（3 歳児健診）

Questionnaire on Checkup for Three-Year-Old Infants

No. Inzai City

◎ Fill out the following by writing strong pressure due to carbon copy. Date of Checkup: / /

Guide Book No.					Sex	Date of Birth **生年月日**	Born on / /			
Furigana					Male Female		Completed -Year-and- Month-Old			
Name of Child						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 **相談に一緒に来た人**	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
2. 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**（ ）
3. 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**（ ）
4. 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
5. Type of having already got a vaccination **今までに受けた予防接種** DPT-IPV (①②③ Addition) MR (①) Japanese encephalitis (①②③)**日本脳炎** 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 eat meat and fibrous vegetables chewing well? **肉や繊維のある野菜をよく噛んで食べていますか。** Yes / No ( )
3. 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**
4. 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**
5. Do you have your infant help with housework such as cooking, preparation of meals and cleaning-up? Yes / No **料理や食事準備・片付けなどのお手伝いをさせていますか。**
6. 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。**
7. 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。**
8. 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〇をつけてください。** 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**( )
9. 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〇をつけてください）** 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.
10. Do you give your infant breast milk or a body bottle? **母乳または哺乳びんを与えていますか。** No / Yes: What is in the bottle?**哺乳びんの中身は**( )
11. 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**( )
12. 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( )
13. 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 / No
14. 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
15. Does your infant any dental floss? **デンタルフロス（糸ようじ）を使用していますか。** Yes, every day. **毎日** / Yes, sometimes. **時々** / Never use. **使用していない**
16. 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 (last time **前回月/日**:) / No
17. 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 (time(s) per day days) / No

18. 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、おふろ、睡眠(ひるね)などの時間を記入してください。)**

―――Getting up――――	Having a breakfast ――――――	Having lunch ――――――――――――	Having dinner ――――	Going to bed ――――
(Time:)	(Time:)	(Time:)	(Time:)	(Time:)
起床	**朝食**	**昼食**	**夕食**	**就寝**

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 have any worries about development of motion? **運動発達について気になることはありますか。** No / Yes

4. Write the result of eyesight test at home: **自宅での視力検査の結果を記入してください。**

★ On the test, write "○" in the case of being able to see or "×" in the case of being able not to see as above. **見えたら○、見えなかったら×を記入**

Index **指標**	Both Eyes **両目**	Right Eye **右目**	Left Eye **左眼**
Big **大**			
Small **小**			

5. Do you have any worries about your infant's eye movement, etc.? **目について気になることはありますか。** No / Yes

Irises are out of the inside/outside **黒目が内や外にずれる** / With the eyes half-closed **目を細める** / Tilting the head or looking sideways **頭を傾けたり横目で見る** /Iris looks whitish **黒目が白っぽく見える** / Others( )

6. Write the result of hearing test at home: **自宅での聴力検査の結果を記入してください。**

★ On the test, write "○" in the case of being able to hear or "×" in the case of being able not to hear as below. **聞こえたら○、聞こえなかったら×を記入**

Whisper Test **ささやき検査**	Dog **いぬ**	Shoes **くつ**	Umbrella **かさ**	Elephant **ぞう**	Cat **ねこ**	Chair **いす**

Fingers Rubbing Test **指こすり検査**	Right Ear **右耳**	Lest Ear **左耳**

7. Do you have any worries about your infant's hearing? **耳の聞こえについて気になることはありますか。** No / Yes

Family history of hearing loss **難聴の家族歴がある/** Often suffering tympanitis **中耳炎を繰り返している/** Nose often stuffed up **普段から鼻づまりがある**

Nasal mucus or mouth breathing **鼻水、口呼吸をする/** No-replying even if someone calls your infant **何度呼んでも返事をしない**

Often asking someone to repeat what to say **聞き返しが多い** / Large sound of TVs **テレビの音を大きくする** / Bad hearing **聞こえが悪い/** Others( )

8. Do you have any worries about your infant's speaking? **ことばについて気になることはありますか。** No / Yes (Circle the applicable item(s) as follows:)

