Nakano City 18-Month-Old Dental Health Check Registration Form

For submission to medical facility

To the parent or guardian: please make a consultation while your child is between 18-24 months old.

Parent or guardian section

Child's name		Boy Girl	Birthday Year Month Day 1 yr. Months
Address	Nakano City Chome		
Parent or guardian's name		Daytime contact	— —

In the event the dentist directs you to make a consultation, please contact the Sukoyaka Health and Welfare Center:

☐Chubu Sukoyaka Health and Welfare Center Tel:3367-7788 ☐Nanbu Sukoyaka Health and Welfare Center Tel:3380-5551

☐Hokubu Sukoyaka Health and Welfare Center Tel:3388-0240 ☐Saginomiya Sukoyaka Health and Welfare Center Tel:3336-7111

以 下 診 察 所 見 歯科医師記入欄

歯の状況

	E	D	C	B	A	A	B	C	D	E	
上											上
右											左
下											下

健全歯 ／ 要観察歯 Co 未処置歯 C1～C4

要観察と銀歯 トCo と銀歯C トC1～C2 喪失歯 △ 処置歯 ○

その他（癒合歯 先欠歯 形成不全 等）

現在歯	本
健全歯	本
要観察歯	本
未処置歯	本
と銀歯	本
処置歯	本
喪失歯	本
その他	本
プラークスコア	

健診結果

1. 問題なし
2. 要経過観察（ について）
3. 精密健診（ について）
4. 要治療 当院で行う・他医療機関紹介（ ）
5. すこやか福祉センターを紹介

【保健 栄養 心理 その他（ ）】

う蝕罹患型
O1 O2 A B C
軟組織の異常
なし 有（ ）
咬合の異常
なし 有（ ）
その他の異常
なし 有（ ）
口腔清掃状態
きれい 少ない 多い

指導内容

☐ 定期健診、予防処置のすすめ
☐ 治療、精密健診のすすめ
☐ 生活習慣の指導、食事の指導
☐ プラークの染出し
☐ 歯磨き指導
☐ その他（ ）

すこやか福祉センターへの連絡事項

歯科健康診査の結果は以上のとおりです。 年 月 日

【医療機関名 所在地 歯科医師氏名】

医療機関コード

18-Month-Old Dental Health Check Questionnaire

Please circle or complete the appropriate item

Date form completed Year Month Day

Family living together: Father Mother Brother (yrs.) Sister (yrs.) Grandfather Grandmother Other ( )

Principal guardian: Daytime (Mother Father Grandmother Grandfather Other_____ Childcare, etc._____Centre)
Night-time ( )

1	Has your child had any significant illness, surgery or injury, etc. up until now?	No Yes ( )
2	Does your child have an appetite?	Eats well Eats moderately Barely eats
3	Is your child drinking breast milk?	No Yes (time(s) per day)
4	Are you using an infant feeding bottle?	No Yes (time(s) per day)
5	What is the reason when you are using an infant feeding bottle or breastfeeding your child?	Craving Feeding when going to bed or during the night Nutrition is a concern Letting nature take its course Other ( )
6	What does your child usually drink?	Water Tea Milk Baby formula Other ( )
7	Has your child drunk sweet beverages like those on the right for more than 5 days in a week?	No Yes Fermented milk beverages Juice Ion beverages Other ( )
8	Has your child eaten sweet confectionary such as those on the right for more than 5 days in a week?	No Yes Hard candy Soft candy Gummies Gum Chocolate Tablet candies Wafers Cookies

9 Please refer to the example below and record what your child ate, drank and did yesterday.

◎Waking・Sleeping ○Meal △Snack ×Drink (Milk, Infant formula, Breast milk, Juice, Ion beverage, etc.)

Morning				Lunch							Evening			
6	7	8	9	10	11	12	1	2	3	4	5	6	7	8

Evening			Midnight							Lunch			
9	10	11	0	1	2	3	4	5	6	E.g. 12	1	2	3
										○	◎	◎	△×

10	Does the parent/guardian finish brushing the child's teeth?	Yes (Every day Sometimes) No →①After the child finishes imitating, the parent or guardian brushes ②Just the parent or guardian finishes brushing.
11	Are you using anything other than a toothbrush to brush your child's teeth?	Yes (Every day Sometimes) No →Toothpaste Fluoro spray Fluoro gel Dental floss tool Dental floss Other ( )
12	Does your child have any habits related to his or her mouth?	No Yes Thumb sucking Pacifier Lip sucking Teeth grinding Sucking on a towel Other ( )
13	Do you have any concerns about the health of your child's mouth?	Yes→ No
14	Please write about anything you would like to consult on in relation to your child's teeth or mouth.	

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