3.5-Year-Old Health Checkup Quetionnaire

Please fill out this form and bring it with you on the day of the checkup.

Checkup Date (YYYY/MM/DD) / / Registration Number:

※ Eligibility: Must be a registered resident of Fujisawa City on the day of the checkup.
This form should be completed by the child's primary caregiver.

Your Relationship to Child

Father / Mother / Grandfather / Grandmother / Others ( )

Write in Katakana, if possible. **Male / Female**

Child's Name

Child's Birthdate (YYYY/MM/DD) **Child's Age (Today)** **Order of birth:[ ]**

/ / Months Old

Address *Please fill this in ONLY IF your current address is different from your mailing address.

City of Fujisawa

NOTE: The information provided may be shared with the Child and Family Center if deemed necessary by the City.

Course of Pregnancy Abnormality: None / Yes ( )
Condition at Delivery Abnormality: None / Yes ( )
Condition at Birth
Weeks of Pregnancy:( ) weeks
Abnormality: None / Yes ( )
Birth weight:( ) g
Birth length: ( ) cm

Phone Number

Parent/Guardian Name	Relationship	Parent/Guardian Name	Relationship

Vaccination Record (Please circle all that apply.)
Hib (Haemophilus influenzae type B): 1st / Booster
Pediatric pneumococcal: 1st / Booster
Hepatitis B: ( ) times **Rotavirus:** ( ) times
4(5) - in -1 vaccine (DTP-IPV-Hib combination vaccine) :Phase 1-1st / Booster
BCG **MR (Measles-Rubella)** **Chickenpox**: ( ) times
Japanese Encephalitis: Phase 1- 1st / Booster
Other ( )

Family Members:( ) people in total *Please circle the members below:

Father Age:( ), Occupation:( )
Mother Age:( ), Occupation:( )
Siblings: Older brother, Older sister, Younger brother, Younger sister
Grandfather / Grandmother / Others ( )

Daytime Caregiver

Father / Mother / Nursery school or Kindergarten (Name:)
Grandfather / Grandmother / Others ( )

About your child's health and safety

For Office Use Only

1 Does your child have any medical conditions present from birth? No / Yes (Condition: , Medical Institution:)

2 Has your child ever taken to a hospital for an accidental injury? No / Yes : Falls / Falls from height / Accidental Ingestion / Drowning / Traffic accidents / Other ( )

3 Do you take steps to prevent possible accidents, such as running out into the street or falls, according to your child's growth? Yes / No

4 Has your child ever had seizures or convulsions? No / Yes

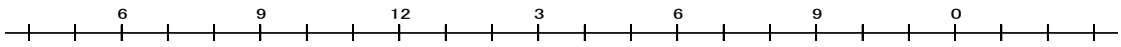
5 Has your child ever been diagnosed with asthma or atopic dermatitis? No / Yes

■健診履歴
1
4
9～10
1．6
2

■感染症
あり・なし

About your child's daily life

1 Please describe your child's daily routine on the timeline below: e.g.,waking up, bedtime, meals, naps, snacks, daycare/nursery, playtime, walks, park time, TV/screen time, bathtime.



2 Does the child have more than two hours of screen time a day? (e.g., TV, tablets, smartphones etc.) No / Yes ( ) hours a day

3 Does your child let you know before they need to pee during the day? Yes / No

4 How often does your child have bowel movements? ( ) times a day

5 Do you finish brushing your child's teeth every day? Yes / No

6 Do you have any concerns about your child's eating habit, such as picky eating or small appetite? No / Yes ( )

7 Does your child chew foods well？ Yes / No

8 What snacks does your child usually have? ( )

9 Does your child frequently drink sugary beverages like juice, sports drinks, or lactic acid drinks? No / Yes

For Office Use Only 父 ・ 母 ・ その他 ( ) 保健師サイン

Please turn over ↓

About your child's development		For Office Use Only
1	Does your child have simple conversations with other children of the same age? Yes / No	
2	Do you have any concerns about your child's speech development? No / Yes	
3	Does your child want to do everything by themselves? Yes / No	
4	Does your child show extreme anxiety or fear? No / Yes	
5	Have you felt your child's behavior excessively rough? No / Yes	
6	Have you felt your child is restless or has a difficulty to concentrate? No / Yes	
7	Do you have any concerns about your child sucking their thumbs, biting their nails, ot showing excessive shyness? No / Yes	
8	Do you have any concerns regarding your child's behavior? No / Yes Acts on their own Severe temper tantrums Rigid routines Does not engage in pretend play	
About yourself		
1	How do you feel about parenting? Enjoyable / Challenging but enjoyable / Often frustrated / Often overwhelmed or unsure what to do	
2	How do you rate your recent physical and mental health? Good / Fairly good / Average / Not so good / Poor	
3	Do you have someone or an organization to go for support with parenting? Yes (Please specify:) / No	
4	Do you have information about local parenting groups or parenting support organizations? Yes / No	
5	How do you feel about your current financial circumstances? Very comfortable / Comfortable / Average / Difficult / Very difficult	
6	Are you currently concerned about any of the following? Your child / Your spouse or partner / Your parents or in-laws / Friends or other parents / Other)	
Please feel free to write any questions or concerns		

Questionnaire based on Basic Policy on Child and Maternal Health and Development This questionnaire is a survey to help create a healthy environment for children's growth, based on national policy guidelines. Survey results will be anonymized and converted into statistical data for reporting to the national government. Your personal information will be strictly protected.		For Office Use Only
1	Does the child's mother currently smoke? (Including e-cigarettes and heat-not-burn tobacco) No / Yes (cigaretts a day)	
2	Does the child's father or partner currently smoke? (Including e-cigarettes and heat-not-burn tobacco) No / Yes (cigaretts a day)	
3	Do you finish brushing your child's teeth every day? I finish after my child brushes. / Only I brush./ Only my child brushes./ Neither of us brushes.	
4	Do you want to continue to raise your child in this community? Yes, definitely / Somewhat yes / Not really / No, not at all	
5	Do you and your spouse/partner share household chores and parenting? Yes, definitely / Somewhat yes / Not really / No, not at all	
6	Do you have time to relax and enjoy spending with your child? Yes / No / Not sure	
7	Do you find it difficult to raise your child? Never / Sometimes / Always	
8	(For those who answered "Sometimes" and "Always" for Question No.7) Do you know how to get support or find a solution when you experience difficulty with parenting? Yes / No	
9	Have any of the following occurred in your household in the past few months? Please circle all that apply: Disciplining too harshly, Hitting or slapping the child emotionally, Leaving the child home alone, Not feeding the child for a long period, Yelling at the child with harsh words, None of the above	
10	Does your child have a regular doctor or pediatrician? Yes / No / Not sure	
11	Does your child have a regular dentist? Yes / No / Not sure	