【宮崎県標準様式 2020】

【様式第１号】

Pregnancy Notification Form

No. －　　（　　：　　～　　：　　）

Furigana		Date of Birth	Year Month Date Age（　　）
Name (Expecting Mother)			
Home Address	Postal Code（　　－　　） Phone Number (Home) (Mobile)	My Number	
		Occupation	

Pregnancy Period	weeks（　months）	Expected Delivery Date	Year Month Date	child (1st, 2nd child etc.)
Name of hospital and midwifery (doctor or midwife) that diagnosed the pregnancy and provided the health guidance				
Medical Examination	STD Test	Year Month received （　　）・ not received		
	Tuberculosis Test	Year Month received （　　）・ 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:　　)

Type of Insurance	National Health Insurance (国保) / Social Insurance (社保) / Mutual Aid Association Insurance (共済) / Seamen's Insurance (船員) / Others（　　） / None

※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 (Expecting mother)　Address
Name　㊞

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）

※発行窓口記入欄

○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 infomation will not be used for purposes other than mother and child health services.

Choice of Hospital for Delivery

1 How is your pregnancy so far?

a. Going well b. Not going well (Details:)

2 How did you feel when you found out about this pregnancy?

a Happy b Confused but happy

c Surprised and confused d Not happy

3 Do you have any of the following concerns or problems?

a. No

b. Yes
- ☐ Your health → physical /mental /Others( )
- ☐ Your baby ( )
- ☐ Elder child(ren) → Child rearing / Health / Others( )
- ☐ Family → Relationship with your husband/partner, family member illness, domestic violence, others( )
- ☐ Financial (delivery expenses / medical expenses/ daily expenses)
- ☐ Work / Household ( )
- ☐ Others:( )

4 Do you (expecting mother) smoke?

a. No b. Stopped after pregnant c. Yes(sticks per day)

5 Do you drink alcohol?

a No b Stopped after pregnant c Yes(times per week)

6 Have you ever underwent infertility treatment?

a No

b Yes (Is this pregnancy the result of infertility treatment? → Yes / No)

7 Have you ever given birth early (<37 weeks) or to a low birth weight child (<2,500g) before?

a No

b Yes (Year Month / Weeks g)

8 Have you ever had a miscarriage or stillbirth before?

a No

b Yes ☐ miscarriage(times) ☐ stillbirth(times) ☐ abortion(times)

☐ losing a babay within a year of birth

9 Was your previous preganancy and delivery experience smooth?(For 2nd time mothers)

a Yes

b No → Pregnancy and labor complications (hypertension / diabetes / C-section / intrauterine growth restriction / placenta praevia / anemia / others:)

Do you have plans to go back to your hometown?

a No → Supporter : Yes ( ) / No

b Yes → Prefecture / Country: ( ) When: ( )

Place: Parents' House / Others ( )

10 Have you experienced insomnia, feeling irritated, crying easily or a lack of motivation for more than 2 weeks in the past year?

a No

b Yes ( )

11 Have you ever consulted a counselor or a psychiatrist etc., about psycological and mental matters before?

a No

b Yes
- ☐ Ongoing (medication / counselling)
- ☐ Used to (medication / counselling)
  When ( )
- ☐ Others ( )

12 Do you have for any other health problems other than Q11?

a No

b Yes (High-blood pressure / Diabetes / Heart disease / Thyroid / Kidney related problems / Others:) ☐undergoing treatment

13 Do you have someone to confide in or consult with if you have problems ?

a Yes → Who (Husband / Partner / Parent / Sibling / Friend / In-law / Medical Insitution / Government Body / Others:)

b No

14 Regarding you partner

☐married ☐not married ☐planning to get married(Year Month)

Name: Occupation:

Date of Birth: Year Month Day (Age)

Contact Number:

15 Please circle the family member(s) living with you

Husband / Partner / Children(pax) / Father / Mother / Father-in-law / Mother-in-law

Others( )

16 Does anyone you are living with smoke?

a No

b Yes Who( )(sticks per day)

17 This questionnaire may be communicated to relevant government bodies, doctors etc. when deemed necessary.

a Agree b Disagree

≪For Hospital Completion≫

《医療機関記入欄》 連携の必要性 ☐なし ☐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≫ ☐ 地区担当保健師 ☐ 母子保健コーディネーター ☐その他: 受付者( )