Infant Health Examination Questionnaire

For 14 ~ 35 Days

Guardian's name		Guardian's resident registration number		Guardian's phone number	
Relationship with the examinee		Name of the examinee		Date of Birth of the examinee	Male ☐ Female ☐
E-mail (mail) address					

The infant health examination is to confirm the normal growth and development of infants and is not to find specific diseases. Do you understand?
Yes □ No □

Do you agree to the examination on the genital organs in the physical examination?
Yes □ No □

1. Child's date of birth: MMDDYYYY
2. Weight at birth: □.□□ kg (up to the first decimal place, but up to the second place for premature babies) Height at birth: □.□□ cm Head circumference: □.□□ cm
3. Was the child born prematurely? ☐ Yes (What is the expected delivery date? MMDDYYYY Or gestational age ____ weeks __ days) ☐ No
4. Was the child born in multiplets? ☐Yes (___ out of ____) ☐ No
5. Number of vaccinations so far (Record on the vaccination helper site)

Number of vaccinations	BCG	Hepatitis B

Nutrition education ☐ Yes ☐ No ☐ N/A

1	Do you breastfeed completely?	①		☐
2	If you breastfeed at night, the amount of breast milk increases due to the rise of lactogenic hormones. Do you breastfeed at night?	①		☐
3	Breast milk should be breastfed whenever the child wants. Do you know in detail the signals (face expressions or gestures) in which the child expresses hunger?	①		☐
4	Do you know that when you have problems with the breast, such as mastitis or breast hyperemia, etc., you have to breastfeed harder to solve the problem?	①	☐	☐
5	When breastfeeding completely, your child may suffer from lack of vitamin D. Is your child consuming vitamin D?	①	☐	☐
6	Do you know that you don't need to disinfect the nipple before breastfeeding?	①	☐	☐
7	It is recommended not to use pacifiers during this period. Do you know this?	①		☐
8	Have you ever stopped breastfeeding because of jaundice?	①		☐
9	Do you know that if a breastfeeding mother intakes excessive nutritional supplements, herbal medicines, or health supplements, it can affect her child?	①	☐	☐

Safety accident prevention education ☐ Yes ☐ No

1	Are you sure to use a car seat that fits the age and weight of your child when moving by car?	①	☐
2	Do you know that you must put your child down on a crib with a railing, etc., before answering a phone call, drinking a cup of coffee, carrying a bag, moving objects, or picking up fallen objects while holding a child?	①	☐
3	Do you know that it's not good to intensely shake your child when you hold and soothe your child ?	①	☐
4	Have you ever put your child to sleep on an electric pad or a hot water mat?	①	☐

Visual related ☐ Yes ☐ No

1	Do you have any abnormal findings in your eyeballs?	①	☐
2	Does anyone in your family have eye-related genetic diseases (retinoblastoma, congenital cataract, congenital glaucoma, etc.)?	①	☐

Hearing related ☐ Yes ☐ No ☐ N/A

1	Does your child wake up, get surprised, or have any reactions such as facial expression changes, etc. when there is a loud noise?	①		☐
2	Did your child take hearing screening (hearing test)? (For premature babies, within 1 month from the expected date of birth)	①		☐
3	Did your child get 'refer' judgment in one or both ears in the newborn hearing screening?	①	☐	☐

Sleep education ☐ Yes ☐ No

1	Do you put your child to sleep on their stomach or on their side?	☐	☐
2	Does your child sleep together in the same bed (bed, pad) with parents?	☐	☐
3	When your child sleeps, do you only cover below the chest with a blanket and not use a swaddle?	☐	☐
4	Do you put a doll or cushion around your child's bed, or put your child to sleep in a bumper bed, a comfortable pad, a car seat, or a boppy newborn lounger?	☐	☐
5	Newborn babies sleep and wake up day and night. Do you know that feeding to your child's sleep rhythm promotes breastfeeding?	☐	☐
6	Do you know that breastfeeding prevents sudden infant death syndrome?	☐	☐
7	Do you take regular actions such as bathing, massage, lullaby, reading, etc. before putting your child to sleep?	☐	☐
8	Are there any smokers in your family or among those who contact your child frequently?	☐	☐

Newborn baby related ☐ Yes ☐ No ☐ Don't know

1	Did your child take the neonatal screening test?	☐	☐	☐
2	Did your child get normal (negative or no abnormality) judgment in the neonatal screening test?	☐	☐	☐
3	Has your child ever been in a postpartum care center after birth?	☐		☐
4	How long were you been in rooming-in (the practice of keeping the baby by the side of the mother's bed in the same room)? ☐ Within 4 hours ☐ During the daytime only ☐ All day ☐ Never			
5	Which color is similar to the color of your child's recent stool? ☐ Green. Dark green ☐ Dark yellow, gold, brown ☐ Lemon color, soybean color, gray, white ☐ N/A			

Hip joint related ☐ Yes ☐ No ☐ Don't know

1	Did 'breech presentation' (a posture where the fetal leg faces down) continue until the end of pregnancy?	☐	☐	☐
2	Did you have 'oligohydramnios (a state of having little amniotic fluid)?'	☐	☐	☐
3	Do you have any family members (parents or siblings) with developmental dysplasia of the hip (a symptom of a problem with the hip joint in infancy)?	☐	☐	☐

Personal hygiene related ☐ Yes ☐ No

1	Do you ever kiss your child's lips directly?	☐	☐
2	Do you always wash your hands after changing a child's diaper?	☐	☐

※ If you receive an examination beyond the specified number of examinations, the cost of the examination will be redeemed as an unfair benefit.

