

(Annex No. 7)

\* Check more information on infant/toddler health exam through NHIS's Web site [www.nhis.or.kr](http://www.nhis.or.kr) or call 1577-1000.

(Address)

use as a substitute for infant/toddler health exam list

**Confirmation for the infant / toddler / children at preschool age exam recipient  
(use for presentation to examiner)**

Full name		ID No.	
Health insurance no.		Branch office	
Months of Examination & Time			
Months of Examination	Health exam period		Exam existence
4 mos	Health Exam (4-6 mos)		Completion/expiration/recipient
9 mos	Health Exam (9-12 mos)		"
18 mos	Health Exam (18-24 mos)		"
	Dental Exam (18-29 mos)		"
30 mos	Health Exam (30-36 mos)		"
42 mos	Health Exam (42-48 mos)		"
	Dental Exam (42-53 mos)		"
54 mos	Health Exam (54-60 mos)		"
	Dental Exam (54-65 mos)		"
66 mos	Health Exam (66-71 mos)		"

**Exam facts for infant / toddler / children at preschool age**

Health exam	Oral health exam
<ul style="list-style-type: none"> <li><input type="checkbox"/> Interview and exam: questionnaire, hearing exam, vision exam</li> <li><input type="checkbox"/> Body measurement: height, weight (body mass index), head circumference</li> <li><input type="checkbox"/> Health education: injury prevention, nutrition &amp; physical activity counseling, sleep position counseling, oral health, preschool counseling, secondhand smoking</li> <li><input type="checkbox"/> Development evaluation and counseling: examination and counseling by Korea Development Screening Test for Infants &amp; Children (K-DST)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Oral health interview or exam: questionnaire, dental exam, oral exam, etc.</li> <li><input type="checkbox"/> Oral health education: for parents or child using manual.</li> </ul>

No expenses for all health exams.

As above, we confirm the infant / toddler / children at preschool age exam recipient for 0000.

**National Health Insurance Co.      President** (signature)

- Note) 1. Infant/toddler health examinations is available for 10 times from 4 months old to 71 months of age (including 3 times of dental examination).
2. [In case you received more checkups than required, we will charge you with the corresponding checkup fee.](#)
3. If you lost the health examination card, apply to the National Health Insurance Co. (telephone: 1577-1000), which can reissue the card. Furthermore, you can also find more information, such as the exam results or examinee or exam center, through the NHIS's Web site ([www.nhis.or.kr](http://www.nhis.or.kr)). Just click on the box "Civil service/health exam".
4. [The checkup cost of the health insurance subscribers is covered by the National Health Insurance Service; as medical care assistance recipients are fully covered by the government and public health institutions, infants and children can have health checkups free of charge.](#)
5. [The medical care assistance recipients who received "Further evaluation recommended" in the evaluation result of their 9-month checkup, and health insurance subscribers who pay an insurance premium in the low 30% can receive a comprehensive development evaluation fee from the government. Please contact your local public health medical center for inquiry.](#)

**Health checkup questionnaire for infants (for 4~6 months old)**

Subject name		Resident registration number		Telephone of guardian	
Name of guardian		Relationship to the subject		E-mail address	

※ If you receive a health checkup exceeding the predetermined number, the corresponding cost will be retrieved from you as unjust enrichment.

1. Date of birth of child: \_\_\_\_\_ year \_\_\_\_\_ month \_\_\_\_\_ day

2. Birth weight:    .    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
Numbers completed						

### Vision

Yes ①
No ②

1	Is your baby able to make good eye contact?	①	②
2	Does the position of the pupil of the baby seem strange? (Are the eyes gathering inward or outward even without focusing?)	①	②
3	Are the baby's pupils unclear?	①	②
4	Does any of your family members have an eye-related genetic disorder?	①	②

### Auditory sense

Yes ①
No ②

1	Does the baby show responses to loud noises such as waking up, being startled, changing facial expression, etc.?	①	②
2	Does the baby seem to calm down or stop moving to listen to the sound when a familiar voice is talking?	①	②
3	Is the baby able to make various sounds (squeaking, guffawing, screaming in high tones, etc.)?	①	②
4	Has the baby been hospitalized in a newborn intensive care unit (NICU) over 5 days after his or her birth?	①	②
5	Did the baby receive a hearing screening test in the newborn period?	①	②
6	If you answer "yes" to question 5, was the test result good (passed for both ears or no abnormality)? (If the answer to question 5 is "No", please skip this question.)	①	②

### Education for prevention of sudden infant death syndrome

Yes ①
No ②

1	Do you have the baby sleep with his/her face down?	①	②
2	Is the bed or mattress of the baby fluffy?	①	②
3	Do parents sleep on the same bed (or mattress, etc.) with the baby?	①	②
4	Do you help the baby play with his/her abdomen down to the floor and head up when the baby is awake?	①	②
5	Are there any smokers among the family members living with the baby or the person the baby frequently gets in contact with?	①	②
6	Is there any person who smokes inside of your home (including balcony)?	①	②
7	Is there any person who smokes inside of the car that the baby rides in?	①	②

### Accident preventative education

Yes ①
No ②

1	Where do you install the car seat when you have the baby in a car? ① Front seat ② Rear seats (If you do not have a car seat or a car ③)	①	②	③
2	Do you install the car seat for the baby to face the rear?(If you do not have a car seat or a car ③)	①	②	③
3	Have you ever left your baby alone on an adult's bed or a sofa even if for a second?	①	②	
4	Have you ever left your baby sit alone in a basin, bathtub, or restroom even if for a second?	①	②	
5	Have you ever consumed a hot drink while holding the baby?	①	②	

### Nutrition education

1 Common	What food do you mainly feed your baby? ① Only breast milk(⇨ Questions 2-4, 10)    ② Only powdered formula (⇨ Questions 5-10) ③ Mixture of breast milk and powdered formula (⇨ Questions 2-10)	①	②	③
2 Breast milk	Until when will you keep feeding your baby with breast milk? ① 6-11 months old    ② 12-23 months old ③ Over 24 months old    ④ I don't know.	①	②	③
3 Breast milk	What kind of problems do you have that hinder you from continuing breast-feeding? ① Amount of breast milk    ② The number of breast-feeding instances ③ The way of breast-feeding ④ Breast-feeding in the nighttime ⑤ Others    ⑥ No problem	①	②	③
4 Breast milk	Which of the following does the mother of the baby consume? ① Caffeinated drinks    ② Alcoholic drinks ③ Cigarettes    ④ Drugs    ⑤ Not applicable	①	②	③
5 Powdered formula	How much formula does the baby have in a day? ① Less than 500 mL    ② 500-999 mL    ③ More than 1,000 mL	①	②	③
6 Powdered formula	Do you use boiled and cooled water when you make the formula? ① Yes    ② No	①	②	
7 Powdered formula	How do you warm up the formula made in advance? ① Water bath    ② Microwave    ③ Others	①	②	③
8 Powdered formula	How did you choose the powdered formula currently being provided to the baby? ① Selected by the guardian ② Recommended by a doctor	①	②	
9 Powdered formula	What do you do with the leftover formula? ① Save it for another time    ② Discard it	①	②	
1 Common	When do you plan to start weaning and providing supplementary meals for an infant (baby food)? ① Already started before the baby became 4 months old.    ② 4-6 months old    ③ After 6 months old    ④ I don't know.	①	②	③

## Health checkup questionnaire for infants (for 9~12 months old)

Subject name		Resident registration number		Telephone of guardian	
Name of guardian		Relationship to the subject		E-mail address	

※ If you receive a health checkup exceeding the predetermined number, the corresponding cost will be retrieved from you as unjust enrichment .

