Fujisawa City

※Eligibility:Must be a registered resident of Fujisawa City on the day of the checkup.

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

4-month-old Health Checkup Questionnaire

Please fill in the thick-lined area.

Your relationship to Child:
Father Mother Other( )

Name of the child Write in Katakana, if possible Male / Female Birth order:	Address:	Parent/Guardian Name	Relashonship
Date of Birth Year: Month: Day: (4 months an days)	Phone number: Father Mother Other( )	Parent/Guardian Name	Relationship

Family members:( ) people Circle all that apply:
Father ( )yrs Occupation( ) Brother(older/younger) Sister(older/younger)
Mother( )yrs Occupation( ) Grandfather Grandmother Other( )

Daytime Caregiver
Father Mother Nursery school(Name:)
Grandfather Grandmother Other( )

Mother's medical history None Yes (Please specify:)

During pregnancy	Delivery	Fetal position	Baby's condition at birth
No problems Yes( )	No problems Yes( )	Head first / Breech Other( )	Weeks of pregnancy ( )weeks, Problems: No Yes( ) Birth weight ( )g Birth length( )cm

Has any blood relative of the child ever been treated for a hip condition? No / Yes

Newborn Screening Test for Congenital Metabolic Disorders Abnormality: None Present ( )

Newborn Hearing Screening Screened(Pass ・ Refer) ・ Not screened

1-month Checkup: Completed(Results: ①Normal ②Follow-up completed ③Under treatment ④Referred to a medical institution) ・ Not completed
Reasons for ②~④( )

Vaccination records: 5-in-1 vaccine(Ⅰ−1st･2nd ･3rd) Pediatric Pneumococcal(Ⅰ−1st･2nd･3rd) BCG Hepatitis B(1st･2nd)
Rotavirus: Rotarix (1st ･2nd) Rota Teq (1st･2nd･3rd) Other ( )

Your child's Development and Daily Life

医師記入欄

1	Does your child have any medical conditions present from birth?	No / Yes ( )
2	Has your child ever been taken to a hospital for an accidental injury?	No / Yes(Falls, Accidental ingestion, Other)
3	Do you take steps to prevent possible accidents, such as falls from beds or sofas?	Yes / No
4	Does your child often spit up or vomit large amount of breast milk or formula?	No / Yes
5	Do your child's lips turn blue when taking a bath, feeding, or crying?	No / Yes
6	Has your child ever had seizures or convulsions?	No / Yes
7	Does your child have noisy breathing (wheezing) when they have a cold?	No / Yes
8	When on thier tummy, does your child push up on their elbows or forearms?	Yes / No
9	When on their back, does your child roll onto their side?	Yes / No
10	Does your child play by bringing their hands together?	Yes / No
11	Have you ever felt your child's body is unusually soft or limp, or too stiff or rigid?	No / Yes
12	Does your child make eye contact with you?	Yes / No
13	Does your child follow moving objects with their eyes?	Yes / No
14	Does your child play by shaking or watching a rattle?	Yes / No
15	Does your child make cooing sounds like "aah" or "ooh"?	Yes / No
16	①How often and how much breast milk or formula does your child take per day?② Please describe your child's bowel movements. ①Breast milk ( ) times a day Formula ( )ml×( ) times a day ②Bowel movements ( ) times a day	

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.

1	Have you received enough support from midwives or public health nurses during the first month after leaving the hospital?	Yes / No / Neither
2	Did the child's mother smoke during pregnancy?	No / Yes( ) cigarettes a day
3	Did the child's father or partner smoke during pregnancy?	No / Yes( ) cigarettes a day
4	Does the child's mother currently smoke?	No / Yes( ) cigarettes a day
5	Does the child's father or partner currently smoke?	No / Yes( ) cigarettes a day
6	Did the child's mother drink alcohol during pregnancy?	No / Yes
7	Do you intend to continue raising your child in this community?	Yes, definitely / Somewhat yes / Not really / No, not at all
8	Do you and your spouse/partner share household chores and parenting?	Yes, definitely / Somewhat yes / Not really / No, not at all
9	Do you have time to relax and enjoy spending with your child?	Yes / No / Not sure
10	Do you find it difficult to raise your child?	Never / Sometimes / Always
11	(For those who answered "Sometimes" or "Always" to the previous question,) Do you have someone or somewhere to go for support with parenting?	Yes / No
12	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 an infant home alone, Shaking the child violently, Not feeding the child for a long period, Yelling at the child with harsh words, Covering the child's mouth with hands None of the above	
13	Do you know that shaking a baby hard enough to make their head move back and forth can lead to serious brain injury (Shaken Baby Syndrome)?	Yes / No
14	Does your child have a regular doctor or pediatrician?	Yes / No

指導項目に☑
☐発育
☐発達
☐予防接種
☐離乳食
☐その他

4か月児健康診査票　（受診日　　年　　月　　日）

About yourself		
1	How do you rate your recent physical and mental health?	Good　Fairly good　Average　Not so good　Poor
2	Do you have anyone or any organization to go for support with parenting?	Yes(Please specify:　　) / No
3	How do you feel about parenting?	Enjoyable /Challenging but enjoyable /Often frustrated / Often overwhelmed or unsure what to do
4	Do you have information about local parenting groups or parenting support organizasions?	Yes / No

Please feel free to write any questions or concerns, such as about your child, partner,finances.

身体発育

体重	身長	頭囲	カウプ指数
g	cm	cm	

診察所見

1	身体的発育異常	所見なし ・ あり	（　　）
2	精神発達障害	所見なし ・ あり	（ ア 笑わない　イ 喃語が出ない　ウ 視線が合わない　）
3	けいれん	所見なし ・ あり	（　　）
4	運動発達異常	所見なし ・ あり	（ ア 定頸未完了（ ± ・ − ）　イ 物をつかまない　）
5	神経系･感覚器系の異常	所見なし ・ あり	（ ア 追視しない　イ 斜視　ウ 聴覚異常　エ 筋緊張異常 オ その他　）
6	血液疾患	所見なし ・ あり	（ ア 貧血　イ その他　）
7	皮膚疾患	所見なし ・ あり	（ ア 湿疹　イ その他　）
8	股関節	所見なし ・ あり	（ ア 開排制限　イ M字型開脚ではない　）
9	斜頸	所見なし ・ あり	（　　）
10	循環器系疾患	所見なし ・ あり	（ ア 心雑音　イ その他　）
11	呼吸器系疾患	所見なし ・ あり	（　　）
12	消化器系疾患	所見なし ・ あり	（ ア 腹部膨満･腹部腫瘤　イ そけいヘルニア　ウ 臍ヘルニア エ 便秘　オ その他　）
13	泌尿器系疾患	所見なし ・ あり	（ ア 停留精巣　イ 外性器異常　ウ その他　）
14	先天性代謝異常	所見なし ・ あり	（　　）
15	先天性形態異常	所見なし ・ あり	（　　）
16	その他の異常	所見なし ・ あり	（　　）

診察結果　※必ずチェックをお願いします。記載もれ、チェックもれの場合、確認のため市からご連絡いたします。

1 異常なし	
2 既医療	病名:
	通院先医療機関名:　　/　　科
3 要経過観察	観察項目:　　経過確認時期:　　か月後
	観察機関:主治医･経過検診療養生活相談･その他(　　)
4 要紹介（要精密）	紹介理由:
	紹介先医療機関名:　　/　　科
5 要紹介（要治療）	紹介理由:
	紹介先医療機関名:　　/　　科

特記事項

市記入欄	医師氏名	医療機関番号