Reference Number（※Please enter the 7 digit number listed in your "Akachan Techo," aka your "baby health record book" in english）

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Instructions for completing this form are on the back

4-Month-Old Health Checkup Questionnaire

※Please complete the questions on this form, and then undergo the health examination. (Please do not forget to bring your maternity health record book on the day of the exam)　（Copy for Otsu City）

Child's Name(with Furigana)	Year Month Day (How many children do you have:)	M・F
Address: Phone Number:		
Parent/Guardian #1: Relation( )	Parent/Guardian #2: Relation( )	

	Weight:	Height:	Chest Size:	Head Size:
At birth	g	cm	cm	cm
At 1 month	g	cm	cm	cm

A. About the mother's pregnancy
- ・No issues
- ・Issues: anemia, threatened miscarriage/premature birth, PIH, diabetes, thyroid issues, infectious disease, other ( )

B. About childbirth
- ・At how many weeks was the child born? (weeks)
- ・Condition: Normal Childbirth, Premature Birth, C-section, Breech Birth, Vacuum Delivery, Forceps Delivery, other ( )

C. Birthplace: Within Shiga ・(Prefecture)
( )Hospital・Clinic・Doctor's Office・Maternity Hospital、Home

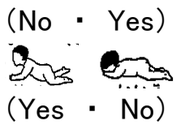
D. Condition of Child Upon Birth
- ・No issues
- ・Issues: Underwent oxygen therapy, entered an incubator, experienced strong skin pigmentation, struggled with receiving milk, other( )

E. Has your child contracted any illnesses?
- ・No　・Yes

F. Newborn Child Hearing Test
- ・Right Ear（Normal ・ Re-examination needed） Left Ear（Normal ・ Re-examination needed）
- ・Child has not undergone the test yet
- ※ If re-examination is needed: Result( )

The results of the 4-Month-Old Health Checkup will be sent one month after examination to the Otsu Mother and Child Health Division, as well as Sukoyaka Health Consultation Center.
You may also be asked about the condition of your child and yourself by Sukoyaka Health Consultation Center. If you have any concerns, please contact the Sukouaka Health Consultation Center.

Current State of Mother and Child

1. Does your child's head wobble when cradling them horizontally in your arms? (No ・ Yes)
2. When lying on their stomach, do they support their body with their elbows and lift their head up?  (Yes ・ No)
3. Can they hold their hands together in front of them when they play? (Yes ・ No)
4. Have you ever felt that their body was too soft and loose? (No ・ Yes)
5. Have you ever felt you child bends too easily making them hard to hold? (No ・ Yes)
6. When you hand them a toy, can they hold it with either hand? (Yes ・ No)
7. Have you ever thought the look in their eyes was strange, or that they do not follow objects with their eyes? (No ・ Yes)
8. When you cuddle your child, do they make noises and smile? (Yes ・ No)
9. Does your child make noises? (Yes ・ No)
10. Circadian Rhythm (please fill in how many hours your child sleeps per day)

0	6	12	18	24

11. What is your child's current daily nutrition? Mother's milk:( )times Baby Formula: 1 day( )ml
12. Do you have any concerns regarding breastfeeding and baby food? (No ・ Yes)
13. If you answered "Yes" on the previous question, please tell us why:
14. How often does the mother eat breakfast per week? In 1 week: ( )times
15. Do you find child raising to be challenging? (1. All the time 2. Sometimes 3. Never)
16. If you answered "1. All the time" or "2. Sometimes" on the previous question
    ① When do you feel this way? Can you give an example?
    ② Do you have a solution for your concerns, such as somewhere/someone you can consult ? (Yes ・ No)
17. How does the mother feel physically and mentally? (Normal ・ Not good)
    For those who answered "Not good," why do you feel this way?
18. In the past month, have you felt very irritated or depressed? (No ・ Yes)
19. Did you receive adequate care and support from public health nurses, etc. during the one month period after giving birth and being released from the hospital? (1. Yes 2. No 3. So-so)
20. Do you want to continue raising your child in the area you currently reside? (Yes ・ No)
21. If you have any other concerns regarding your child, the mother, or anything else you would like to discuss, please write them here:

※The fields below are to be filled out by the attending physician

Examination Results

※The weight gain curve is located in your maternity health record book.

Weight:	Height:	Chest Size:	Head Size:
Kaup Index:	Staus of Weight Growth (Normal ・ Slow ・ Fast)	Anterior Fontanel (×) cm	

Category	Normal	Physician's Opinion(Either circled, or written)
1. Skin		Rash ・ Hemangioma ・ Birthmark ( )
2. Eyes		Squint ・ Droopy Eyelids ・ Involuntary Eye Movements( )
3. Mouth		Cleft Lip ・ Cleft Palate ・ Thrush( )
4. Neck		Lump ・ Stiff Neck( )
5. Chest		Heart murmur ・ Wheezing ・ Retractive Breathing ( )
6. Stomach		HSM ・ Lump( )
7. Groin		Hernia ・ Cryptorchidism ・ Hydrocele testis ( )
8. Hip Joints		Struggles to open hips ・ Leg size difference( )
9. Mental Development		Does not laugh ・ Does not follow objects with eyes ・ Does not speak
10. Physical Development		Can not hold head up・Difference between left and right movement・Does not try to hold objects
11. Hearing		Reaction to Noises: Right ear – no reaction ・ Left ear – no reaction
12. Muscle Tone		Advancing ・ Declining
13 Other opinions		

14. Please assess the following positions:

a. Supine Position (①・②・③・Can't Determine)

b. Reaction to Being Pulled Upwards (①・②・③・Can't Determine)

c. Landau Reflex (①・②・③・Can't Determine)

15. Conclusions

① No Issues

② ( )

In accordance:

a. I refer you to(Recommendation:)

b. We will follow-up at our medical institution.

c. Undergoing Treatment/Monitoring

d. I recommend a baby consultation group

※ In the case that support for the child's nutrition, child raising, or development is necessary, or if some other further monitoring or follow-ups are necessary, please recommend the baby consultation group.

