

Health checkup questionnaire for infants (for 42–48 months old)

Subject name		Resident registration number		Telephone of guardian	
Name of guardian		Relationship to the subject		E-mail address	

The purpose of a health checkup for infants is to check on their normal growth and development rather than detecting particular ailments. Have you understood the purpose of the checkup?

Yes ☐ No ☐

1. Date of birth of child: Year Month Day		2. Birth weight: ■ ■ kg (round off to the nearest tenth)							
3. Please check the vaccinations completed so far. (Please indicate the frequency of the corresponding box.)									
	BCG	Hepatitis B	DPT	Poliomyelitis (polio)	Pneumococcus	Haemophilus B	Measles, mumps, rubella	Chickenpox	Japanese encephalitis
Numbers completed									
4. Has your baby been diagnosed with a development problem, or does he/she have a disease currently undergoing treatment?									
① Yes ② No If you answer “yes,” what is the specific diagnosis? _____									

Vision

	Yes ①	No ②
1 Does the position of the pupil of the baby seem strange?	①	②
2 Does the baby turn his/her head and turn sideways to see forward (objects in front of him/her) or does he/she look with his/her head tilted?	①	②
3 Does your baby read a book / watch TV / see things at a very close distance or frown to see?	①	②
4 Does the visual acuity of each eye of your child seem different when comparing each eye when you make him/her to see as covering one eye?	①	②

Auditory sense

	Yes ①	No ②
1 Is the child able to listen and repeat correctly the words (pencil, school, etc.) whispered from the distance of an arm radius in a quiet setting with his/her one ear covered at a time?	①	②
2 Are you able to understand the majority of what the child speaks?	①	②
3 Has the baby been hospitalized in a newborn intensive care unit (NICU) over 5 days after his or her birth?	①	②
4 Is the pronunciation of the child accurate?	①	②
5 Does the child speak as well as kids in his/her age group?	①	②

Emotion and sociality education

	Yes ①	No ②
1 Does the child voluntarily play with kids in his/her age group?	①	②
2 Does the child hurt his/her friend/s often, or deprive him/her/them of belongings?	①	②
3 Did you start to teach the child to do simple household errands? (e.g., Disposing waste in a waste bin, cleaning up his/her toys after playing, etc.)	①	②
4 Do you teach the child to behave in public places?	①	②
5 Do you teach the child to say hello first when he/she run into the acquaintance? / Do you teach the child to say “Thanks.” or “Thank you.” when somebody does a favor to him/her?	① ③	② ④
6 Is the child able to perform imagination play and role-playing? Is the child able to play in groups as dividing the sides?	①	②
7 Is the child able to explain what he/she has experienced in a simple manner?	①	②
8 Is the child able to explain jobs and roles that he/she frequently sees?	①	②

Accident preventative education

	Yes ①	No ②
1 Are there safety devices, such as a safety door or latch, for the child in the stairways, windows, and balcony areas?	①	②
2 Have you ever left your baby sitting alone in a pool or bathtub?	①	②
3 Do you keep cigarettes, lighters, electronic appliances, and electrical cords out of reach of children?	①	②
4 Does the child always wear a helmet and joint protection equipment when riding a bicycle, wearing inline skates, etc.?	①	②
5 Does your child play on the road where cars are passing by?	①	②
6 How do you have your child seated in a car? ① Using a car seat ② Using a booster seat ③ Fastening a seat belt ④ Just seated without any equipment	① ③	② ④

Nutrition education

1 How many times does your child have a meal? ① Once ② 2 times ③ 3 times ④ Over 4 times	① ② ③ ④
2 How many times does your child have a snack? ① Once ② 2 times ③ Over 3 times	① ② ③
3 How many times does your child drink fresh milk? ① He/she does not drink at all ② Less than 200 mL ③ 200–499 mL ④ 500–999 mL ⑤ Over 1,000 mL	① ② ③ ④ ⑤
4 How much amount of fruit juice or sugar added beverage (e.g. carbonated drink, sports drink, kids drink, etc.) does the child drink a day? ① Less than 200 mL (1 full cup) ② 200–499 mL ③ Over 500 mL	① ② ③
5 Do you ensure that the food you cook for the child and the family has low salt content? ① Yes ② No	① ②
6 How is the attitude of the child in a dining table? (Please check all corresponding numbers if applicable.) ① He/she takes too long time to finish a meal. (over 30 minutes) ② He/she refuses to eat new kinds of food. ③ He/she only eats what he/she wants to eat. ④ It is hard to make him/her eat. ⑤ Not applicable	① ② ③ ④ ⑤
7 Does your child watch TV or is exposed to the monitor (computer, game console, smartphone, etc.) for over 2 hours? ① Yes ② No	① ②
8 Does your child perform vigorous physical activities (playing, exercise, etc.) for over 1 hour a day? ① Yes ② No	① ②

※ If you receive a health checkup exceeding the predetermined number, the corresponding cost will be retrieved from you as unjust enrichment.