Health checkup questionnaire for infants

For 4–6 months old

Subject name		Resident Reg. No.		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 □

Do you agree to the examination on the genital organs during the physical examination?
Yes □ No □

1. Date of birth of child: _____ year _____ month _____ day
2. Weight at birth: ____.____ kg(round off to the nearest tenth; to the nearest hundredth for premature babies)
3. Was the baby born prematurely? ① Yes(☞Expected date of confinement? _____ Year _____ Month _____ Day or Gestational Age ____ weeks __ days) ② No
4. Number of vaccinations so far (Record on the vaccination helper site)

Number of vaccinations	BCG	Hepatitis B	DPT	Poliomyelitis (polio)	Pneumococcus	Haemophilus B

Nutrition education

① Yes ② No ③ N/A

1	If you are completely breastfeeding, your child may be deficient in iron during weaning. Are you giving your child iron supplements or iron-rich weaning supplements (baby foods)?	①	②	③
2	Did you know that you can continue to breastfeed the child even after 24 months of age in parallel with weaning supplements (baby foods) or child's meal?	①	②	③
3	Did you know that expressed breast milk can be stored for up to 4 hours only at room temperature?	①	②	③
4	Did you know that even if a breastfeeding mother takes painkillers, cold medicines, antibiotics, and other drugs, she does not have to stop breastfeeding unless under special circumstances?	①	②	③
5	How long did you continue perfect breast-feeding (the period of breast-feeding without dry milk or weaning food)? ① less than 1 month ② less than 2 months ③ less than 3 months ④ less than 4 months ⑤ less than 5 months ⑥ less than 6 months			

Sleep training

① Yes ② No

1	Do you place your child on his/her back to sleep?	①	②
2	Do you let your child play on his/her stomach when he/she is awake to prevent flat head and promote development?	①	②
3	Do parents sleep on the same bed (or mattress, etc.) with the baby?	①	②
4	Do you hold or rock your child while breastfeeding or formula feeding him/her, and get him/her to the bed after he/she falls asleep?	①	②
5	Do you take regular actions such as bathing, massage, lullaby, reading, etc. before putting your child to sleep?	①	②
6	When your child wakes up from sleep, do you breastfeed or formula feed him/her to sleep?	①	②

Electronic media exposure training

① Yes ② No

1	※ Experts recommend limiting the exposure of young child to electronic media (e.g., smartphones, TV, tablet PC, etc.) before the age of two. Do you let your child watch electronic media?	①	②
2	Do parents use electronic media while with their child?	①	②
3	When allowing the child to watch electronic media, does his/her guardian also watch it together?	①	②
4	How long is your child exposed to electronic media per day on average? ① None at all ② less than 1 hour ③ less than 2 hours ④ Over 2 hours		

Hip joint-related

① Yes ② No

1	Has your child ever been tested for hip ultrasonography in relation to developmental dysplasia of the hip?	①	②
2	Has your child ever been diagnosed with developmental dysplasia of the hip?	①	②

Accident preventative education

① Yes ② No

1	When moving in a car, do you always use a stepwise car seat?	①	②
2	Have you ever left your baby alone on an adult's bed or a sofa even if for a second?	①	②
3	Did you know that your child can sustain a serious injury while using a walker?	①	②
4	Did you know that it's not good to intensely rock your child while holding and soothing him/her?	①	②
5	Have you ever left your baby sit alone in a basin, bathtub, or restroom even if for a second?	①	②
6	Have you ever consumed a hot drink while holding the baby?	①	②
7	Have you ever put your child to sleep on an electric pad or a hot water mat?	①	②

Vision-related

① Yes ② No

1	Is your baby able to make good eye contact?	①	②
2	Does the position of the pupil of the baby seem strange? (Are the eyes gathering inward or outward even without focusing?)	①	②
3	Are the baby's pupils unclear?	①	②

Auditory sense-related

① Yes ② No ③ N/A

1	Can your child make various sounds (e.g., "ah," "woah," and "yee") or make sounds when laughing?	①		②
2	Has the baby been hospitalized in a newborn intensive care unit (NICU) over 5 days after his or her birth?	①		②
3	Has the child been tested for a hearing screening (hearing test) within one month of his/her birth? (As for premature babies, within one month from the expected date of his/her birth)	①		②
4	Did your child get "refer" judgment in one or both ears in the newborn hearing screening?	①	②	③
5	Has your child been diagnosed to have "hearing impairment" in one or both of his/her ears?	①		②

Personal hygiene-related

① Yes ② No

1	Do you always wash your hands before and after washing your child's eyes, nose and mouth?	①	②

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

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Health checkup questionnaire for infants

For 9–12 months old

Subject name		Resident Reg. No.		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 □

Do you agree to the examination on the genital organs during the physical examination?