1. Date of birth of child: \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Day

2. Birth weight:  .  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
Numbers completed						

5. Has your baby been diagnosed with a development problem, or does he/she have a disease currently undergoing treatment? ①Yes ② No If you answer "yes," what is the specific diagnosis? \_\_\_\_\_

**Vision**

Yes ①

No ②

1	Is your baby able to make good eye contact?	①	②
2	Does the position of the pupil of the baby seem strange? (Are the eyes gathering inward or outward even without focusing?)	①	②
3	Are the baby's pupils unclear?	①	②
4	Does any of your family members have an eye-related genetic disorder?	①	②

**Auditory sense**

Yes ①

No ②

1	Does the baby respond to the sound of calling names, telephone rings, human voice, etc.?	①	②
2	Is the baby cooing and babbling even when he/she is alone?	①	②
3	Does the baby follow to see where the sound is coming from?	①	②
4	Does the baby listen to you as a form of concentration when you are talking to him/her?	①	②
5	Does the baby make sounds resembling the sound of b, p, and m?	①	②

**Accident preventative education**

Yes ①

No ②

1	Does the baby play with small objects such as peanuts, grapes, or buttons?	①	②
2	Have you ever had the baby ride on a baby walker?	①	②
3	Do you put hot drinks or food on the edge of the table?	①	②
4	Have you ever left your baby sit alone in a basin, bathtub, or restroom even if for a second?	①	②
5	Do you install the car seat for the baby to face the rear? (If you do not have a car seat or a car ③)	①	② ③

**Oral health education**

Yes ①

No ②

1	Does the baby sleep with a feeding bottle in his/her mouth or while being breast-fed?	①	②
2	Are you training the baby to wean from a feeding bottle?	①	②
3	Do you think the baby has dental caries?	①	②
4	Does the baby have any tooth with white spots?	①	②
5	Do you think the oral hygiene of the baby is in good condition?	①	②
6	Do you brush the teeth of the baby regularly?	①	②

**Nutrition education**

1	How many times does the baby have supplementary food (baby food)? ① Once      ② 2 times      ③ 3 times      ④ Over 4 times	①	②	③	④
2	What kind of food do you feed the baby with as supplementary food (baby food)? (Please check all corresponding numbers if applicable.) ① Grain      ② Vegetables      ③ Fruit      ④ Egg      ⑤ Fish      ⑥ Meat	①	②	③	④ ⑤ ⑥
3	What are you currently feeding the baby with? (Please check all corresponding numbers if applicable.) ① Breast milk      ② General powdered formula      ③ Specialized powdered formula ④ Fresh milk      ⑤ Fermented dairy products (Cheese/plain yogurt, etc.)	①	②	③	④ ⑤
4	Have you ever fed the baby with the following food? (Please check all corresponding numbers if applicable.) ① Grain powder      ② Honey      ③ Salt or sugar      ④ Not applicable	①	②	③	④

**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	

※ If you receive a health checkup exceeding the predetermined number, the corresponding cost will be retrieved from you as unjust enrichment.

1. Date of birth of child: \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Day

2. Birth weight: .  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



**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



**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



**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

Health checkup questionnaire for infants (for 30–36 months old)

Subject name		Resident registration number		Telephone of guardian	
Name of guardian		Relationship to the subject		E-mail address	

※ If you receive a health checkup exceeding the predetermined number, the corresponding cost will be retrieved from you as unjust enrichment.


1. Date of birth of child: \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Day

2. Birth weight: .  kg (round off to the nearest tenth)


3. 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									


4. 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	Does the baby turn his/her head and turn sideways to see forward (objects in front of him/her) or does he/she look with his/her head tilted?	① ②
3	Does your baby read a book / watch TV / see things at a very close distance or frown to see?	① ②
4	Does the visual acuity of each eye of your child seem different when comparing each eye when you make him/her to see as covering each eye?	① ②

 **Auditory sense** Yes ① No ②


1	Does the number of words the child can speak continuously increase?	① ②
2	Is the child able to speak by connecting two clauses? (e.g., "Give them all.", "Read me books.", etc.)	① ②
3	Does the child turn up the TV volume louder than other people do?	① ②
4	Is the child able to use words that include consonants such as k, t, p, g, etc.?	① ②
5	Has the child infected with acute otitis media several times? (more than 4 times in 6 months, more than 6 times in 1 year)	① ②

 **Accident preventative education** Yes ① No ②

1	Does your child play on the road where cars are passing by?	① ②
2	Are there safety devices for the child in the stairways, windows, and balcony areas?	① ②
3	Do you keep matches or lighters out of reach of children?	① ②
4	Have you ever left your child alone in a car?	① ②
5	Do you keep electronic appliances that might hurt the child, such as electrical cords, outlets, etc., out of reach of children?	① ②
6	Do you keep drugs, chemical agents (bleach, detergent, etc.), and sharp objects out of reach of children?	① ②
7	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

 **Electronic media** Yes ① No ②

1	Is the TV or Internet available for use in the room where the child sleeps?	① ②
2	Do you have your own rules in your home about the use of the TV, Internet, or smartphones?	① ②
3	Do you know what kind of applications or video games the child use frequently?	① ②
4	Do you join your child when he/she uses a smartphone or the Internet or watch TV, movie, videos, etc.?	① ②
5	Does the child use a smartphone while lying down on his/her back or abdomen?	① ②

 **Nutrition education**

1	How is the appetite of the child? ① Good ② Middle ③ Bad	① ② ③
2	How many times does your child have a meal? ① Once ② 2 times ③ 3 times ④ Over 4 times	① ② ③ ④
3	How many times does your child have a snack? ① Once ② 2 times ③ Over 3 times	① ② ③
4	How many days in a week does the child have a meal with the family? ① 1-2 days ② 3-4 days ③ More than 5 days	① ② ③
5	How many times does your child drink fresh milk? ① He/she does not drink at all. ② Less than 200 mL ③ 200-499 mL ④ 500-999 mL ⑤ Over 1,000 mL	① ② ③ ④ ⑤
6	Does the child eat a lot of sweet food? (e.g.: candy, snack, cake, fruit juice, sugar-added beverage, etc.) ① Yes ② No	① ②
7	Have you ever restricted certain food to the child because of worries related to allergic reactions? ① Yes ② No	① ②
8	Does your child perform vigorous physical activities (playing, exercise, etc.) for over 1 hour a day? ① Yes ② No	① ②

## Health checkup questionnaire for infants (for 42~48 months old)

Subject name		Resident registration number		Telephone of guardian	
Name of guardian		Relationship to the subject		E-mail address	

※ If you receive a health checkup exceeding the predetermined number, the corresponding cost will be retrieved from you as unjust enrichment.


