistake <b>誤って飲み込む(食べる)</b>	2. Fall <b>落ちる</b>
3. Burn <b>やけど</b>	4. Accident in a car due to non-use of a child safety seat <b>チャイルドシート未使用による乗車中の事故</b>
5. Accident in a walk <b>歩行中の事故</b>	6. Tumble <b>転ぶ</b>
7. Nearly drown <b>溺れる</b>	8. Others( )

2. Write something to be concerned/worried about your infant or want to consult someone, if any: 心配なこと、困っていること、相談したいことなどがありましたら教えてください。

V. We will ask you some questions regarding your infant. Circle the most applicable item as follows.

\*The items (questions) regarding your infant's health, etc. specified by Ministry of Health, Labour and Welfare are as follows.

1. We will ask you some questions regarding parents' smoking status. 両親の喫煙状況についてお聞きます。				
1) Are you (infant's mother) a smoker now?	現在、あなた(お母さん)は喫煙していますか。	1. No	2. Yes (smoking ( ) cigarette(s) per day) (1日 本)	
2) Is the infant's father a smoker now?	現在、お子さんのお父さんは喫煙していますか。	1. No	2. Yes (smoking ( ) cigarette(s) per day)(1日 本)	
2. Does the guardian brush the infant's teeth as finishing every day? 保護者が、毎日、仕上げ磨きをしていますか。				
1. Yes (the guardian always brushes the infant's teeth after the infant brushes his/her teeth by himself/herself).	仕上げ磨きをしている(子どもが磨いた後、保護者が仕上げ磨きをしている)			
2. Yes (the guardian only brushes the infant's teeth).	子どもが自分で磨かずに、保護者だけで磨いている			
3. No (the infant only brushes the his/her teeth).	子どもだけで磨いている			
4. No (both the guardian and the infant do not brush his/her teeth).	子どもも保護者も磨いていない			
3. We will ask you some questions regarding vaccination. 予防接種についてお聞きます。				
• Has your infant already got DPT-IPV vaccine for diphtheria, whooping cough, tetanus and polio (1st period: 3 times firstly)?	四種混合(ジフテリア・百日せき・破傷風・ポリオ)の予防接種(第1期初回3回)を済ませましたか。			1. Yes 2. No
• Has your infant already got rubella/measles vaccine?	麻疹・風しんの予防接種を済ませましたか。			1. Yes 2. No
4. Do you want to raise your infant at this area in the future?	1. Yes.	2. Yes, if anything.	3. No, if anything.	4. No.
この地域で、今後も子育てをしていきたいですか。	そう思う	どちらかといえばそう思う	どちらかといえばそう思わない	そう思わない
5. Does your infant's father raise him/her?	1. Yes, always.	2. Yes, sometimes.	3. No, hardly.	4. I can never say anything.
お子さんのお父さんは、育児をしていますか。	よくやっている	時々やっている	ほとんどしない	何ともいえない
6. Is the door in a bathroom taken any idea not to be opened solely by your infant?	浴室のドアには、子どもが一人で開けることができないような工夫がしてありますか。			1. Yes 2. No 3. Not applicable 該当しない
7. Do you have a comfortable time with your infant?	お母さんはゆったりとした気分でお子さんと過ごせる時間がありますか。			1. Yes. 2. No. 3. I can never say anything. 何ともいえない
8. (1) Do you feel any trouble in child-raising?	あなたは、お子さんに対して、育てにくさを感じていますか。			1. Yes, always. いつも感じる 2. Yes, sometimes. 時々感じる 3. No. 感じない
(2) In the case of feel any trouble in child-raising, do you know how to solve the trouble such as talking to someone about child-raising?	育てにくさを感じた時に、相談先を知っているなど、何らかの解決する方法を知っていますか。			1. Yes 2. No
9. Do you know that most infants aged approximately one and a half years – two years try to point their own finger at something interested in? 1歳半から2歳頃までの多くの子どもは、「何か興味を持った時に、指さして伝えようとする」ことを知っていますか。				
10. Have you ever experienced any of the following events at home for recent several months? Circle the applicable item(s) as follows: この数か月間に、ご家庭で以下のことがありましたか。あてはまるものすべてに○を付けて下さい。				
1. Too much discipline	2. Spank your infant's body, etc. emotionally	3. Going out as leaving only your infant at home		
しつけのし過ぎがあった	感情的に叩いた	乳幼児だけを家に残して外出した		
4. Fail to give your infant any food for a long time	5. Emotionally yell in anger	6. Cover your infant's mouth		
長時間食事を与えなかった	感情的な言葉で怒鳴った	子どもの口をふさいだ		
7. Strongly shake your infant's body, etc.	8. Everything not applicable as above			
子どもを激しく揺さぶった	いずれも該当しない			

【Staff Use Only】 スタッフ記入欄

Today's Result of Physical Examination 本日の身体計測結果	Weigh 体重: kg	Height 身長: cm	Degree of Obesity 肥満度: %
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\*1: What is "Principal food and main/side dish?": "principal food" (dish mainly made with grain such as rice, bread or noodle), "main dish" (dish mainly made with meat, fish, eggs, soybeans, soy products, etc.), "side dish" (dish mainly made with vegetables, seaweed, mushrooms, potatoes, etc.)

\*2: Except meals in nursery schools and kindergartens.

\*3: Juice, etc." include any juices, vegetable juice, isotonic sports drink, lactic acid drink, carbonated drink, etc.

★ What is "Degree of Obesity?"  
Standard of obesity and thinness based on your height/weight.  
• Thinness: -19.9% - -15.0%  
• Normal: -14.9% - +14.9%  
• Obesity: +15.0% - +19.9%

In the case of something to be concerned about your infant or want to consult someone, contact the Central Health Center (Chuo-Hoken-Center) (TEL: 0476-42-5595).