Yes □ No □

1. Date of birth of child: ____ year ____ month ____ day
2. Weight at birth: ____.____ kg (round off to the nearest tenth; to the nearest hundredth for premature babies)
3. Was the baby born prematurely? ① Yes(☞Expected date of confinement?____ Year ____ Month ____ Day or Gestational Age ____ weeks __ days) ② No
4. Number of vaccinations so far (Record on the vaccination helper site)

Number of vaccinations	BCG	Hepatitis B	DPT	Poliomyelitis (polio)	Pneumococcus	Haemophilus B

5. Does your baby have a disease due to a development problem and which was diagnosed or treated?
①Yes ② No (If you answer is "yes," what is the specific diagnosis? _____)

Nutrition education

		① Yes	② No
1	Do you feed your child the weaning supplement (baby food) 3 times a day?	①	②
2	Does the weaning supplement (baby food) contain grains, vegetables, fruits, eggs, fish, and meat?	①	②
3	Are you currently breastfeeding your child?	①	②
4	Are there any foods that you particularly avoid or restrict consumption because you are worried about your child's allergies or asthma?	①	②
5	Did you know that from 9 months of age, a child should starting using cups to eat on his/her own?	①	②
6	How long have you been completely breastfeeding your child? (This refers to the period during which your child was fed with only breast milk without any formula or baby food.) If not applicable, please write "0."	( ) months	

Emotion and sociality education

		① Yes	② No
1	Does your baby like to play with new games or toys with his/her mother or fosterer?	①	②
2	Does your child show interest in how other children play?	①	②
3	Is your baby afraid of strange persons but approach them if his/her mother or fosterer is with them?	①	②
4	Does your child feel uneasy without his/her mother or fosterer but feel assured when his/her mother or fosterer comes back?	①	②
5	Does your child laugh readily while playing peekaboo?	①	②
6	Can you soothe your child when he/she is angry?	①	②

Oral health education

		① Yes	② No	③ N/A
1	Do you feed your child (either breast milk or formula) during the night?	①	②	
2	Is your child practicing to drink from a cup, transitioning from bottle?	①	②	③
3	Does your child have any teeth that are suspected to have cavities or that appear strange in color or shape?	①	②	③
4	How many teeth does you child have broken through his/her gums?	( ) teeth		
5	Do you brush your child's teeth at least twice a day?	①	②	③

Accident preventative education

		① Yes	② No
1	Did you know that your child is in danger of choking from playing with small items that may get in his/her mouth, such as peanuts, corn grains, grapes, buttons, and small toys?	①	②
2	Did you know that if your child swallows a magnet or button battery (button cell), it may cause dangerous complications, such as intestinal perforation?	①	②
3	Do you keep your child out of reach of electric products, electric cords, electric outlets, etc. that may cause electric shocks?	①	②
4	Are safety devices such as safety door and locker provided for your child near stairways, windows, and veranda?	①	②
5	Did you place your child's bed away from the window or curtain?	①	②
6	Do you put the handles of kitchen utensils (pots and frying pans, etc.) out of reach of your child on a gas range?	①	②
7	Have you ever left your baby sit alone in a basin, bathtub, or restroom even if for a second?	①	②
8	When moving in a car, do you always use a stepwise car seat?	①	②

Auditory sense-related

		① Yes	② No
1	Has the baby been hospitalized in a newborn intensive care unit (NICU) over 5 days after his or her birth?	①	②
2	Is there any relative or parent who has had hard of hearing (hearing impairment) since childhood?	①	②
3	Has your child been diagnosed to have "hearing impairment" in one or both of his/her ears?	①	②

Vision-related

		① Yes	② No
1	Is your baby able to make good eye contact?	①	②
2	Does the position of the pupil of the baby seem strange? (Are the eyes gathering inward or outward even without focusing?)	①	②
3	Is there any difference (size, color, light reflection) between the eyes (pupils) of your child?	①	②

Personal hygiene-related

		① Yes	② No
1	Did you know that you shouldn't be feeding your child honey before 12 months of age?	①	②
2	Do you always wash your child's hands with water and soap after returning home?	①	②

Health checkup questionnaire for infants

For 18-24 months old

Subject name		Resident Reg. No.		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. Weight at birth: ___.___ kg (round off to the nearest tenth; to the nearest hundredth for premature babies)

3. Was the baby born prematurely? ① Yes(☞Expected date of confinement? _____ Year _____ Month _____ Day or Gestational Age ____ weeks __ days) ② No

4. Number of vaccinations so far (Record on the vaccination helper site)

Number of vaccinations	BCG	Hepatitis B	DPT	Poliomyelitis (polio)	Pneumococcus	Haemophilus B	Measles, mumps, rubella	Chickenpox	Japanese encephalitis

5. Does your baby have a disease due to a development problem and which was diagnosed or treated?①Yes ② No If you answer "yes," (what is the specific diagnosis? _____)

Nutrition education

① Yes ② No

1	Do you think there is a problem with your child's eating habits?	①	②
2	Do you add salt to the food your child eats?	①	②
3	Does the child drink sugary drinks or fruit juice?	①	②
4	Did you know that eating whole grains benefits your health?	①	②
5	Do you offer the child dietary supplements like vitamins, minerals other than meals?	①	②

Toilet training

① Yes ② No

1	Has the urinating term of the baby prolonged than before? (about 2 hours)	①	②
2	Is the child able to put his/her pants down by him/herself?	①	②
3	Is the child able to understand or express words regarding defecation and urination (poop, pee, etc.)?	①	②
4	Does the child show interest in the potty?	①	②
5	Have you ever tried toilet training?	①	②