1. Date of birth of child: \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Day

2. Birth weight :  .  kg (round off to the nearest tenth)

3. 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									

4. 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 the position of the pupil of the baby seem strange?	①	②
2	Does the baby turn his/her head and turn sideways to see forward (objects in front of him/her) or does he/she look with his/her head tilted?	①	②
3	Does your baby read a book / watch TV / see things at a very close distance or frown to see?	①	②
4	Does the visual acuity of each eye of your child seem different when comparing each eye when you make him/her to see as covering one eye?	①	②




**Auditory sense**

Yes ①

No ②

1	Is the child able to listen and repeat correctly the words (pencil, school, etc.) whispered from the distance of an arm radius in a quiet setting with his/her one ear covered at a time?	①	②
2	Are you able to understand the majority of what the child speaks?	①	②
3	Has the baby been hospitalized in a newborn intensive care unit (NICU) over 5 days after his or her birth?	①	②
4	Is the pronunciation of the child accurate?	①	②
5	Does the child speak as well as kids in his/her age group?	①	②




**Emotion and sociality education**

Yes ①

No ②

1	Does the child voluntarily play with kids in his/her age group?	①	②
2	Does the child hurt his/her friend/s often, or deprive him/her/them of belongings?	①	②
3	Did you start to teach the child to do simple household errands? (e.g., Disposing waste in a waste bin, cleaning up his/her toys after playing, etc.)	①	②
4	Do you teach the child to behave in public places?	①	②
5	Do you teach the child to say hello first when he/she run into the acquaintance? / Do you teach the child to say "Thanks." or "Thank you." when somebody does a favor to him/her?	①	②
6	Is the child able to perform imagination play and role-playing? Is the child able to play in groups as dividing the sides?	①	②
7	Is the child able to explain what he/she has experienced in a simple manner?	①	②
8	Is the child able to explain jobs and roles that he/she frequently sees?	①	②




**Accident preventative education**

Yes ①

No ②

1	Are there safety devices, such as a safety door or latch, for the child in the stairways, windows, and balcony areas?	①	②
2	Have you ever left your baby sitting alone in a pool or bathtub?	①	②
3	Do you keep cigarettes, lighters, electronic appliances, and electrical cords out of reach of children?	①	②
4	Does the child always wear a helmet and joint protection equipment when riding a bicycle, wearing inline skates, etc.?	①	②
5	Does your child play on the road where cars are passing by?	①	②
6	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



**Nutrition education**

1	How many times does your child have a meal? ① Once ② 2 times ③ 3 times ④ Over 4 times	①	②	③	④
2	How many times does your child have a snack? ① Once ② 2 times ③ Over 3 times	①	②	③	
3	How many times does your child drink fresh milk? ① He/she does not drink at all ② Less than 200 mL ③ 200~499 mL ④ 500~999 mL ⑤ Over 1,000 mL	①	②	③	④ ⑤
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	Do you ensure that the food you cook for the child and the family has low salt content? ① Yes ② No	①	②		
6	How is the attitude of the child in a dining table? (Please check all corresponding numbers if applicable.) ① He/she takes too long time to finish a meal. (over 30 minutes) ② He/she refuses to eat new kinds of food. ③ He/she only eats what he/she wants to eat. ④ It is hard to make him/her eat. ⑤ Not applicable	①	②	③	④ ⑤
7	Does your child watch TV or is exposed to the monitor (computer, game console, smartphone, etc.) for over 2 hours? ① Yes ② No	①	②		
8	Does your child perform vigorous physical activities (playing, exercise, etc.) for over 1 hour a day? ① Yes ② No	①	②		

## Health checkup questionnaire for infants (For 54~60 months)

Subject name		Resident registration number		Telephone of guardian	
Name of guardian		Relationship to the subject		E-mail address	

※ If you receive a health checkup exceeding the predetermined number, the corresponding cost will be retrieved from you as unjust enrichment.

1. Date of birth of child: \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Day

2. Birth weight: \_\_\_\_\_ kg (round off to the nearest tenth)

3. 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									

4. 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 the position of the pupil of the baby seem strange?	①	②
2	Does the baby turn his/her head and turn sideways to see forward (objects in front of him/her) or does he/she look with his/her head tilted?	①	②
3	Does your baby read a book / watch TV / see things at a very close distance or frown to see?	①	②
4	Does the visual acuity of each eye of your child seem different when comparing each eye when you make him/her to see as covering each eye?	①	②

### Auditory sense

Yes ①
No ②

1	Is the child able to answer the questions after listening to a simple fairytale or story?	①	②
2	Is the child able to communicate naturally with other people using simple sentences?	①	②
3	Is the child able to understand and follow a command composed of two different actions? (Pick up the book, and put it in a bag.)	①	②
4	Is the child able to talk about happenings in a kindergarten, playground, a friend's house, etc.?	①	②
5	Is the child able to use words that include consonants such as s, th, j, ch, etc.?	①	②

### Accident preventative education

Yes ①
No ②

1	Does the child always wear a helmet and joint protection equipment when riding a bicycle, wearing inline skates, etc.??	①	②
2	Does your child play on the road where cars are passing by?	①	②
3	Do you put your child in a booster seat and fasten his/her seat belt when you take him for a ride in a car?(If you do not have a car ③)	①	② ③
4	Does the child know the rules he/she has to observe in a pool?	①	②
5	Does the child play with matches, lighters, or fireworks?	①	②
6	Do you keep drugs, chemical agents (bleach, detergent, etc.), and sharp objects out of reach of children?	①	②

### Personal hygiene education

Yes ①
No ②

1	Does the child wash his/her hands before eating?	①	②
2	Does the child wash his/her hands after touching toys or animals?	①	②
3	Does the child wash his/her hands after using the toilet?	①	②
4	Does the child frequently touch his/her eyes, nose, or mouth with his/her hands?	①	②
5	How do you manage when the child cannot use water to wash the hands outside? ① Clean them with dry tissue. ② Clean them with wipes. ③ Use a hand sanitizer containing alcohol. ④ Leave it just as it is.	① ③	② ④

