Questionnaire For Pregnancy Registration

*Please fill in the bold frame

Name /よみかた		Date of Birth	
		Year /Month /Day (years old)	
Name of Family members living together	relation ship	Date of Birth /y/o	Work / School attendance (If there are no objections…)
		(y/o)	
		(y/o)	
		(y/o)	
		(y/o)	
		(y/o)	
		(y/o)	

The name and date of birth of your spouse/partner who doesn't live with you		
Name	Date of Birth /y/o	Work / School attendance

※包括記入欄 ※Please don't fill in the form below.

面接内容

母子健康手帳交付番号(　　)

面接者サイン：□基幹　□佐野中　□三中　□長南中　□日根中　サイン（　　）

来所者：本人・夫（パートナー）他（　　）

※1 多胎（別に配布数）：□母子健康手帳(　　)冊□双胎セット□新生児聴覚(　　)枚　□１か月児健康診査(　　)枚

※2 転出予定時説明事項：　□母子健康手帳は転出後も使用可　□受診券は転出日から使用不可□タクシー券は使用不可

※3 償還払い制度説明事項：(□妊婦健診　□妊産婦歯科健診　□産婦健診　□１か月児健診・新生児聴覚　□予防接種)

※チラシ：□たばこ □就労　□ファミサポ　□助産制度　□その他(　　)

※妊婦健康診査等受診券手渡し：□済　　妊産婦タクシー券交付申請書記入：□済

※妊婦支援給付金申請書手渡し：□済（□本人　□代理人（続柄：　　））

We would like to support your safe and secure pregnancy and childbirth. Please tell us about yourself by filling in the questionnaire below. According to The Pregnancy Registration Form, we may contact you if necessary. Thank you for your understanding. 記入者（□本人 □代理人続柄（ ））

1. Are you planning to move to another city while you are pregnant?
□No □Yes To（ ） When（ ）.

2. Where are you going to live after childbirth and discharge?
□Your house □Your parent's house □Not yet determined

3. Are you married?
□Registered Marriage □We will register Marriage.(When;) □We will not register Marriage.

4. How did you feel when you found out that you were pregnant?
□Happy □Unexpected but happy □Unexpected and confused □Felt trouble

5. Which picture describes your feeling best now? 

6. Do you adore the baby in your belly? □Yes □No

7. Has the course of pregnancy been well so far?
□Yes
□No⇒□Morning sickness □Threatened miscarriage □Preeclampsia □Gestational diabetes
□Anemia □Other（ ）

8. Are there any diseases that you have currently under the treatment?
□No
□Yes⇒□High blood pressure □Diabetes □Heart disease □Kidney disease □Tuberculosis
□Other( )⇒When did you start treatment?（ ）
The name of hospital( ) Treatment content( )

9. Have you ever seen the doctor for any mental condition?
□No
□Yes⇒□I have done before. When?（ ）
⇒□Currently being treated. When did you start treatment?（ ）
The name of hospital( ) Treatment content( )

10. Do you have any worries and/or any specific consultation requests?
□No
□Yes⇒□About your health condition □Course of pregnancy □About baby in your body
□About delivery □Life after giving birth □Child care for elder child(ren) □Work
□About the relationship with your partner □The family budget □Other( )

11. Did you feel the affection of your parents/ guardians while growing up?
□Yes □A little □Somehow □Not at all

12. Do you have persons who can help you during the pregnancy and/or the delivery?
□Yes⇒□Husband/Partner □Mother □Father □Mother in law □Father in law
□Siblings□Friends □Other( ) (Residence;)
□No

13. Do you smoke?
□No □Stopped since found out being pregnant □Reduced the amount（From cigarettes to cigarettes） □No change before being pregnant(cigarettes/day) □Hoping to stop

14. Does anyone living with you smoke?
□No □Stopped since found out after you became pregnant □Still smokes but limiting because of your pregnancy□No change and smokes like before you became pregnant

15. Do you consume alcohol?
□No □Stopped since found out being pregnant □Drinks sometimes
□Drinks everyday Kind(ML/Day)

16. Are there any social services which you have been taking/holding now?
□None □Welfare □Health Benefits Recordbook for Mentally Ill（ ）
□Physical Disability Recordbook( ) □Special Education Recordbook（ ）
□Financial Aid for Medical Treatment Aimed at Improving Independence