Personal hygiene training

① Yes ② No

1	Does your child wash his/her hands with soap and water when he/she returns home?	①	②
2	Does your child often touch his/her eyes, nose and mouth with his/her hands?	①	②
3	Do you carry an alcohol-based hand sanitizer in case you won't be able to wash your child's hands with soap and water when you go out?	①	②

Vision-related

① Yes ② No

1	Does your baby have difficulty in making eye contact, or do his/her pupils falter?	①	②
2	Does the baby rotate or tilt his/her head to see forward (objects in front of him/her) with his/her lateral staring?	①	②
3	Does your child read books or materials or watch TV at too close a distance or with his/her eyes squinted?	①	②
4	Does the child's eyes sometimes move towards the center or outward?	①	②

Training on the exposure to electronic media

① Yes ② No

1	Do parents use electronic media (e.g., smartphones, TV, tablet PC, etc.) while with their child?	①	②
2	Do you know what your child watches on electronic media?	①	②
3	The following question is about the rules on the use of electronic media. Are there any rules about where your child is allowed to use electronic media?	①	②
4	Are there any rules about the days of the week on which your child is allowed to use electronic media?	①	②
5	Are there any rules about the hours during which your child is allowed to use electronic media?	①	②
6	How long is your child exposed to electronic media per day on average? ① None at all ② less than 1 hour ③ less than 2 hours ④ Over 2 hours		

Accident preventative education

① Yes ② No

1	Do you keep drugs, chemical agents (bleach, detergent, etc.), and sharp objects out of reach of children?	①	②
2	Did you put the baby's bed away from the window or curtains?	①	②
3	Are safety devices such as safety door and locker provided for your child near stairways, windows, and veranda?	①	②
4	Do you change the direction of the handle of kitchen utensils on the stove so that it is out of your baby's reach?	①	②
5	Do you keep your child out of reach of electric products, electric cords, electric outlets, etc. that may cause electric shocks?	①	②
6	Have you ever left your child alone in the bathroom or toilet even for a short time?	①	②
7	When moving in a car, do you always use a stepwise car seat?	①	②
8	Have you ever left your child alone in a car?	①	②

Auditory sense-related

① Yes ② No

1	Has the baby been hospitalized in a newborn intensive care unit (NICU) over 5 days after his or her birth?	①	②
2	Is there any relative or parent who has had hard of hearing (hearing impairment) since childhood?	①	②
3	Has the child infected with acute otitis media several times? (more than 4 times in 6 months, more than 6 times in 1 year)	①	②
4	Has your child been diagnosed to have "hearing impairment" in one or both of his/her ears?	①	②
5	Does the child wear hearing aids or cochlear implant in one or both of his/her ears?	①	②

Infant/Toddler Dental Health Screening Program (18–29 months old)

Name of health examinee		Resident registration number	-	Contact information of guardian	
Name of guardian		Relationship to the health examinee		E-mail	

The Infant/Toddler Dental Health Screening Program offers appropriate phased dental examinations for infants and toddlers at 2 years old (18–29 months), 3 years old (30–41 months), 4 years old (42–53 months), and 5 years (54–65 months). This survey is to evaluate the child's condition prior to an oral examination and to provide information through a consultation with a dentist.
All information provided are confidential and, therefore, please answer all questions with honesty and to the best of your knowledge. Parents or legal guardians should answer this questionnaire. If you are unsure, please carefully observe your child before answering.

(Dental) Medical history and symptoms

1. Have you taken your child to a dentist or dental clinic to treat or prevent oral diseases since the child was born?

① Yes ② No

2. Has your child told you about his/her toothache?

① Yes ② No

3. Do you think your child currently has cavity?

① Yes ② No ③ I do not know

4. Does the child's parents or siblings currently have cavities?

① Yes ② No ③ I do not know

5. **Is your child currently being treated for any illnesses (excluding dental diseases) or taking any medications?**

① Yes ② No

Dietary habit

6. Is the child currently eating solid food?

① Yes ② No

7. In a day, how often does your child consume sweet snacks such as cookies, candies, cakes, etc. or snacks that stick to the teeth?

① Never
② Once
③ twice
④ 3 time
⑤ More than 4 times

8. In a day, how often does the child drink fruit juices or beverages with added sugar (beverages for children, Yakult, etc.)?

① Never
② Once
③ twice
④ 3 time
⑤ More than 4 times

Dental hygiene management

9. Does the guardian regularly brush the child's teeth?

① Yes ② No

10. How often does the guardian brush the child's teeth?

① Less than once a week
② At least once a week but not every day
③ Once a day
④ Twice a day
⑤ More than 3 times a day

Fluorine use

11. Does your child's toothpaste contain fluoride?

① Yes
② No
③ I do not know
④ He or she does not use toothpaste

12. How much toothpaste is used in every brush?

① Very little (the size of a rice grain)
② The size of a small pea
③ Half the length of the toothbrush head
④ As long as the head of a toothbrush
⑤ He or she does not use toothpaste

13. Are you giving fluorine regularly to your child?

① Yes ② No

Please write any questions or specific information concerning your child's condition that needs extra attention by the doctor, if any.

