(受付番号　　)　健診日

# 3 year old Health Checkup Questionnaire

| | 希望 | 相談内容 | 済 |
|---|---|---|---|
| 内科相談 | | | |
| 栄養相談 | | | |
| 歯みがき相談 | | | |
| ことば・発達相談 | | | |

**＊Please leave this sheet at the checkup place when you come.**
**Please fill inside the thick-frame box.( Front and back )**
**Please circle those that apply.**

| | | | | |
|---|---|---|---|---|
| Name | | Male / Female | Date of birht | /　/ ( 3 year and ___ months ) |
| Name of the parent or a guardian | | Possibility of mother's pregnancy | No / Yes (Due date　　) | |
| Address | | Phone | ( Father / Mother ) | |
| Family member | Father / Mother / Older brother (　years old ) / Older sister (　years old ) | | | |
| | Younger brother (　years old ) / Younger sister (　years old ) / Other (　　) | | | |

【Who takes care of the baby during the day?】
Father / Mother / Grandparent(s) / Day-care center / Kindergarten / Nintei Kodomoen / Private day-care place / Other

【 Developmental history 】
Length of pregnancy (　　weeks )　Weight at birth (　　g )
Did you have any sickness or problems during pregnancy and delivery?　No / Yes (　　)
Your child's development thus far　Stable neck (　months )　Unsupported walking (　months )
Speaking simple word (　months )
Did you take 18 months Health Checkup?　Yes /　No

| | | | |
|---|---|---|---|
| 1 | Circle the illness your child had since birth.( Chicken Pox / Mumps / Pertussis / Measles / Rubella ) | | |
| 2 | Circle the vaccination your child has taken<br>Hib(Hemophilic influenza type b vaccine) 1st / 2nd / 3rd / Additional　Childhood pneumococcal vaccination 1st / 2nd / 3rd / Additional　Hepatitis B vaccine 1st / 2nd / 3rd　Diphtheria,pertussis,tetanus,and polio 1st / 2nd / 3rd / Additional<br>BCG (Tuberculosis)　Measles and rubella　Varicella(Chickenpox) 1st / 2nd　Japanese encephalitis 1st / 2nd　rotavirus 1st / 2nd / 3rd ☐ | | |
| 3 | Went to a hospital due to an accident or major injury?<br>( Fall / Bruise / Cut / Accidental ingestion / Near-drowning / Traffic accident / Burn / Other ) | Yes | No |
| 4 | Any major illness or disease<br>If Yes , what is it? (　　) | Yes | No |
| 5 | Is your child currently being treated for an illness or allergy?<br>If Yes , what is it? (　　) | Yes | No |
| 6 | Is there anything you would like to talk about or worried about?<br>Sleep / Diet / teeth / Excretion ( peeing and pooping ) / Speaking ability / Other (　　) | Yes | No |

**＜About growth and development＞ Please circle those that apply.**

| | | | |
|---|---|---|---|
| 1 | Can your child stand on one foot for a few seconds? | Yes | No |
| 2 | Does your child go up the stairs without using hand? | Yes | No |
| 3 | Does your child want to change clothes by him/herself? | Yes | No |
| 4 | Can your child tell the difference between big and small? | Yes | No |
| 5 | Does your child call him/herself by name ( nickname ) ? | Yes | No |
| 6 | Does your child make a sentence over 3 words? | Yes | No |
| 7 | Do you have any concerns about your child's speaking ability or pronunciation? | No | Yes |
| 8 | Does your child role-play with friends while playing? ( such as playing a hero or play house ) | Yes | No |
| 9 | Does your child play away from where you are? | Yes | No |
| 10 | Circle the things you are concerned/worried about.<br>☐ Hard to have eye contacts　☐ Extremely hyperactive<br>☐ Have trouble having a control of your child　☐ Easily get upset<br>☐ Has or had obsessions with something that you are concerned about ( Which is… )<br>☐ Other （　　） | | |

＜About Eyes and Ears Test＞

**Follow the instructions on the Test sheet and proceed the test at home and complete this sheet by the checkup day.** **Circle the appropriate answers.**