### Nutrition education

1	How do you think of the child's appearance (size)? ① Kind of fat ② Middle ③ Kind of skinny	①	②	③
2	Does the child eat at a similar pace with other family members? ① Faster ② Similar ③ Slower	①	②	③
3	Does the child regularly have meals and snacks? ① Yes ② No	①	②	
4	How is the amount the child eats at a time when compared to kids in his/her age group? ① Less ② Similar ③ More	①	②	③
5	Does the child only eat what he/she wants to? ① Yes ② No	①	②	
6	Does the child eat greasy, sweet, or salty food a lot? (e.g., Fast food, precooked food, etc.) ① Yes ② No	①	②	
7	Does the child prefer drinks other than water? ① Yes ② No	①	②	
8	Does your child watch TV or is exposed to the monitor (computer, game console, smartphone, etc.) for over 2 hours? ① Yes ② No	①	②	
9	Does your child perform vigorous physical activities (playing, exercise, etc.) for over 1 hour a day? ① Yes ② No	①	②	

## Health checkup questionnaire for infants (For 66~71 months)

Subject name		Resident registration number		Telephone of guardian	
Name of guardian		Relationship to the subject		E-mail address	

※ If you receive a health checkup exceeding the predetermined number, the corresponding cost will be retrieved from you as unjust enrichment.

1. Date of birth of child: \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Day

2. Birth weight: \_\_\_\_\_ kg (round off to the nearest tenth)

3. 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									

4. 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 the position of the pupil of the baby seem strange?	①	②
2	Does the baby turn his/her head and turn sideways to see forward (objects in front of him/her) or does he/she look with his/her head tilted?	①	②
3	Does your baby read a book / watch TV / see things at a very close distance or frown to see?	①	②
4	Does the visual acuity of each eye of your child seem different when comparing each eye when you make him/her to see as covering each eye?	①	②

### Auditory sense

Yes ①
No ②

1	Is the child able to pronounce the majority of the vowels and consonants correctly?	①	②
2	Does the child understand well when being told in a small voice?	①	②
3	Does the child easily communicate with other people verbally?	①	②
4	Is the child able to repeat exactly what an adult says?	①	②
5	Is there any relative or parent who has a hearing impairment since childhood?	①	②

### Accident preventative education

Yes ①
No ②

1	Does the child always wear a helmet and joint protection equipment when riding a bicycle, wearing inline skates, etc.?	①	②
2	Has the child ever crossed the road alone?	①	②
3	Do you put your child in a booster seat and fasten his/her seat belt when you take him for a ride in a car?(If you do not have a car ③)	①	② ③
4	Does the child know the phone number to report to in case of fire?	①	②
5	Do you allow the child to play in a playground alone for you to perform other activities?	①	②

### Preschool readiness education

Yes ①
No ②

1	Is the child able to distinguish the good and bad behaviors by him/herself?	①	②
2	Is the child able to wait for things he/she wants to do, to eat, and to have?	①	②
3	Does the child play along with other kids well? (e.g.: Is the child able to make compromises when playing with his/her friends?)	①	②
4	Is the child able to sit at one place during a lesson in a nursery or kindergarten?	①	②
5	Is the child able to follow the instructions of an adult and rules provided by parents or teachers?	①	②
6	Is it hard for the child to separate from his/her parents when going to kindergarten?	①	②
7	Is the child able to manage to go to a toilet by him/herself?	①	②
8	Is the child able to ask for help from other people when necessary?	①	②
9	Does the child wake up and go to bed at a regular time?	①	②

### Nutrition education

1	Does the child tend to have his/her breakfast? ① Yes ② Not every day but generally ③ No	①	②	③
2	How many dinners does the family have together in a week? ① 1-2 times ② 3-4 times ③ More than 5 times	①	②	③
3	Does the child often eat dairy products containing calcium (such as milk, plain yogurt, cheese, etc.)? ① Yes ② No	①	②	
4	When does the child have a snack? ① He/she does not have a snack. ② Between meals ③ Before going to bed or late at night ④ Whenever he/she wants	①	②	③ ④
5	What kind of food does he/she mainly eat as a snack? (Please check all corresponding numbers if applicable.) ① Sugar-added beverage (e.g.: Carbonated drink, sports drink, kids' drink, etc.) ② Greasy, sweet, or salty food (e.g.: Fast food, precooked food, etc.) ③ Not applicable	①	②	③
6	Does your child perform vigorous physical activities (playing, exercise, etc.) for over 1 hour a day? ① Yes ② No	①	②	

## Infant/Toddler Dental Health Screening Program

(This screening program is for 18-29 months of age.)

Name of health examinee		Resident registration number		Contact information of guardian	
Name of guardian		Relationship to the health examinee		E-mail	

Infant/toddler dental health examinations are available at 2 years old (18-29 months), 4 years old (42-53 months), and 5 years old (54-65 months). Each examination consisted of tests suitable for developmental stage.

This screening test is to collect information about your child before the examination and very important for evaluating the dental health of your child. All information provided are confidential and, therefore, please answer all questions with honesty and to the best of your knowledge. Parents or legal guardians should answer this questionnaire. If you are unsure, please carefully observe your child before answering.

**※ These are questions about dental history and awareness about the oral health of your child.**

1. Have you brought your child to dental clinic since his/her birth?      ① Yes      ② No
2. Has your child told you about his/her toothache?      ① Yes      ② No
3. Do you think your child currently has cavity?      ① Yes      ② No      ③ I do not know

**※ These are questions about your child's oral health habits (sugar intake, oral hygiene, and use of fluoride).**

4. Does your child stop bottle of milk?      ① yes      ② no
5. How often does your child eat sweets or sticky snacks, such as cookies, candies, and cakes per day?  
 ① Never      ② Once      ③ 2-3 times      ④ More than 4 times      ⑤ I do not know
6. How many times does your child drink soda or sweet drinks (including sports drink, ion supply drink, and fruit juice)?  
 ① Never      ② Once      ③ 2-3 times      ④ More than 4 times      ⑤ I do not know
7. Have you learned how to brush your child's teeth from a dental clinic or health center?  
 ① Yes      ② No
8. Do you regularly brush your child's teeth?      ① Yes      ② No
9. How many times does your child brush his/her teeth in a regular day or how many times do you brush your child's teeth?  
 ① Less than once a week      ② At least once a week but not every day  
 ③ Once a day      ④ Twice a day      ⑤ More than 3 times a day
10. Has your child started using toothpaste?      ① Yes      ② No
11. Does your child's toothpaste contain fluoride?  
 ① Yes      ② No      ③ I do not know      ④ He or she does not use toothpaste
12. How much toothpaste is used in every brush?  
 ① Very little      ② Size of a small bean      ③ Half the length of the head of a toothbrush  
 ④ As long as the head of a toothbrush      ⑤ He or she does not use toothpaste

**※ Please write any question(s) to ask or describe if your child has a special condition that needs a doctor's attention.**

## Infant/Toddler Dental Health Screening Program

(This screening program is for 42-53 months of age.)