Health checkup questionnaire for infants

For 30-36 months old

Subject name		Resident Reg. No.		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. Weight at birth: ___.___ kg (round off to the nearest tenth; to the nearest hundredth for premature babies)

3. Was the baby born prematurely? ① Yes(☞Expected date of confinement? _____ Year _____ Month _____ Day or Gestational Age ____ weeks __ days) ② No

4. Number of vaccinations so far (Record on the vaccination helper site)

Number of vaccinations	BCG	Hepatitis B	DPT	Poliomyelitis (polio)	Pneumococcus	Haemophilus B	Measles, mumps, rubella	Chickenpox	Japanese encephalitis

5. Does your baby have a disease due to a development problem and which was diagnosed or treated?①Yes ② No (If you answer is "yes," what is the specific diagnosis? _____)

Nutrition education

① Yes ② No

1	Do you think there is a problem with your child's eating habits?	①	②
2	Does your child eat three times a day?	①	②
3	Did you know that eating whole grains benefits your health?	①	②
4	Does your child eat with other family members every day?	①	②
5	Does the child eat a lot of sweet food?	①	②
6	For how many months did you breastfeed your child after his/her birth even in small quantities? If you did not breastfeed your child, please write "0." ( ) months		

Toilet training

① Yes ② No

1	Can your child control his/her bowel and bladder?	①	②
2	Is your child potty-trained?	①	②
3	Does your child poop regularly without difficulty?	①	②
4	Is your child afraid of wetting or pooping in his/her pants by accident?	①	②

Emotion and sociality education

① Yes ② No

1	Does your child show interest in his/her surroundings (people, toys, food, etc.)?	①	②
2	Does your child play around other children?	①	②
3	Does your child copy the behavior of adults or other children?	①	②
4	Can your child be apart from his/her mother or fosterer for a while?	①	②
5	Does your child express his/her feelings with words or gestures?	①	②
6	Can your child calm him/herself down even when he/she is angry?	①	②

Personal hygiene-related

① Yes ② No

1	Does your child always wash his/her hands with water and soap after peeing or pooping?	①	②

Preschool preparatory education (Nuri course)

① Yes ② No

1	Can your child run and jump?	①	②
2	Does your child eat and sleep regularly?	①	②
3	Can your child apprehend and understand short, fun stories told by others?	①	②
4	Can your child speak while looking at the listener?	①	②
5	Does your child show interest in his/her friends' play?	①	②
6	(Following simple rules) Can your child wait for his/her turn?	①	②
7	Can your child count to three with his/her fingers (pointing to an object or counting on his/her fingers)?	①	②
8	When did your child start going to a daycare center or kindergarten? (Applicable only to children attending kindergartens or daycare centers) ① ( ) months ② N/A		

Auditory sense-related

① Yes ② No

1	Has the baby been hospitalized in a newborn intensive care unit (NICU) over 5 days after his or her birth?	①	②
2	Is there any relative or parent who has had hard of hearing (hearing impairment) since childhood?	①	②
3	Has the child infected with acute otitis media several times? (more than 4 times in 6 months, more than 6 times in 1 year)	①	②
4	Has your child been diagnosed to have "hearing impairment" in one or both of his/her ears?	①	②
5	Does the child wear hearing aids or cochlear implant in one or both of his/her ears?	①	②

Vision-related

① Yes ② No

1	Does the baby turn his/her head and turn sideways to see the objects in front of him/her or does he/she look with his/her head tilted?	①	②
2	Does your baby read a book / watch TV / see things at a very close distance or frown to see?	①	②
3	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 each eye?	①	②

Infant/Toddler Dental Health Screening Program (30–41 months old)

Name of health examinee		Resident registration number	-	Contact information of guardian	
Name of guardian		Relationship to the health examinee		E-mail	

The Infant/Toddler Dental Health Screening Program offers appropriate phased dental examinations for infants and toddlers at 2 years old (18–29 months), 3 years old (30–41 months), 4 years old (42–53 months), and 5 years old (54–65 months). This survey is to evaluate the child's condition prior to an oral examination and to provide information through a consultation with a dentist.
All information provided are confidential and, therefore, please answer all questions with honesty and to the best of your knowledge. Parents or legal guardians should answer this questionnaire. If you are unsure, please carefully observe your child before answering.

(Dental) Medical history and symptoms

1. Have you taken your child to a dentist or dental clinic to treat or prevent oral diseases since the child was born?

① Yes ② No

2. Has your child told you about his/her toothache?

① Yes ② No

3. Do you think your child currently has cavity?

① Yes ② No ③ I do not know

4. Does the child's parents or siblings currently have cavities?

① Yes ② No ③ I do not know

5. **Is your child currently being treated for any illnesses (excluding dental diseases) or taking any medications?**

① Yes ② No

Dental hygiene management

8. Does the guardian regularly brush the child's teeth?

① Yes ② No

9. Please mark all times when the guardian brushed the child's teeth or the child brushed his/her own teeth yesterday.

① Before breakfast
② After breakfast
③ After lunch
④ After dinner
⑤ Before sleeping

Dietary habit

6. In a day, how often does your child consume sweet snacks such as cookies, candies, cakes, etc. or snacks that stick to the teeth?

① Never
② Once
③ Twice
④ 3 time
⑤ More than 4 times

7. In a day, How often does the child drink fruit juices or beverages with added sugar (beverages for children, Yakult, etc.)?

