Health checkup for 3~4 month - olds

Name:
Address:

☆Please fill out your child's household information.

① Order of birth: Sex: Male・Female Date of birth: Y M D

② Household information: In total people

	Name	Age	Sex	Occupation	Health status	Medical history	Allergies
Child him/herself			M・F				Yes No
Father			M・F				Yes No
Mother			M・F				Yes No
			M・F				Yes No
			M・F				Yes No
			M・F				Yes No
			M・F				Yes No
			M・F				Yes No

③ Who cares for your child during the day? Mother・Father・Grandmother・Grandfather
Nursery・Kindergarten ( )

④ Contact information (Phone number):

☆During your pregnancy

① Did you attend prenatal classes during pregnancy?

Yes □ No □ : If you checked "yes", did you attend the class with your husband? → Yes □ No □

② Did you experience any abnormalities during pregnancy?

No □ Yes □ Due to : Hypertension during pregnancy / threatened premature delivery / other

③ Did you smoke during your pregnancy?

No □ Stopped after pregnancy□ Yes □ (cigarettes per day)

⑤ Did you drink alcohol?

No □ Stopped after pregnancy□ Yes □ (glasses per day)

☆Please answer about your postpartum condition.

① Did you have a postpartum checkup after delivery?

No □ Yes□→ Result ： Abnormal [anemia, protein in urine, sugar in urine, hypertension (BP /)]

② Do you sometimes get depressed or feel like you don't have any energy?

No □ Yes □ Difficult to say □

③ Please check the items below which describe your current condition.

Good □ Bad □ Get tired easily □ Sleep badly □ Poor appetite □

④ Please check the items below which describe your current emotional state.

Good □ Bad □ Difficult to say □ Feel insecure □

⑥ Do you eat three meals per day?

Yes □ No □

⑦ Please use the space below to write down any questions or concerns.

☆We would like to ask the parents or guardian about child rearing.

① How do you feel being with your baby?

1.You enjoy each day. 2. You enjoy child rearing despite the increased workload. 3.You feel tired due to the increased workload.4.You often feel irritable. .5 It's a huge burden on you because you cannot love your child. 6. You feel pain because you don't have enough free time. 7.Other( )

②Do you have any worries about child rearing？

1. None 2.You can solve the problems by yourself. 3.You don't want to worry about it.

4. You have trouble right now.

③ What are you worrying about?

1. You have no confidence in your child rearing. 2. You are uncomfortable associating with other parents.

3. Interference by relatives.4.You don't know how to raise your child (breastfeeding,; bathing,; changing diapers; how to respond when your child is crying; how to care for your baby,; how to hold your child.)

④ If your baby has siblings, do you have any worries about them?

1. There are no siblings 2.There is nothing to worry about. 3. They are restless. 4. They cannot play with other children. 5. His/her language delay. 6. They are violent. 7. They are acting like a baby (sucking his/her thumb, nail biting, bed wetting, crying at night) 8 Other( )

⑤ Do you have any trouble in your family?

1.There is nothing to worry about. 2. Child rearing styles are different. 3. You cannot get any support for child rearing. 4 Finances 5.Differences in how to manage finances 6 .You don't communicate much. 7.How to associate with relatives. 8 Gambling issues 9. Alcohol and medication problems. 10. Domestic violence. 11.Unemployment. 12.Career change 13.Unplaned debt 14. Other( )

⑥ Do you have anyone or any organization who can support you when you have worries?

1.Spouse 2. Friends 3. Parent's home 4. Neighbors 5.Private services 6.Nursely 7.Telephone consultation 8.PHN in your region 9. Internet 10.None 11. Others ( )

☆About your Child

① Please fill out the form below.

Place of birth		Weight g
Duration of pregnancy	Weeks days	Height cm
Delivery type	Normal・C-section (planned/urgent)・ Other	Chest circumference cm
Congenital metabolic Disorder check up	Not completed Completed → Result(Normal/ Abnormal)	Head circumference cm
Neonatal healing check up	Not completed Completed→ Result (Normal/ Abnormal) Method of examination (automatic ABR/OAE)	Jaundice None/ Normal/ Severe
Condition at time of hospital discharge	_____days after birth His/her weight_____g	Nursing (sucking)ability Normal/weak

② Has your child received his/her 1 month health checkup? Yes (date /) No

Weight g	Height cm	Chest circumference cm	Head circumference cm

③ Please mark the number of vaccinations your child completed.

Hib	1st 2nd 3rd	DPT-IPV	1st 2nd 3rd	Hepatitis B	1st 2nd
Streptococcus pneumoniae	1st 2nd 3rd	BCG		No ☐ completed☐	

④ Has your baby ever had convulsions ☐No / ☐Yes

⑤ Please answer the questions below about your baby's current condition.

1 Is your child in a good mood?	Yes ☐ No ☐
2. Does your child laugh when you play with him/her?	Yes ☐ No ☐
3. Does your child follow moving objects with his/her eyes?	Yes ☐ No ☐
4. Does your child look in the right direction when he/she hears sound?	Yes ☐ No ☐
5. Does your child hold his/her head up without support?	Yes ☐ No ☐
6. Does your child grip when he/she touches something?	Yes ☐ No ☐
7. Does your child move his/her arms and legs freely?	Yes ☐ No ☐
8. Does your child suck his/her thumb?	Yes ☐ No ☐

a. Does your child have difficulty opening his/her legs?	Yes ☐ No ☐
b. You feel uncomfortable that your child arches his/her back too much.	Yes ☐ No ☐
c. Your child wakes up often due to unstable sleep.	Yes ☐ No ☐
d. Your child doesn't open his/her hand when he/she grips something.	Yes ☐ No ☐
e. Your child doesn't move his/her arm or leg on one side.	Yes ☐ No ☐
f. Your child always looks in the same direction.	Yes ☐ No ☐
g. Your child often trembles.	Yes ☐ No ☐
h. Does he/she push down on his/her legs strongly?	Yes ☐ No ☐
i. Your child doesn't move his/her arms or legs so much.	Yes ☐ No ☐
j. Is your child's body too flexible or his/her muscle tone too weak ?	Yes ☐ No ☐

⑦ About feeding

Breastfeeding (　　) times /day　(　　) minutes/per feeding

Formula (　　) times /day　(　　)cc / per feeding

② How often does your baby have　bowel moovements?　　(　　) times per day.

⑨ Do you have any questions or concerns?

<That's all for the questions. Please check the list below for those who could not have a consultation.>

① He/she had a health checkup at a hospital or with a family doctor.

② The day was inconvenient for you.

③ He/she was abroad or staying at a different place(Place/ country:　　)

④ He/she was sick or was being hospitalized.

⑤ He/she had a health checkup before moving to Machida.(At　　city)

⑥ He/she belongs to a nursery.

⑦ Other：