Date of Examination: Year Month Day　Medical Institution Code:　Name of Medical Institution:　Name of Attending Physician:

Revised May 2023

◇ How to Fill in the 4-Month-Old Health Checkup Questionnaire ◇

①➡

Reference Number （※Please enter the 7 digit number listed in your "Akachan Techo," aka your "baby health record book" in english）

0 0 0

Instructions for completing this form are on the back

4-Month-Old Health Checkup Questionnaire

※Please complete the questions on this form, and then undergo the health examination. (Please do not forget to bring your maternity health record book on the day of the exam)　（Copy for Otsu City）

②➡

Child's Name（with Furigana）

Year　Month　Day　M・F

（How many children do you have:　）

Address:

Phone Number:

Parent/Guardian #1:　Relation(　)

Parent/Guardian #2:　Relation(　)

	Weight:	Height:	Chest Size:	Head Size:
At birth	g	cm	cm	cm
At 1 month	g	cm	cm	cm

③➡

A. About the mother's pregnancy

・No issues

・Issues:　anemia, threatened miscarriage/premature birth, PIH,

diabetes, thyroid issues, infectious disease, other (　)

B. About childbirth

・At how many weeks was the child born? (　weeks)

・Condition: Normal Childbirth, Premature Birth, C-section, Breech Birth,

Vacuum Delivery, Forceps Delivery, other (　)

C. Birthplace:　Within Shiga・(　Prefecture)

(　)Hospital・Clinic・Doctor's Office・Maternity Hospital、Home

④➡

D. Condition of Child Upon Birth

・No issues

・Issues:　Underwent oxygen therapy, entered an incubator

experienced strong skin pigmentation, struggled with receiving milk

other(　)

⑥➡

E. Has your child contracted any illnesses?

・No　・Yes

F. Newborn Child Hearing Test

・Right Ear（Normal・Re-examination needed）Left Ear（Normal・Re-examination needed）

・Child has not undergone the test yet

※ If re-examination is needed:　Result(　)

The results of the 4-Month-Old Health Checkup will be sent one month after examination to the Otsu Mother and Child Health Division, as well as Sukoyaka Health Consultation Center.
You may also be asked about the condition of your child and yourself by Sukoyaka Health Consultation Center. If you have any concerns, please contact the Sukouaka Health Consultation Center.

Current State of Mother and Child

1. Does your child's head wobble when cradling them horizontally in your arms?　(No ・ Yes)
2. When lying on their stomach, do they support their body with their elbows and lift their head up?　(Yes ・ No)
3. Can they hold their hands together in front of them when they play?　(Yes ・ No)
4. Have you ever felt that their body was too soft and loose?　(No ・ Yes)
5. Have you ever felt you child bends too easily making them hard to hold?　(No ・ Yes)
6. When you hand them a toy, can they hold it with either hand?　(Yes ・ No)
7. Have you ever thought the look in their eyes was strange, or that they do not follow objects with their eyes?　(No ・ Yes)
8. When you cuddle your child, do they make noises and smile?　(Yes ・ No)
9. Does your child make noises?　(Yes ・ No)
10. Circadian Rhythm (please fill in how many hours your child sleeps per day)

0　6　12　18　24

11. What is your child's current daily nutrition?　Mother's milk:(　)times　Baby Formula: 1 day(　)ml
12. Do you have any concerns regarding breastfeeding and baby food?　(No ・ Yes)
13. If you answered "Yes" on the previous question, please tell us why:
14. How often does the mother eat breakfast per week?　In 1 week:　(　)times
15. Do you find child raising to be challenging?　(1. All the time　2. Sometimes　3. Never)
16. If you answered "1. All the time" or "2. Sometimes" on the previous question
    ① When do you feel this way? Can you give an example?
    ② Do you have a solution for your concerns, such as somewhere/someone you can consult v　(Yes ・ No)
17. How does the mother feel physically and mentally?　(Normal ・ Not good)
    For those who answered "Not good," why do you feel this way?
18. In the past month, have you felt very irritated or depressed?　(No ・ Yes)
19. Did you receive adequate care and support from public health nurses, etc. during the one month period after giving birth and being released from the hospital?　(　1. Yes　2. No　3. So-so　)
20. Do you want to continue raising your child in the area you currently reside?　(Yes ・ No)
21. If you have any other concerns regarding your child, the mother, or anything else you would like to discuss, please write them here:

⑤➡

＜ Important ＞

① Please fill in the 7 digit number listed in your "Akachan Techo"（赤ちゃん手帳/Baby Health Record Book）

② For those that live at multiple addresses, please also enter a phone number you can be reached at.

③ Please reference the "State of Childbirth"（出産の状態）and "1-Month Old Health Checkup"（1か月健診）pages of the maternity health record book.

④ Please reference the "Newly Born Child"（早期新生児期）page of the maternity health record book.

⑤ When filling in the "Current State of Mother and Child" section, please reference the third page of the "Akachan Techo"

⑥ If your examination result was "パス pass," circle "正常"（normal）. If your result was "ファー refer," circle "要再検"（re-examination necessary）

The 4-Month-Old Health Checkup Questionnaire is an important record of your child's health. Make sure to take the copy you are given (the "本人控"), and paste it in your maternity health record book (母子健康手帳). It will be necessary for when your child undergoes the 10-Month-Old Health Checkup (１０か月児健診).