① Never
② Once
③ Twice
④ 3 time
⑤ More than 4 times

Fluorine use

10. Does your child's toothpaste contain fluoride?

① Yes ② No
③ I do not know ④ He or she does not use toothpaste

11. How much toothpaste is used in every brush?

① Very little (the size of a rice grain)
② The size of a small pea
③ Half the length of the toothbrush head
④ As long as the head of a toothbrush
⑤ He or she does not use toothpaste

12. Have you been advised to use fluorine to prevent your child from getting cavities?

① Yes ② No

13. Are you giving fluorine regularly to your child?

① Yes ② No

Please write any questions or specific information concerning your child's condition that needs extra attention by the doctor, if any.

Health checkup questionnaire for infants

For 42-48 months old

Subject name		Resident Reg. No.		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. Weight at birth: ____.____ kg (round off to the nearest tenth; to the nearest hundredth for premature babies)

3. Was the baby born prematurely? ① Yes(☞Expected date of confinement? ____ Year ____ Month ____ Day or Gestational Age ____ weeks __ days) ② No

4. Number of vaccinations so far (Record on the vaccination helper site)

Number of vaccinations	BCG	Hepatitis B	DPT	Poliomyelitis (polio)	Pneumococcus	Haemophilus B	Measles, mumps, rubella	Chickenpox	Japanese encephalitis

5. Does your baby have a disease due to a development problem and which was diagnosed or treated?①Yes ② No (If you answer is "yes," what is the specific diagnosis? ____)

Accident preventative education

① Yes ② No

1	Are safety devices such as safety door and locker provided for your child near stairways, windows, and veranda?	①	②
2	Have you ever left your baby sitting alone in a pool or bathtub?	①	②
3	Do you keep candless, 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, scooter etc.?	①	②
5	Does your child play on the road where cars are passing by?	①	②
6	When moving in a car, do you always use a stepwise car seat or an auxiliary chair?	①	②

Auditory sense-related

① Yes ② No ③ N/A

1	Has the baby been hospitalized in a newborn intensive care unit (NICU) over 5 days after his or her birth?	①	②	
2	Is there any relative or parent who has had hard of hearing (hearing impairment) since childhood?	①	②	
3	Has your child been diagnosed to have "hearing impairment" in one or both of his/her ears?	①	②	
4	Has the child infected with acute otitis media several times? (more than 4 times in 6 months, more than 6 times in 1 year)	①	②	
5	Has your child received whisper test?	①	②	
6	Did your child correctly point to all the pictures during the whisper test?	①	②	③

Nutrition education

① Yes ② No

1	Does your child eat three times a day?	①	②
2	Does your child drink two glasses of raw milk (500 mL) a day?	①	②
3	Do you know that intake of whole grains is helpful for health?	①	②
4	Does your child avoid consuming sugary drinks (carbonated drinks, sports drinks, children's drinks, etc.) or fruit juices?	①	②
5	Do you tend to add little salt to the food your child eats?	①	②

Sleep-related

① Yes ② No

1	At what time does your child fall asleep at night? ① Before 9 pm ② Before 9 pm–10 pm ③ Before 10 pm–11 pm ④ Before 11 pm–12 am ⑤ After 12 am		
2	Does your child snore more than 3 days a week?	①	②
3	How many hours does your child sleep on average a day? ① Nap: ( ) hours ( ) minutes ② Night sleep: ( ) hours ( ) minutes		
4	Is there any problem with your child's sleep?	①	②

Vision-related

① Yes ② No

1	Does the baby turn his/her head and turn sideways to see the objects in front of him/her or does he/she look with his/her head tilted?	①	②
2	Does your baby read a book / watch TV / see things at a very close distance or frown to see?	①	②
3	Does the child's eyes sometimes move towards the center or outward?	①	②

Infant/Toddler Dental Health Screening Program
(42–53 months old)

Name of health examinee		Resident registration number	-	Contact information of guardian	
Name of guardian		Relationship to the health examinee		E-mail	

The Infant/Toddler Dental Health Screening Program offers appropriate phased dental examinations for infants and toddlers at 2 years (18–29 months), 3 years old (30–41 months), 4 years old (42–53 months), and 5 years old (54–65 months). This survey is to evaluate the child's condition prior to an oral examination and provide information through a consultation with a dentist.
All information provided are confidential and, therefore, please answer all questions with honesty and to the best of your knowledge. Parents or legal guardians should answer this questionnaire. If you are unsure, please carefully observe your child before answering.

(Dental) Medical history and symptoms

1. Have you taken your child to a dentist or dental clinic with the purpose of dental treatment or management in the past year?

① Yes ② No

2. Has your child told you about his/her toothache?

① Yes ② No

3. Do you think your child currently has cavity?

① Yes ② No ③ I do not know

4. Does the child's parents or siblings currently have cavities?

① Yes ② No ③ I do not know

5. **Is your child currently being treated for any illnesses (excluding dental diseases) or taking any medications?**

① Yes ② No

Dietary habit

6. In a day, how often does your child consume sweet snacks such as cookies, candies, cakes, etc. or snacks that stick to the teeth?

① Never
② Once
③ Twice
④ 3 time
⑤ More than 4 times

7. In a day, how often does the child drink fruit juices or beverages with added sugar (beverages for children, Yakult, etc.)?