Name of health examinee		Resident registration number		Contact information of guardian	
Name of guardian		Relationship to the health examinee		E-mail address	

Infant/toddler dental health examinations are available at 2 years old (18-29 months), 4 years old (42-53 months), and 5 years old (54-65 months). Each examination consisted of tests suitable for developmental stage.

This screening test is to collect information about your child before the examination and very important for evaluating the dental health of your child. All information provided are confidential and, therefore, please answer all questions with honesty and to the best of your knowledge. Parents or legal guardians should answer this questionnaire. If you are unsure, please carefully observe your child before answering.

### ※ These are questions about dental history and awareness about oral health of your child

1. Have you brought your child to a dental clinic in the last year?      ① Yes      ② No
2. Has your child told you about his/her toothache?      ① Yes      ② No
3. Do you think your child currently has cavity?      ① Yes      ② No      ③ I do not know

### ※ These are questions about your child's oral health habits (sugar intake, oral hygiene, and use of fluoride)

4. How often does your child eat sweets or sticky snacks, such as cookies, candies, and cakes per day?  
① Never      ② Once      ③ 2-3 times      ④ More than 4 times      ⑤ I do not know
5. How many times does your child drink soda or sweet drinks (including sports drink, ion supply drink, and fruit juice)?  
① Never      ② Once      ③ 2-3 times      ④ More than 4 times      ⑤ I do not know
6. Has your child learned how to brush his/her teeth from a dental clinic or health center?  
① Yes      ② No
7. Do you regularly brush your child's teeth?      ① Yes      ② No
8. Please select all occasions in which your child brushes his/her teeth.  
① Before breakfast      ② After breakfast      ③ Before lunch      ④ After lunch      ⑤ Before going to bed  
⑥ After a snack
9. Does your child's toothpaste contain fluoride?  
① Yes      ② No      ③ I do not know      ④ He or she does not use toothpaste
10. How much toothpaste is used in every brush?  
① Very little      ② Size of a small bean      ③ Half the length of the head of a toothbrush  
④ As long as the head of a toothbrush      ⑤ He or she does not use toothpaste
11. Have you ever been advised about using fluoride to prevent cavity of your child?  
① Yes      ② No

### ※ Please write any question(s) to ask or describe if your child has a special condition that needs a doctor's attention.

## Infant/Toddler Dental Health Screening Program

(This screening program is for 54-65 months of age.)

Name of health examinee		Resident registration number		Contact information of guardian	
Name of guardian		Relationship to the health examinee		E-mail address	

Infant/toddler dental health examinations are available at 2 years old (18-29 months), 4 years old (42-53 months), and 5 years old (54-65 months). Each examination consisted of tests suitable for developmental stage.

This screening test is to collect information about your child before the examination and very important for evaluating the dental health of your child. All information provided are confidential and, therefore, please answer all questions with honesty and to the best of your knowledge. Parents or legal guardians should answer this questionnaire. If you are unsure, please carefully observe your child before answering.

**※ These are questions about dental history and awareness about oral health of your child.**

1. Have you brought your child to dental clinic in the last year?      ① Yes      ② No
2. Has your child told you about his/her toothache?      ① Yes      ② No
3. Do you think your child currently has cavity?      ① Yes      ② No      ③ I do not know

**※ These are questions about your child's oral health habits (sugar intake, oral hygiene, and use of fluoride)**

4. How often does your child eat sweets or sticky snacks, such as cookies, candies, and cakes per day?  
① Never      ② Once      ③ 2-3 times      ④ More than 4 times      ⑤ I do not know
5. How many times does your child drink soda or sweet drinks (including sports drink, ion supply drink, and fruit juice)?  
① Never      ② Once      ③ 2-3 times      ④ More than 4 times      ⑤ I do not know
6. Has your child learned how to brush his/her teeth from a dental clinic or health center?  
① Yes      ② No
7. Do you regularly brush your child's teeth?      ① Yes      ② No
8. Please select all occasions in which your child brushes his/her teeth.  
① Before breakfast      ② After breakfast      ③ Before lunch      ④ After lunch      ⑤ Before going to bed      ⑥ After a snack
9. Does your child's toothpaste contain fluoride?  
① Yes      ② No      ③ I do not know      ④ He or she does not use toothpaste
10. How much toothpaste is used in every brush?  
① Very little      ② Size of a small bean      ③ Half the length of the head of a toothbrush  
④ As long as the head of a toothbrush      ⑤ He or she does not use toothpaste
11. Have you ever been advised about using fluoride to prevent cavity of your child?  
① Yes      ② No

**※ Please write any question(s) to ask or describe if your child has a special condition that needs a doctor's attention.**

**Health checkup result report for infants (for 4~6 months old)**

Subject name		Resident registration number						
Body measuring	Height (cm)		Body weight (kg)		Head circumference (cm)			
	□ □ □ cm (      Percentile)		□ □ □ kg (      Percentile)		□ □ □ cm (      Percentile)			
	□ Good □ Further evaluation required		□ Good □ Further evaluation required		□ Good □ Further evaluation required			
* Percentile refers to an order from the smallest among 100 infants with the same sex and age. The developmental curve of the graphs above indicates percentile of 5, 10, 25, 50, 75, 90, and 95 from the bottom to top, respectively.								
Physical examination impression	General status		□ Good	□ Abnormal	Chest		□ Good	□ Abnormal
	Skin		□ Good	□ Abnormal	Lungs		□ Good	□ Abnormal
	Head/face		□ Good	□ Abnormal	Heart		□ Good	□ Abnormal
	Eyes		□ Good	□ Abnormal	Abdomen		□ Good	□ Abnormal
	Nose		□ Good	□ Abnormal	Genitals		□ Good	□ Abnormal
	Ears		□ Good	□ Abnormal	Extremities		□ Good	□ Abnormal
	Oral		□ Good	□ Abnormal	Spinal		□ Good	□ Abnormal
	Neck		□ Good	□ Abnormal	Neurological examination		□ Good	□ Abnormal
Vision	Questionnaire	□ Good □ Further evaluation required [Questionnaires related to the condition: □ 1 □ 2 □ 3 □ 4]						
Auditory sense	Questionnaire	□ Good □ Further evaluation required [Questionnaires related to the condition: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6]						
Conducting health education		□ Accident preventative education		□ Nutritional education		□ Education for prevention of sudden infant death syndrome		
General determination		□ Good      □ Caution      □ Further evaluation required						
Impression and actions taken								
Medical institution number		Name of health checkup institution						
examination		License number		Name of doctor		(signature)		

\* In case of a certain disease with low prevalence, it might not be detected by the health checkup.

\* Even if the result of a health checkup is determined as Good, please keep the continuous effort to maintain a good state of health, and if the result is determined as “Caution” or “Further evaluation required,” please consult your doctor.

\* If the doctor’s impression in which the subject needs medical care is stated on the notification letter of the health checkup result, the notification letter can serve as a medical care referral (treatment referral) for treatment at a more advanced hospital.