## 【Questions about eyes】

1 Does your child ever cross his/her eyes, or does his/her eye wander upward or to one side? ・・・Yes No
2 Does your child extremely dazzling when he go to bright please? ・・・Yes No
3 Does your child squint or narrowed his/her eyes? ・・・Yes No
4 Does your child need to look close? ・・・Yes No
5 Does your child tilt his/her head or turn head and look from the corner of his/her eye? ・・・Yes No
6 Do the irises ever shift inward, outward, upward or obliquely upward? ・・・Yes No
7 Does your child ever look at things with one eye closed in bright outdoors? ・・・Yes No
8 Do the irises look whitish? ・・・Yes No
9 Are the irises uneven? ・・・Yes No
10 Do the eyes ever shake? ・・・Yes No
11 Are the eyelids drooping? ・・・Yes No
12 Do the parents or siblings have amblyopia, strabismus, or other eye diseases from birth? ・・・Yes No
13 If you have any other concerns about your child's eyes please leave comments.
( )

**Result of Home eye test**

（Please follow the instructions on the different sheet.）

Write the result on the right boxes.
○・・・Your child could see more than 3 directions of the rings.
×・・・Your child saw 1 or 2 directions of the rings.

| Both eyes | Right eye | Left eye |
|---|---|---|
| | | |

【職員記入欄】

| SVS | 完了・精密・その他 |
|---|---|

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## 【Questions about ears】

1 Is your child currently being treated at an ear,nose,and throat doctor? ・・・Yes No
2 Is there anyone in your family or relatives who has hearing problems since baby? ・・・Yes No
3 Has your child repeated middle-ear inflammation within the last 6 months? ・・・Yes No
4 Does your child often experience stuffy nose, or runny nose, mouth breathing? ・・・Yes No
5 Does your child ever not answer when you call, ask you to repeat, turn up the TV volume, or cause you to think his/her hearing is poor? ・・・Yes No
6 Has your child's nursery school teacher or someone in contact with him/her ever said his/her hearing is poor? ・・・Yes No
7 Have you ever noticed your child's ability to speak appears delayed, or pronounces word strangely? ・・・Yes No
8 Does your child have problem understanding what you say if you don't add gestures? ・・・Yes No
9 When you talk to your child, does he/she turn head to certain side or look around? ・・・Yes No
10 If you have any other concerns about your child's ears and hearing please leave comments.
( )

**Result of Home hearing test**

（Please follow the instructions on the different sheet.）

1）Home Whisper Test with picture sheet by a parent

| Dog | Shoes | Umbrella | Elephant | Cat | Chair |
|---|---|---|---|---|---|
| | | | | | |

2）Hearing Test by finger rubbing

| Right ear | Left ear |
|---|---|
| | |

＜Child-rearing affairs＞ Please circle those that apply.

| | | | | | |
|---|---|---|---|---|---|
| 1 | Do you think your family spend a lot of time with your child? | | | Yes | No |
| 2 | Do you have anyone to talk about raising the child?<br>Yes If yes, Who are they? Your spouse / Parent (s) / Friend(s) / Other ( )<br>No | | | | |
| 3 | Do you enjoy raising your child? | Yes | Hard to say | No | |
| 4 | Do you fell that raising a child is tiring? | No | Hard to say | Yes | |
| 5 | How is your physical and mental health? | Good | Hard to say | No good | |
| 6 | Does the child's mother smoke currently? | No | Yes ( / day ) | | |
| 7 | Does the child's father smoke currently? | No | Yes ( / day ) | | |
| 8 | Are you aware of the fact that most children between the age of 3 and 4 years always try to join the play when invited by other children? | | | Yes | No |
| 9 | Does the child's mother have plenty of relaxed time to spend with her child? | Yes | Hard to say | No | |
| 10 | Is the child's father involved in childcare / upbringings? | Often | Sometimes | Hardly any | Hard to say |
| 11 | Do you feel some difficulties with childcare / upbringings? | Always | Sometimes | Not at all | |
| 12 | If you answer 1 or 2 in the previous questions: Do you know any solutions, for example you know where to get help? | | | Yes | No |
| 13 | Would you like to bring up your child in this area in the future? | Yes | Probably | Unlikely | No |
| 14 | Please circle any of the events on the right which apply to your family within the last few months.<br>Gave too much discipline Smacked child when angry<br>Left the child home alone Did not give any meal for a long time<br>Yelled at child emotionally<br>None of the above | | | | |
| 15 | Does your child have a regular doctor? | Yes | No | Not sure | |
| 16 | Does your child have a regular dentist? | Yes | No | Not sure | |

