様式第１号（第２条関係）

Pregnancy Notification Form

<table>
<tr><td>Date of Notification:</td><td colspan="2">_____/_____/_____
(DD/MM/YYYY)</td><td>Maternal and Child Health Handbook Number</td><td></td></tr>
<tr><td rowspan="2">Name</td><td colspan="2" rowspan="2"></td><td>Individual Number</td><td></td></tr>
<tr><td>Age
Date of Birth</td><td>years old
____/____/_____(DD/MM/YYYY)</td></tr>
<tr><td>Address</td><td colspan="4">(Please provide your full address, including the apartment name.)</td></tr>
<tr><td>Mobile Phone Number</td><td colspan="2"></td><td>Home Phone Number</td><td></td></tr>
<tr><td>Occupation</td><td colspan="4">□Company employee/Civil servant　□Self-employed
□Housewife/Unemployed
□Part-time job　□Student　□Others (　　)</td></tr>
<tr><td>Health Insurance</td><td colspan="4">□National Health Insurance　□Others</td></tr>
<tr><td>Name of the medical institution where you were diagnosed:</td><td colspan="4"></td></tr>
<tr><td>Name of the medical institution where you plan to give birth:</td><td colspan="4">□Same as the above medical institution
□Others
Name of the medical institution：
Address：</td></tr>
<tr><td>Expected Date of Giving Birth:</td><td colspan="4">_____/_____/_____　(DD/MM/YYYY)</td></tr>
<tr><td>Tuberculosis checkup (Chest X-ray)</td><td colspan="2">□Already done　□Not yet</td><td>STD testing (Blood test)</td><td>□Already done　□Not yet</td></tr>
<tr><td>Weeks of pregnancy (At the time of notification)</td><td>_____
Weeks</td><td>Number of your children(including baby(s) in the womb)
_____</td><td>Number of times of your pregnancy</td><td>time(s)
(Including miscarriages, abortions, etc.)</td></tr>
<tr><td>Experience with miscarriage, abortions, etc.</td><td colspan="4">□None　□Spontaneous abortion (　time(s))　□Abortion (　time(s))
□Premature birth (　time(s))　□Stillbirth (　time(s))</td></tr>
<tr><td>Experience with abnormal pregnancy or delivery</td><td colspan="4">□None
□Experienced (Previous pregnancy:
This Pregnancy:　　)</td></tr>
<tr><td rowspan="3">Have you had any serious diseases?

*If “Yes”, please select your treatment status, and check all diseases that apply.
Please enter the age at the time of disease in brackets.</td><td rowspan="3">□No

□Yes</td><td colspan="3">□Taking medication　□Progress observation without medication
□Treatment completed　□Treatment suspended</td></tr>
<tr><td>Physical Diseases</td><td colspan="2">□Diabetes(Age:　)　□Hypertension (Age:　)
□Kidney disease(Age:　)　□Heart disease (Age:　)
□Thyroid disease (Age:　)　□Hepatitis (Age:　)
□Others (Age:　)</td></tr>
<tr><td>Mental Diseases</td><td colspan="2">□Depression (Age:　)　□Postpartum depression (Age:　)
□Panic disorder (Age:　)　□Adjustment disorder (Age:　)
□Schizophrenia (Age:　)　□Bipolar disorder (Age:　)
□Eating disorders (Age:　)　□Others(Age:　)</td></tr>
<tr><td>Remarks</td><td colspan="4"></td></tr>
</table>

In accordance with the provisions of Article 15 of the Maternal and Child Health Act, I submit the notification as described above.

Name _____

To the Mayor of Mito City

アンケート

Mito City provides consultations and information regarding pregnancy, childbirth, childrearing, and maternal and child health. Please answer the following questions.to receive appropriate support according to your circumstances,

◆About you

Marital Status: □Married □Unmarried (Do you have a plan to marriage?： Yes / No)

Husband's(Partner's)Name:_____

Date of birth (Age):_____(DD/MM/YYYY)_____years old

Phone number:_____

◆Details about your pregnancy

About this pregnancy, have you undergone any fertility treatment?
□No (Conceived naturally) □Yes (Duration of the treatment：)

How did you feel when you found out your pregnancy?
□Happy □Unexpected, but happy □Unexpected, and bewildered
□Troubled □ Nothing special
□Others ( )

Do you have someone who helps you with childcare and housework during your pregnancy? Please check all that apply.
□Husband(Partner) □Parents □Parents-in-law □Siblings □Friends
□Others( ) □None

Do you have someone you can talk to when you have a problem or concern? Please check all that apply.
□Husband(Partner) □Parents □Parents-in-law □Siblings □Friends
□Others( ) □None

◆About your lifestyle

Smoking Habits:	Before pregnancy	□Did not smoke □Smoked(cigarette(s)/day)
	During pregnancy	□Do not smoke □Smoke (cigarette(s)/day)

Does anyone in your family smoke? Please check all that apply.
□No □Husband（Partner） □Parents □Siblings □Others( )

Drinking Habits:	Before pregnancy	□Did not drink □Drank(ml/day)
	During pregnancy	□Do not drink □Drink(ml/day)

Have you had any of the following symptoms continued for more than two weeks?
□No □Can't sleep □Irritated □Anxiety for no reason □Easily tearful
□Depression □Lethargy □Others（ ）

Do you have any concerns or worries that you would like to talk to someone about pregnancy or childbirth?
□No □About physical condition and mental health □About childbirth □About not having anyone to talk to
□About the elder child(ren) □About money □About not having anyone to help with my housework or childcare
□About illness or caring of husband(partner) or family members □About attitude of husband(partner) or relationship with him
□Others ( )

I agree that the contents of this questionnaire and Pregnancy Notification Form are shared with related organizations if necessary.

Signature_____