

## Pregnancy Notification Form

【様式第 1 号】

No. \_\_\_\_\_ ( \_\_\_\_\_ : \_\_\_\_\_ ~ \_\_\_\_\_ : \_\_\_\_\_ )

<b>Furigana</b>			<b>Date of Birth</b>	Year	Month	Date
<b>Name (Expecting Mother)</b>				Age( _____ )		
<b>Home Address</b>	Postal Code ( _____ )		<b>My Number</b>			
	Phone Number (Home) (Mobile)			<b>Occupation</b>		
<b>Pregnancy Period</b>	weeks( _____ ) months)	<b>Expected Delivery Date</b>	Year	Month	Date	child (1 <sup>st</sup> , 2 <sup>nd</sup> child etc.)
<b>Name of hospital and midwifery (doctor or midwife) that diagnosed the pregnancy and provided the health guidance</b>						
<b>Medical Examination</b>	STD Test		received ( _____ Year _____ Month ) • not received			
	Tuberculosis Test		received ( _____ Year _____ Month ) • not received			

All the information provided above is accurate, current and true to the best of my knowledge.

Year \_\_\_\_\_ Month \_\_\_\_\_ Date \_\_\_\_\_

市(町村)長殿

Name of Applicant: \_\_\_\_\_

(Relationship to expecting mother: \_\_\_\_\_ )

<b>Type of Insurance</b>	National Health Insurance (国保) / Social Insurance (社保) / Mutual Aid Association Insurance (共済) / Seamen's Insurance (船員) / Others( _____ ) / None
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**※If you could not submit the form in person for unavoidable reasons, please appoint a proxy.**

### Proxy Form (to be filled in by expecting mother)

I hereby appoint the following person to act as my proxy to undertake on my behalf all proceedings for submitting the Pregnancy Notification Form, collecting the Mother and Child Health Handbook and handling My Number information. \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Day

Applicant \_\_\_\_\_ Address \_\_\_\_\_  
(Expecting mother) Name \_\_\_\_\_

(印)

Proxy \_\_\_\_\_ Address \_\_\_\_\_  
Name \_\_\_\_\_

Regarding the use of contact information: Municipalities carry out various mother and child health services to support healthy pregnancy, childbirth and childcare. Your contact information may be used in necessary situation in the future for mother and child health related matters, such as expecting mother medical checkup, Hello Baby Program, infant health examination etc.

※For Counter Staff Completion (発行窓口記入欄)

<b>※発行窓口記入欄</b>			
○届出者(本人)	①個人番号確認	【個人番号カード・通知カード・その他( _____ )】	
	②本人確認書類	1点で可【個人番号カード・運転免許証・パスポート】 2点以上【保険証・年金手帳・その他( _____ )】	
○届出者(代理人)	①委任状【有・無】	②代理人の身元確認【個人番号カード・運転免許証・パスポート・その他( _____ )】	
		③本人個人番号確認【個人番号カード・通知カード・その他( _____ )】	

**We provide support for babies and mothers. Please answer the following questionnaire.**

※This information will not be used for purposes other than mother and child health services.

Choice of Hospital for Delivery	Do you have plans to go back to your hometown?
	a No → Supporter : Yes ( ) / No b Yes → Prefecture / Country: ( ) When: ( ) Place: Parents' House / Others ( )
<b>1 How is your pregnancy so far?</b> a. Going well b. Not going well (Details: )	
<b>2 How did you feel when you found out about this pregnancy?</b> a Happy b Confused but happy c Surprised and confused d Not happy	<b>10 Have you experienced insomnia, feeling irritated, crying easily or a lack of motivation for more than 2 weeks in the past year?</b> a No b Yes ( )
<b>3 Do you have any of the following concerns or problems?</b> a. No b. Yes { <input type="checkbox"/> Your health → physical /mental /Others( ) <input type="checkbox"/> Your baby ( ) <input type="checkbox"/> Elder child(ren) → Child rearing / Health / Others( ) <input type="checkbox"/> Family → Relationship with your husband/partner, family member illness, domestic violence, others( ) <input type="checkbox"/> Financial (delivery expenses / medical expenses/ daily expenses) <input type="checkbox"/> Work / Household ( ) <input type="checkbox"/> Others:( )	<b>11 Have you ever consulted a counselor or a psychiatrist etc., about psychological and mental matters before?</b> a No { <input type="checkbox"/> Ongoing ( medication / counselling ) <input type="checkbox"/> Used to ( medication / counselling ) When ( ) <input type="checkbox"/> Others ( )
<b>4 Do you (expecting mother) smoke?</b> a. No b. Stopped after pregnant c. Yes( sticks per day)	<b>12 Do you have for any other health problems other than Q11?</b> a No b Yes ( High-blood pressure / Diabetes / Heart disease / Thyroid / Kidney related problems / Others: ) <input type="checkbox"/> undergoing treatment
<b>5 Do you drink alcohol?</b> a No b Stopped after pregnant c Yes( times per week)	<b>13 Do you have someone to confide in or consult with if you have problems ?</b> a Yes → Who (Husband / Partner / Parent / Sibling / Friend / In-law / Medical b No Institution / Government Body / Others: )
<b>6 Have you ever underwent infertility treatment?</b> a No b Yes (Is this pregnancy the result of infertility treatment? → Yes / No )	<b>14 Regarding you partner</b> <input type="checkbox"/> married <input type="checkbox"/> not married <input type="checkbox"/> planning to get married( Year Month ) Name: Occupation: Date of Birth: Year Month Day (Age ) Contact Number:
<b>7 Have you ever given birth early (&lt;37 weeks) or to a low birth weight child (&lt;2,500g) before?</b> a No b Yes ( Year Month / Weeks g )	<b>15 Please circle the family member(s) living with you</b> Husband / Partner / Children( pax) / Father / Mother / Father-in-law / Mother-in-law Others( )
<b>8 Have you ever had a miscarriage or stillbirth before?</b> a No b Yes <input type="checkbox"/> miscarriage( times ) <input type="checkbox"/> stillbirth( times ) <input type="checkbox"/> abortion( times ) <input type="checkbox"/> losing a babay within a year of birth	<b>16 Does anyone you are living with smoke?</b> a No b Yes Who( )( sticks per day)
<b>9 Was your previous preganancy and delivery experience smooth?(For 2nd time mothers)</b> a Yes { Pregnancy and labor complications (hypertension / diabetes / C-section / intrauterine growth restriction / placenta praevia / anemia / others: ) b No	<b>17 This questionnaire may be communicated to relevant government bodies, doctors etc. when deemed necessary.</b> a Agree b Disagree

《For Hospital Completion》

《医療機関記入欄》 連携の必要性 <input type="checkbox"/> なし <input type="checkbox"/> あり(具体的に記載してください)	
《行政記入欄・備考》 来所者:妊婦本人・他( )	《本人へ伝えたこと》
《今後の担当》 <input type="checkbox"/> 地区担当保健師 <input type="checkbox"/> 母子保健コーディネーター <input type="checkbox"/> その他: 受付者( )	