(1)Speak only words **単語だけしか話さない** (2)Speak only simple sentences **二語文だけしか話さない** (3)Stutter **どもる**

(4)I have any worries about the infant's pronunciation **発音が気になる** (5)Others( )

9. Is there any case that your infant cannot understand any of words spoken by you without your movement, etc.? No / Yes

あなたの言うことばの意味が、動作などを加えないと伝わらないことがありますか。

10.Are you concerned about any of the following items? **以下の項目で心配なことはありますか。** No / Yes (Circle the applicable item(s) as follows):

(1) Biting his/her nails **爪かみ** (2) Finger sucking **指しゃぶり** (3) Irritability **かんが強い** (4) Violence **乱暴**(5) Neurosis **神経質**(6) Others ( )

11. Does your infant enjoy with anyone such as playing house as speaking some words ("Here you are," "Thank you for food," etc.)? Yes / No

ままごとなどで「はいどうぞ」、「いただきます」などの人とのやりとり遊びをしますか。

12. Does your infant often play with his/her friends? **友達とよく遊びますか。** No / Yes

13. Does your infant wash his/her hands and put on/take off clothes by himself/herself? **自分で、手洗いや衣服の着脱をしますか。** Yes / No

14. Is your infant out of diapers? **昼間のオムツはとれましたか。** Yes / No

15. Has your infant had a medical examination at any medical institution for a recent half year due to any accident or injury, etc.? No / Yes

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。

1. Swallow (eat) food by mistake **誤って飲み込む(食べる)** 2. Fall **落ちる**

3. Burn **やけど** 4. Accident in a car due to non-use of a child safety seat **チャイルドシート未使用による乗車中の事故**

5. Accident in a walk **歩行中の事故** 6. Tumble **転ぶ**

7. Nearly drown **溺れる** 8. Others( )

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? **育児が楽しいと思える時間がよくありますか。** Yes / No

b. Do you think child-raising for your infant suits you? **自分はこの子の育児に向いていますか。** Yes / No

c. Does any of your health conditions affect child-raising now? **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。** No / Yes

d. How many hours do you show your infant any video such as TVs, DVDs or Smartphones? **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。**

Approximately ( ) hour(s) per day

e. Do you often play outside with your infant? **外遊びをよくしていますか。** Yes / No

f. Do you have someone to talk to about child-raising? **育児の相談相手はいますか。** Yes / No

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します。**

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. 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

3. 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

4. Do you have a comfortable time with your infant? 1. Yes. 2. No. 3. I can never say anything. **何ともいえない**
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。

5. (1) Do you feel any trouble in child-raising? 1. Yes, always.**いつも感じる** 2. Yes, sometimes. **時々感じる** 3. No. **感じない**
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。 ↓ ↓

(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? 1. Yes 2. No
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。

6. Do you know that most infants aged approximately three years – four years try to join the play in the case of any invitation by another child? 1. Yes 2. No
3歳から4歳頃までの多くの子どもは、「他の子どもから誘われれば遊びに加わろうとする」ことを知っていますか。

7. 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 **しつけのし過ぎがあった**
2. Spank your infant's body, etc. emotionally **感情的に叩いた**
3. Going out as leaving only your infant at home **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 **長時間食事を与えなかった**
5. Emotionally yell in anger **感情的な言葉で怒鳴った**
6. Cover your infant's mouth **子どもの口をふさいだ**
7. Strongly shake your infant's body, etc. **子どもを激しく揺さぶった**
8. Everything not applicable as above **いずれも該当しない**

8. (1) Does your infant have a family doctor? **お子さんのかかりつけの医師はいますか。** 1. Yes. 2. No. 3. I can never say anything. **何ともいえない**

(2) Does your infant have family dentist? **お子さんのかかりつけの歯科医師はいますか。** 1. Yes. 2. No. 3. I can never say anything. **何ともいえない**

Today's Result of Physical Examination **本日の身体計測結果**	Weight **体重**: kg	Height **身長**: cm	Degree of Obesity **肥満度**: %

*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).