\* It is helpful to bring your result report of this time for your next checkup.

**Health checkup result report for infants (for 9–12 months old)**

Subject name		Resident registration number		
Body measurement	Height (cm)	Body weight (kg)		Head circumference (cm)
	<input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> cm ( Percentile)	<input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> kg ( Percentile)		<input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> cm ( Percentile)
	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required		<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required
	* Percentile refers to an order from the smallest among 100 infants with the same sex and age. The developmental curve of the graphs above indicates percentile of 5, 10, 25, 50, 75, 90, and 95 from the bottom to top, respectively.			
Impression of physical examination	General status	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Chest	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Skin	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Lungs	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Head/face	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Heart	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Eyes	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Abdomen	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Nose	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Genitals	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Ears	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Extremities	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Oral	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Spinal	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Neck	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Neurological test	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
Vision	Questionnaire	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required [Questionnaires related to the condition: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 ]		
Auditory sense	Questionnaire	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required [Questionnaires related to the condition: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Regarding K-DST]		
Conducting health education		<input type="checkbox"/> Accident preventative education <input type="checkbox"/> Nutritional education <input type="checkbox"/> Oral health education		
Result of development evaluation		<input type="checkbox"/> Good <input type="checkbox"/> Follow-up examination required [ <input type="checkbox"/> Gross motor exercise <input type="checkbox"/> Fine motor exercise <input type="checkbox"/> Cognition <input type="checkbox"/> Language <input type="checkbox"/> Social skill] <input type="checkbox"/> Further evaluation recommended [ <input type="checkbox"/> Gross motor exercise <input type="checkbox"/> Fine motor exercise <input type="checkbox"/> Cognition <input type="checkbox"/> Language <input type="checkbox"/> Social skill] [Regarding additional questions <input type="checkbox"/> Motor development(M) ] <input type="checkbox"/> Continuous management required		
General determination		<input type="checkbox"/> Good <input type="checkbox"/> Caution <input type="checkbox"/> Further evaluation required		
Impression and actions taken				
Medical institution number	Name of health checkup institution			
examination	License number	Name of doctor	(signature)	

\* In case of a certain disease with low prevalence, it might not be detected by the health checkup.  
 \* Even if the result of a health checkup is determined as Good, please keep the continuous effort to maintain a good state of health, and if the result is determined as “Caution” or “Further evaluation required,” please consult your doctor.  
 \* If the doctor’s impression in which the subject needs medical care is stated on the notification letter of the health checkup result, the notification letter can serve as a medical care referral (treatment referral) for treatment at a more advanced hospital.  
 \* It is helpful to bring your result report of this time for your next checkup.

**Health checkup result report for infants (For 18~24 months)**

Subject name				Resident registration number			
Body measurement	Height (cm)		Body weight (kg)		Head circumference (cm)		
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> cm ( <input type="checkbox"/> Percentile)		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> kg ( <input type="checkbox"/> Percentile)		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> cm ( <input type="checkbox"/> Percentile)		
	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required		<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required		<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required		
* Percentile refers to an order from the smallest among 100 infants with the same sex and age. The developmental curve of the graphs above indicates percentile of 5, 10, 25, 50, 75, 90, and 95 from the bottom to top, respectively.							
Impression of physical examination	General status		<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal	Chest		<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Skin		<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal	Lungs		<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Head/face		<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal	Heart		<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Eyes		<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal	Abdomen		<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Nose		<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal	Genitals		<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Ears		<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal	Extremities		<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Oral		<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal	Spinal		<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Neck		<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal	Neurological test		<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
Vision	Questionnaire	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required [Questionnaires related to the condition: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 ]					
Auditory sense	Questionnaire	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required [Questionnaires related to the condition: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Regarding K-DST]					
Conducting health education		<input type="checkbox"/> Accident preventative education		<input type="checkbox"/> Nutritional education		<input type="checkbox"/> Toilet training	
Result of development evaluation		<input type="checkbox"/> Good <input type="checkbox"/> Follow-up examination required [ <input type="checkbox"/> Gross motor exercise <input type="checkbox"/> Fine motor exercise <input type="checkbox"/> Cognition <input type="checkbox"/> Language <input type="checkbox"/> Social skill <input type="checkbox"/> Self-help] <input type="checkbox"/> Further evaluation recommended [ <input type="checkbox"/> Gross motor exercise <input type="checkbox"/> Fine motor exercise <input type="checkbox"/> Cognition <input type="checkbox"/> Language <input type="checkbox"/> Social skill <input type="checkbox"/> Self-help] [Regarding additional questions <input type="checkbox"/> Motor development(M) <input type="checkbox"/> Language development (L) <input type="checkbox"/> Social skill development (S)] <input type="checkbox"/> Continuous management required					
General determination		<input type="checkbox"/> Good		<input type="checkbox"/> Caution		<input type="checkbox"/> Further evaluation required	
Impression and actions taken							
Medical institution number		Name of health checkup institution					
examination		License number		Name of doctor		(signature)	

\* In case of a certain disease with low prevalence, it might not be detected by the health checkup.  
 \* Even if the result of a health checkup is determined as Good, please keep the continuous effort to maintain a good state of health, and if the result is determined as "Caution" or "Further evaluation required," please consult your doctor.  
 \* If the doctor's impression in which the subject needs medical care is stated on the notification letter of the health checkup result, the notification letter can serve as a medical care referral (treatment referral) for treatment at a more advanced hospital.  
 \* It is helpful to bring your result report of this time for your next checkup.

## Health checkup result report for infants (For 30~36 months)

Subject name						Resident registration number			
Body measurement	Height (cm)		Body weight (kg)		Head circumference (cm)		BMI(kg/m <sup>2</sup> )		
	□ □ □ cm (      Percentile)		□ □ □ kg (      Percentile)		□ □ □ cm (      Percentile)		□ □ □ cm (      Percentile)		
	□ Good    □ Further evaluation required		□ Good    □ Further evaluation required		□ Good    □ Further evaluation required		□ Good    □ Further evaluation required		
* Percentile refers to an order from the smallest among 100 infants with the same sex and age. The developmental curve of the graphs above indicates percentile of 5, 10, 25, 50, 75, 90, and 95 from the bottom to top, respectively.									
Impression of physical examination		General status	□ Good	□ Abnormal	Chest	□ Good	□ Abnormal		
		Skin	□ Good	□ Abnormal	Lungs	□ Good	□ Abnormal		
		Head/face	□ Good	□ Abnormal	Heart	□ Good	□ Abnormal		
		Eyes	□ Good	□ Abnormal	Abdomen	□ Good	□ Abnormal		
		Nose	□ Good	□ Abnormal	Genitals	□ Good	□ Abnormal		
		Ears	□ Good	□ Abnormal	Extremities	□ Good	□ Abnormal		
		Oral	□ Good	□ Abnormal	Spinal	□ Good	□ Abnormal		
		Neck	□ Good	□ Abnormal	Neurological test	□ Good	□ Abnormal		
Vision	Questionnaire	□ Good    □ Further evaluation required [Questionnaires related to the condition:    □ 1 □ 2 □ 3 □ 4 ]							
Auditory sense	Questionnaire	□ Good    □ Further evaluation required [Questionnaires related to the condition:    □ 1 □ 2 □ 3 □ 4 □ 5    □ Regarding K-DST]							
Conducting health education		□ Accident preventative education      □ Nutritional education      □ Oral health education							
Result of development evaluation		□ Good							
		□ Follow-up examination required		□ Gross motor exercise	□ Fine motor exercise	□ Cognition	□ Language	□ Social skill	□ Self-help skill]
		□ Further evaluation recommended		□ Gross motor exercise	□ Fine motor exercise	□ Cognition	□ Language	□ Social skill	□ Self-help skill]
		[Regarding additional questions	□ Motor development(M)	□ Language development (L)	□ Social skill development (S)]				
		□ Continuous management required							
General determination		□ Good                      □ Caution                      □ Electronic media exposure training							
Impression and actions taken									
Medical institution number		Name of health checkup institution							
examination		License number		Name of doctor		(signature)			