＜Dental condition＞ Please circle those that apply.

| | | | | | |
|---|---|---|---|---|---|
| 1 | Are there any wobbly or missing teeth? | | | Yes | No |
| 2 | Does your child brush his/her teeth?<br>( 1 ) After breakfast Every day Sometimes Never<br>( 2 ) After dinner Every day Sometimes Never | | | | |
| 3 | After your child brush his/her teeth, do you do a follow-up brushing? | Every day | Sometimes | Never | |

＜about your child's lifestyle and dietary habit＞ Please circle those that apply.

| | | | | | |
|---|---|---|---|---|---|
| 1 | Dose your child get up around the same time every day? | Yes (at : ) | | | No |
| 2 | Does your child go to bed around the same time every day? | Yes (at : ) | | | No |
| 3 | Dose your child use potty or toilet during the day? | | | Yes | No |
| 4 | How many hours a day does your child spend watching TV, videos, tablets and smartphones? | About hours | | | |
| 5 | Has the child finished with drinking breast milk?<br>Yes ( year and months ) No | | | | |
| 6 | Does he/she use a baby bottle?<br>No Yes ( because ) | | | | |
| 7 | Does he/she try to use a spoon, fork and chopsticks and eat by him/herself? | | | Yes | No |
| 8 | Does your child have a good appetite?<br>Yes No ( because ) It depends (because ) | | | | |
| 9 | Does he/she chew his/her food properly?<br>Yes Swallow without chewing much Keeps the food in the mouth | | | | |
| 10 | Is your child a picky eater? If so, circle the food the child does not eat.<br>Yes Milk / Dairy product / Meat / Fish / Egg / Soy product / Vegetables / Potatoes / Other ( )<br>No, my child is not a picky eater. | | | | |
| 11 | Does your child concentrate on eating at meal times?<br>Yes No ( Watch TV / Play / Curious about his/her surroundings / Other [ ] ) | | | | |
| 12 | Does your child have a meal times around the same time every day?<br>Breakfast Yes ( about : ) No ( because )<br>Lunch Yes ( about : ) No ( because )<br>Dinner Yes ( about : ) No ( because ) | | | | |
| 13 | How long does your child take to finish eating? | Less than 10 min | Less than 30 min | 30 min or more | |
| 14 | How many times does your child have snacks ( including juice ) a day? times / day | | | | |
| 15 | Is there a specific time for having snacks ( including juice ) ?<br>Yes No.Give it as much as he/she wants. | | | | |
| 16 | Is there a specific amount of snacks ( including juice ) ?<br>Yes No.Give it as much as he/she wants. | | | | |
| 17 | Circle the snacks you often give.<br>Bread / Rice ball / Potatoes / Fruits / Dried sardine / Biscuit / Rice cracker / Snacks<br>Chocolate / Ice cream / Jelly / Dairy product / Candy / Chewing gum<br>Chewing candy / Milk / Lactobacillus beverage / Soft drink / Juice / Other | | | | |
| 18 | Do you feed your child a snack after dinner before going to bed? ( Other than water or tea )<br>Yes ( Snack / Fruits / Milk / Soft drink or Juice / Other [ ] ) No | | | | |

19 Please draw a circle in an appropriate box.

| | Egg | Meat / Fish / Processed food | Soy / Soy product | Milk / Dairy | Light-colored vegetables | Green and yellow vegetables | Potatoes | Fruits |
|---|---|---|---|---|---|---|---|---|
| Does not eat so much | | | | | | | | |
| About 3 times a week | | | | | | | | |
| Almost every day | | | | | | | | |

| | | | | |
|---|---|---|---|---|
| 20 | Are you interested in making meals? | Yes | Not so much | No |
| 21 | Leave a comment if you have any concerns about meals. | | | |

＊ To parents/guardians
To support your child's healthy growth and development, we may contact related organizations like nursery schools regarding the results of the checkup etc. ( Agree / Disagree )

栄 養 相 談

管理栄養士氏名
( )