① Never
② Once
③ Twice
④ 3 time
⑤ More than 4 times

Dental hygiene management

8. Does the guardian regularly brush the child's teeth?

① Yes ② No

9. Please mark all times when you brushed the child's teeth or the child brushed his/her own teeth yesterday.

① Before breakfast
② After breakfast
③ After lunch
④ After dinner
⑤ Before sleeping

Fluorine use

10. Does your child's toothpaste contain fluoride?

① Yes ② No
③ I do not know ④ He or she does not use toothpaste

11. How much toothpaste is used in every brush?

① Very little (the size of a rice grain)
② The size of a small pea
③ Half the length of the toothbrush head
④ As long as the head of a toothbrush
⑤ He or she does not use toothpaste

12. Have you been advised to use fluorine to prevent your child from getting cavities?

① Yes ② No

13. Are you giving fluorine regularly to your child?

① Yes ② No

Please write any questions or specific information concerning your child's condition that needs extra attention by the doctor, if any.

Health checkup questionnaire for infants

For 54-60 months old

Subject name		Resident Reg. No.		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. Weight at birth: ___.___ kg (round off to the nearest tenth; to the nearest hundredth for premature babies)
3. Was the baby born prematurely? ① Yes(☞Expected date of confinement? ____ Year ____ Month ____ Day or Gestational Age ____ weeks __ days) ② No
4. Number of vaccinations so far (Record on the vaccination helper site)

Number of vaccinations	BCG	Hepatitis B	DPT	Poliomyelitis (polio)	Pneumococcus	Haemophilus B	Measles, mumps, rubella	Chickenpox	Japanese encephalitis

5. Does your baby have a disease due to a development problem and which was diagnosed or treated?
①Yes ② No (If you answer is "yes," what is the specific diagnosis? _____)

Accident preventative education

① Yes ② No

1	Does the child always wear a helmet and joint protection equipment when riding a bicycle, wearing inline skates, etc.?	①	②
2	Does your child play on the road where cars are passing by?	①	②
3	When moving in a car, do you always use a stepwise car seat or an auxiliary chair?	①	②
4	Does your child know the rules that he/she must follow when playing in the water?	①	②
5	Do you keep candless, lighters, electronic appliances, and electrical cords out of reach of children?	①	②
6	Do you store medicines, chemicals (bleaches, detergents, polishes, etc.) or sharp objects in a locked place beyond the reach of your child?	①	②

Vision-related

① Yes ② No

1	Does your child's eyes sometimes look glazed or out of focus?	①	②

Electronic media exposure training

① Yes ② No

1	Do you know what your child watches on electronic media (smartphones, TV, tablet PC, etc.)?	①	②
2	Are there any rules on the use of electronic media?	①	②
3	Does your child follow the rules on the use of electronic media?	①	②
4	How long is your child exposed to electronic media per day on average? ① None at all ② less than 1 hour ③ less than 2 hours ④ Over 2 hours		

Nutrition education

① Yes ② No

1	Does your child have a healthy diet?	①	②
2	Does your child prefer and often drink beverages and fruit juices instead of water?	①	②
3	Does your child eat dairy products (milk, plain yogurt, cheese, etc.) every day?	①	②
4	Does you child drink low-fat milk instead of whole milk?	①	②
5	Does your child eat a variety of mixed grains, vegetables, and fruits every day?	①	②
6	Does your child take sweet, salty, and fatty instant foods or fast foods frequently for refreshments or when eating outdoors? (For example, cookies, ice cream, hamburger, chicken, pizza, etc.)	①	②
7	Does your child spend more than 2 hours a day watching or playing TV, videos, smartphone, and games?	①	②
8	Does your child romp around or exercise enough to be out of breath or sweat for at least one hour a day?	①	②

Auditory sense-related

① Yes ② No

1	Has the baby been hospitalized in a newborn intensive care unit (NICU) over 5 days after his or her birth?	①	②
2	Is there any relative or parent who has had hard of hearing (hearing impairment) since childhood?	①	②
3	Do you have any concerns about your child's listening and speaking skills?	①	②
4	Did your child receive a hearing test (pure tone audiometry) to lead a smooth elementary school life?	①	②
5	Has your child been diagnosed to have "hearing impairment" in one or both of his/her ears?	①	②
6	Does the child wear hearing aids or cochlear implant in one or both of his/her ears?	①	②

Infant/Toddler Dental Health Screening Program
(54–65 months old)

Name of health examinee		Resident registration number	-	Contact information of guardian	
Name of guardian		Relationship to the health examinee		E-mail	

The Infant/Toddler Dental Health Screening Program offers appropriate phased dental examinations for infants and toddlers at 2 years (18–29 months), 3 years old (30–41 months), 4 years old (42–53 months), and 5 years old (54–65 months). This survey is to evaluate the child's condition prior to an oral examination and provide information through a consultation with a dentist.
All information provided are confidential and, therefore, please answer all questions with honesty and to the best of your knowledge. Parents or legal guardians should answer this questionnaire. If you are unsure, please carefully observe your child before answering.

(Dental) Medical history and symptoms

1. Have you taken your child to a dentist or dental clinic with the purpose of dental treatment or management in the past year?

① Yes ② No

2. Has your child told you about his/her toothache?

① Yes ② No

3. Do you think your child currently has cavity?

① Yes ② No ③ I do not know

4. Does the child's parents or siblings currently have cavities?

① Yes ② No ③ I do not know

5. **Is your child currently being treated for any illnesses (excluding dental diseases) or taking any medications?**

① Yes ② No

Dietary habit

6. In a day, how often does your child consume sweet snacks such as cookies, candies, cakes, etc. or snacks that stick to the teeth?