\* In case of a certain disease with low prevalence, it might not be detected by the health checkup.

\* Even if the result of a health checkup is determined as Good, please keep the continuous effort to maintain a good state of health, and if the result is determined as “Caution” or “Further evaluation required,” please consult your doctor.

\* If the doctor’s impression in which the subject needs medical care is stated on the notification letter of the health checkup result, the notification letter can serve as a medical care referral (treatment referral) for treatment at a more advanced hospital.

\* It is helpful to bring your result report of this time for your next checkup.

### Health checkup result report for infants (for 42-48 months old)

Subject name		Resident registration number		
Body measuring	Height (cm)	Body weight (kg)	Head circumference (cm)	
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> cm ( <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Percentile)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> kg ( <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Percentile)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> cm ( <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Percentile)	
	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required	
	* Percentile refers to an order from the smallest among 100 infants with the same sex and age. The developmental curve of the graphs above indicates percentile of 5, 10, 25, 50, 75, 90, and 95 from the bottom to top, respectively.			
Physical examination impression	General status	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Chest	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Skin	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Lungs	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Head/face	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Heart	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Eyes	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Abdomen	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Nose	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Genitals	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Ears	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Extremities	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Oral	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Spinal	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Neck	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Neurological test	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
Vision	Questionnaire	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required [Questionnaires related to the condition: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4]		
	Visual acuity test	<input type="checkbox"/> Picture eye chart <input type="checkbox"/> Number eye chart	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required <input type="checkbox"/> Not able to follow the test	Left eye: Right eye: Both eyes:
Auditory sense	Questionnaire	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required [Questionnaires related to the condition: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Regarding K-DST]		
Conducting health education		<input type="checkbox"/> Accident preventative education <input type="checkbox"/> Nutritional education <input type="checkbox"/> Emotion and sociality education		
Result of development evaluation		<input type="checkbox"/> Good <input type="checkbox"/> Follow-up examination required [ <input type="checkbox"/> Gross motor exercise <input type="checkbox"/> Fine motor exercise <input type="checkbox"/> Cognition <input type="checkbox"/> Language <input type="checkbox"/> Social skill <input type="checkbox"/> Self-help skill] <input type="checkbox"/> Further evaluation recommended [ <input type="checkbox"/> Gross motor exercise <input type="checkbox"/> Fine motor exercise <input type="checkbox"/> Cognition <input type="checkbox"/> Language <input type="checkbox"/> Social skill <input type="checkbox"/> Self-help skill] [Regarding additional questions <input type="checkbox"/> Motor development(M) ] <input type="checkbox"/> Language development (L) <input type="checkbox"/> Continuous management required		
General determination		<input type="checkbox"/> Good <input type="checkbox"/> Caution <input type="checkbox"/> Further evaluation required		
Impression and actions taken				
Medical institution number	Name of health checkup institution			
examination	License number	Name of doctor	(signature)	

\* In case of a certain disease with low prevalence, it might not be detected by the health checkup.  
 \* Even if the result of a health checkup is determined as Good, please keep the continuous effort to maintain a good state of health, and if the result is determined as "Caution" or "Further evaluation required," please consult your doctor.  
 \* If the doctor's impression in which the subject needs medical care is stated on the notification letter of the health checkup result, the notification letter can serve as a medical care referral (treatment referral) for treatment at a more advanced hospital.  
 \* It is helpful to bring your result report of this time for your next checkup.

## Health checkup result report for infants (for 54~60 months old)

Subject name				Resident registration number			
Body measuring	Height (cm)	Body weight (kg)	Head circumference (cm)		BMI(kg/m <sup>2</sup> )		
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> cm (                  Percentile)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> kg (                  Percentile)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> cm (                  Percentile)		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> cm (                  Percentile)		
	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required		<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required		
	* Percentile refers to an order from the smallest among 100 infants with the same sex and age. The developmental curve of the graphs above indicates percentile of 5, 10, 25, 50, 75, 90, and 95 from the bottom to top, respectively.						
Physical examination impression		General status	<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal	Chest	<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal
		Skin	<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal	Lungs	<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal
		Head/face	<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal	Heart	<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal
		Eyes	<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal	Abdomen	<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal
		Nose	<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal	Genitals	<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal
		Ears	<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal	Extremities	<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal
		Oral	<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal	Spinal	<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal
		Neck	<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal	Neurological test	<input type="checkbox"/> Good	<input type="checkbox"/> Abnormal
Vision	Questionnaire	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required [Questionnaires related to the condition: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4]					
	Visual acuity test	<input type="checkbox"/> Picture eye chart <input type="checkbox"/> Number eye chart					
		<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required	<input type="checkbox"/> Not able to follow the test	Left eye:                      Right eye:                      Both eyes:			
Auditory sense	Questionnaire	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required [Questionnaires related to the condition: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Regarding K-DST]					
Conducting health education		<input type="checkbox"/> Accident preventative education <input type="checkbox"/> Nutritional education <input type="checkbox"/> Personal hygiene education					
Result of development evaluation		<input type="checkbox"/> Good					
		<input type="checkbox"/> Follow-up examination required    [ <input type="checkbox"/> Gross motor exercise <input type="checkbox"/> Fine motor exercise <input type="checkbox"/> Cognition <input type="checkbox"/> Language <input type="checkbox"/> Social skill <input type="checkbox"/> Self-help]					
		<input type="checkbox"/> Further evaluation recommended    [ <input type="checkbox"/> Gross motor exercise <input type="checkbox"/> Fine motor exercise <input type="checkbox"/> Cognition <input type="checkbox"/> Language <input type="checkbox"/> Social skill <input type="checkbox"/> Self-help]					
		[Regarding additional questions				<input type="checkbox"/> Social skill development (S) ]	
		<input type="checkbox"/> Continuous management required					
General determination		<input type="checkbox"/> Good <input type="checkbox"/> Caution <input type="checkbox"/> Further evaluation required					
Impression and actions taken							
Medical institution number			Name of health checkup institution				
examination			License number			Name of doctor	(signature)

\* In case of a certain disease with low prevalence, it might not be detected by the health checkup.  
 \* Even if the result of a health checkup is determined as Good, please keep the continuous effort to maintain a good state of health, and if the result is determined as "Caution" or "Further evaluation required," please consult your doctor.  
 \* If the doctor's impression in which the subject needs medical care is stated on the notification letter of the health checkup result, the notification letter can serve as a medical care referral (treatment referral) for treatment at a more advanced hospital.  
 \* It is helpful to bring your result report of this time for your next checkup.

