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.

9/10-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	Rel.
Date of Birth Year: Month: Day: (months and days)	Phone number: Father Mother Other ( )	Parent/Guardian Name	Rel.

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	Baby's condition at birth
No problems Yes( )	No Problems Yes( )	Weeks of pregnancy ( )weeks, Problems: No Yes( ) Birth weight ( )g Birth length( )cm

Developmental Milestones	
Holding head steady	months
Rolling over	months
Sitting up	months
Crawling	months
Pulling up to stand	months

Vaccination records: Circle all that apply

5-in-1 vaccine(I −1st･2nd ･3rd) Pediatric Pneumococcal(I−1st･2nd･3rd) BCG

Hepatitis B(1st･2nd･3rd) Rotavirus: Rotarix (1st ･2nd) Rota Teq (1st･2nd･3rd)

Other:

Newborn Hearing Screening

1-month Checkup 4-month Checkup

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	Are you taking precautions against home accidents, such as falls(stairs/tubs), accidental ingestion(medicine/e-cigarettes), or burns(kettles/cookers)?	Yes / No	
4	Has your child ever had seizures or convulsions?	No / Yes	
5	Does your child have noisy breathing (wheezing) when they have a cold?	No / Yes	
6	Does your child sit unsupported and play with toys for a while?	Yes / No	
7	Does your child crawl?	Yes / No	
8	Does your child pick up small objects?	Yes / No	
9	Does your child make repetitive sounds, such as "ah-ah" or "ma-ma"?	Yes / No	
10	Does your child distinguish family members from strangers?	Yes / No	
11	Does your child follow you around?	Yes / No	
12	Does your child turn around when you whisper to them?	Yes / No	
13	Have you ever noticed anything unusual about your child's eyes or eye movements?	No / Yes	
14	Do you have any concerns about your child's teeth, such as their alignment, color, or shape?	No / Yes	
15	Is your child eating more solid food (amount/variety) and drinking less breast milk or formula?	Yes / No	
16	At what age did your child start solids? How many times a day now?	Started:( )mo. Now: 2 / 3 times daily	指導項目に☑
17	Does your child chew soft food that can be mashed with their tongue?	Yes / No	□発育
18	How often does your child have bowel movements?	( ) times a day	□発達
19	Do you find it difficult to raise your child?	Never / Sometimes / Always	□予防接種
20	(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	□離乳食 □その他
21	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		

9～10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,or finances.

身体発育

体重	身長	頭囲	カウプ指数
g	cm	cm	

診察所見

発達確認					
	1	おすわり	＋ ・ ± ・ －	2	はいはい　たか這い ・ ずり這い ・ －
	3	つかまり立ち	＋ ・ ± ・ －	4	パラシュート反応　＋ ・ ± ・ －

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	(　　)
3	けいれん	所見なし ・ あり	(　　)
4	運動発達異常	所見なし ・ あり	(　　)
5	神経系･感覚器系の異常	所見なし ・ あり	(　ア 斜視　イ 聴覚異常　ウ 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	(　　)
9	循環器系疾患	所見なし ・ あり	(　ア 心雑音　イ その他　　)
10	呼吸器系疾患	所見なし ・ あり	(　　)
11	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　　)
12	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　　)
13	先天性代謝異常	所見なし ・ あり	(　　)
14	先天性形態異常	所見なし ・ あり	(　　)
15	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