① Never
② Once
③ Twice
④ 3 time
⑤ More than 4 times

7. In a day, how often does the child drink fruit juices or beverages with added sugar (beverages for children, Yakult, etc.)?

① Never
② Once
③ Twice
④ 3 time
⑤ More than 4 times

Dental hygiene management

8. Does the guardian regularly brush the child's teeth?

① Yes ② No

9. Please mark all times when the child brushed his/her own teeth yesterday.

① Before breakfast
② After breakfast
③ After lunch
④ After dinner
⑤ Before sleeping

Fluorine use

10. Does your child's toothpaste contain fluoride?

① Yes ② No

③ I do not know ④ He or she does not use toothpaste

11. How much toothpaste is used in every brush?

① Very little (the size of a rice grain)
② The size of a small pea
③ Half the length of the toothbrush head
④ As long as the head of a toothbrush
⑤ He or she does not use toothpaste

12. Have you been advised to use fluorine to prevent your child from getting cavities?

① Yes ② No

13. Are you giving fluorine regularly to your child?

① Yes ② No

Please write any questions or specific information concerning your child's condition that needs extra attention by the doctor, if any.

Health checkup questionnaire for infants

For 66-71 months old

Subject name		Resident Reg. No.		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. Weight at birth: ____.____ kg (round off to the nearest tenth; to the nearest hundredth for premature babies)

3. Was the baby born prematurely? ① Yes(☞Expected date of confinement? _____ Year _____ Month _____ Day or Gestational Age ____ weeks __ days) ② No

4. Number of vaccinations so far (Record on the vaccination helper site)

Number of vaccinations	BCG	Hepatitis B	DPT	Poliomyelitis (polio)	Pneumococcus	Haemophilus B	Measles, mumps, rubella	Chickenpox	Japanese encephalitis

5. Does your baby have a disease due to a development problem and which was diagnosed or treated?①Yes ② No If you answer "yes," (what is the specific diagnosis? _____)

Accident preventative education

① Yes ② No

1	Does the child always wear a helmet and joint protection equipment when riding a bicycle, wearing inline skates, etc.?	①	②
2	Has the child ever crossed the road alone?	①	②
3	When moving in a car, do you always use a stepwise car seat or an auxiliary chair?	①	②
4	Does the child know the phone number to report to in case of fire?	①	②
5	Do you allow the child to play in a playground alone for you to perform other activities?	①	②

Nutrition education

① Yes ② No

1	Does your child have a healthy diet?	①	②
2	Does your child eat breakfast every day?	①	②
3	Does your child prefer and often drink beverages and fruit juices instead of water?	①	②
4	Does your child eat dairy products (milk, plain yogurt, cheese, etc.) every day?	①	②
5	Does you child drink low-fat milk instead of whole milk?	①	②
6	Does your child eat a variety of mixed grains, vegetables, and fruits every day?	①	②
7	Does your child often eat sweet, salty, and greasy instant food or fast food for snacks or eating out? (e.g., snacks, ice cream, hamburgers, fried chicken, pizza, etc.)	①	②
8	Does your child spend more than 2 hours a day watching or playing TV, videos, smartphone, and games for any purpose other than learning?	①	②
9	Does your child romp around or exercise enough to be out of breath or sweat for at least one hour a day?	①	②

Personal hygiene-related

① Yes ② No

1	Did your child receive all routine vaccinations required by the age of 6?	①	②
2	What does your child cover his/her mouth with when he/she coughs or sneezes? ① Hands ② Lower arm	①	②
3	Do you always teach your child to wash his/her hands after he/she blows his/her nose or coughs or sneezes into his/her hands?	①	②

Preschool readiness education

① Yes ② No

1	Can your child sit in one place during the class at the daycare center or kindergarten?	①	②
2	Does your child keep the fixed bedtime and wake up schedule?	①	②
3	Does the child play along with other kids well? (e.g.: Is the child able to make compromises when playing with his/her friends?)	①	②
4	Does your child follow the instructions of the adult and observe the rule established by his/her parents, fosterer, or teacher?	①	②
5	Can your child speak what he/she desires to say clearly and logically?	①	②
6	Is the child able to ask for help from other people when necessary?	①	②
7	Can your child count to 20 and add one digits with his/her fingers?	①	②
8	Can your child wipe him/herself after peeing or pooping?	①	②
9	Do you think your child lacks concentration or is less attentive?	①	②

Auditory sense-related

① Yes ② No

1	Has your child been admitted to the intensive care unit for more than 5 days since birth?	①	②
2	Is there any relative or parent who has had hard of hearing (hearing impairment) since childhood?	①	②
3	Do you have any concerns about your child's listening and speaking skills?	①	②
4	Did your child receive a hearing test (pure tone audiometry) to lead a smooth elementary school life?	①	②
5	Has your child been diagnosed to have "hearing impairment" in one or both of his/her ears?	①	②
6	Does the child wear hearing aids or cochlear implant in one or both of his/her ears?	①	②

Vision-related

① Yes ② No ③ N/A

1	As a result of the child health examination, have you ever visited an ophthalmologist with a recommendation of ophthalmologic diagnosis?	①	②	③