

[6] 단순서식변경

Health checkup questionnaire for infants (For 18–24 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: <input type="text"/> <input type="text"/> kg (round off to the nearest tenth)							
3. Was the baby born prematurely? ① Yes (≠Expected date of confinement?) _____ Year _____ Month _____ Day _____ ② No									
4. 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									
5. 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 your baby have difficulty in making eye contact, or do his/her pupils falter?	① ②
2	Are the baby's pupils unclear?	① ②
3	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
4	Does your baby read a book / watch TV / see things at a very close distance or frown to see?	① ②



Accident preventative education

Yes ① No ②

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	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
4	Have you ever left your baby sitting alone in a basin or bathtub even if for a second?	① ②
5	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 ② ③ ④



Auditory sense

Yes ① No ②

1	Is the baby able to distinguish the sound of regular level from every direction?	① ②
2	Does the baby understand and respond to the simple yes/no questions such as “Are you hungry?” or “Do you want to pee?”	① ②
3	Is the baby able to say his/her name (even if it is not very accurate)?	① ②
4	Is the baby able to locate the picture of the object in a book when you are telling its title?	① ②
5	Does the baby understand as hearing simple oral instructions (Give me a cup, bring the ball, etc.)?	① ②



Toilet training

Yes ① No ②

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	Does the child defecate smoothly and regularly?	① ②
6	Have you ever tried toilet training?	① ②



Nutrition education

1	Does the child have regular meals at designated place on a fixed time? ① Yes ② No	① ②
2	Is the child using a feeding bottle? ① Yes ② No	① ②
3	How do you cook your child's food? ① Use just the same amount of salt as that found in an adult's food ② Use less salt than that found in an adult's food ③ Do not use salt at all	① ② ③
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	What kind of food do you give the child during a day? (Please check all corresponding numbers if applicable.) ① Grain ② Vegetables ③ Fruit ④ Meat/fish/egg/bean ⑤ Milk and dairy products ⑥ Others	① ② ③ ④ ⑤ ⑥
6	How does the child react when you give him/her food? ① He/she eats well and evenly whatever is given. ② He/she eats only one or two food items that he/she wants to eat. ③ He/she does not pick a certain food to eat but eat just a little amount. ④ He/she hates food that he/she has to chew. ⑤ He/she shows no interest in food.	① ② ③ ④ ⑤
7	Do you enjoy sharing a meal with your child? ① Yes ② No	① ②
8	Do you offer the child dietary supplements other than meals? (e.g., vitamins, minerals, probiotics, red ginseng, etc.) 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.