**Health checkup result report for infants (for 66~71 months old)**

Subject name		Resident registration number		
Body Measurement	Height (cm)	Body weight (kg)	Head circumference (cm)	
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> cm ( <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Percentile)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> kg ( <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Percentile)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> cm ( <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Percentile)	
	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required	
* Percentile refers to an order from the smallest among 100 infants with the same sex and age. The developmental curve of the graphs above indicates percentile of 5, 10, 25, 50, 75, 90, and 95 from the bottom to top, respectively.				
Physical examination impression	General status	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Chest	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Skin	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Lungs	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Head/face	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Heart	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Eyes	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Abdomen	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Nose	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Genitals	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Ears	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Extremities	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Oral	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Spinal	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
	Neck	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal	Neurological test	<input type="checkbox"/> Good <input type="checkbox"/> Abnormal
Vision	Questionnaire	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required [Questionnaires <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 ]		
	Visual acuity test	<input type="checkbox"/> Picture eye chart <input type="checkbox"/> Number eye chart	Left eye: Right eye: Both eyes:	
Auditory sense	Questionnaire	<input type="checkbox"/> Good <input type="checkbox"/> Further evaluation required [Questionnaires <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Regarding K-DST]		
	Conducting health education	<input type="checkbox"/> Accident preventative education <input type="checkbox"/> Nutritional education <input type="checkbox"/> Personal hygiene education		
Result of development evaluation	<input type="checkbox"/> Good			
	<input type="checkbox"/> Follow-up examination required [ <input type="checkbox"/> Gross motor exercise <input type="checkbox"/> Fine motor exercise <input type="checkbox"/> Cognition <input type="checkbox"/> Language <input type="checkbox"/> Social skill <input type="checkbox"/> Self-help]			
	<input type="checkbox"/> Further evaluation recommended [ <input type="checkbox"/> Gross motor exercise <input type="checkbox"/> Fine motor exercise <input type="checkbox"/> Cognition <input type="checkbox"/> Language <input type="checkbox"/> Social skill <input type="checkbox"/> Self-help]			
[Regarding additional questions <input type="checkbox"/> Social skill development (S) ]				
<input type="checkbox"/> Continuous management required				
General determination	<input type="checkbox"/> Good <input type="checkbox"/> Caution <input type="checkbox"/> Further evaluation required			
Impression and actions taken				
Medical institution number	Name of health checkup institution			
examination	License number	Name of doctor	(signature)	

\* In case of a certain disease with low prevalence, it might not be detected by the health checkup.

\* Even if the result of a health checkup is determined as Good, please keep the continuous effort to maintain a good state of health, and if the result is determined as "Caution" or "Further evaluation required," please consult your doctor.

\* If the doctor's impression in which the subject needs medical care is stated on the notification letter of the health checkup result, the notification letter can serve as a medical care referral (treatment referral) for treatment at a more advanced hospital.

\* It is helpful to bring your result report of this time for your next checkup.

## Results of Infant/Toddler Dental Health Screening

(This result is for infants/toddlers between 18 months to 29 months of age.)

Name		Residential ID No.	- 3(4)
Address		Contact information	

### Screening test results

(Dental) medical history	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Oral health habits	Sugar intake	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Awareness about oral health	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Oral hygiene	<input type="checkbox"/> No	<input type="checkbox"/> Yes
				Use of fluoride	<input type="checkbox"/> No	<input type="checkbox"/> Yes

### Oral examination results

Section	Disease	List	Results	Note																					
Tooth test	Dental caries (cavity)	<b>Teeth condition</b>																							
		<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td style="padding: 2px;">55</td><td style="padding: 2px;">54</td><td style="padding: 2px;">53</td><td style="padding: 2px;">52</td><td style="padding: 2px;">51</td><td style="padding: 2px;">61</td><td style="padding: 2px;">62</td><td style="padding: 2px;">63</td><td style="padding: 2px;">64</td><td style="padding: 2px;">65</td> </tr> <tr> <td style="padding: 2px;">85</td><td style="padding: 2px;">84</td><td style="padding: 2px;">83</td><td style="padding: 2px;">82</td><td style="padding: 2px;">81</td><td style="padding: 2px;">71</td><td style="padding: 2px;">72</td><td style="padding: 2px;">73</td><td style="padding: 2px;">74</td><td style="padding: 2px;">75</td> </tr> </table>			55	54	53	52	51	61	62	63	64	65	85	84	83	82	81	71	72	73	74	75	
		55	54	53	52	51	61	62	63	64	65														
		85	84	83	82	81	71	72	73	74	75														
<b>Indication</b>	Cavity	●	Cavity suspected	●	Repaired	F																			
<b>Dental caries</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	※ Milk tooth caries incident rate (2006/%) <table border="1" style="margin: auto; border-collapse: collapse; width: 80%;"> <thead> <tr> <th></th> <th>Total</th> <th>Boy</th> <th>Girl</th> </tr> </thead> <tbody> <tr> <td>2 yrs</td> <td style="text-align: center;">13</td> <td style="text-align: center;">9</td> <td style="text-align: center;">32</td> </tr> <tr> <td>3 yrs</td> <td style="text-align: center;">27</td> <td style="text-align: center;">15</td> <td style="text-align: center;">23</td> </tr> </tbody> </table> (Ministry of Health and Welfare. 2006 National Oral Health Survey data in 2007)				Total	Boy	Girl	2 yrs	13	9	32	3 yrs	27	15	23								
	Total	Boy	Girl																						
2 yrs	13	9	32																						
3 yrs	27	15	23																						
<b>Proximal caries suspected tooth</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	※ List of examination ① Dental caries: tooth with cavity. ② Proximal caries suspected tooth: Interdental cavity suspected tooth. ③ Repaired tooth: Tooth repaired by capping with gold, resin, or amalgam to remedy cavity.																						
<b>Repaired tooth</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes																							

#### Examination of other parts

Dental health test	Dental caries	Residual food and dental plaque	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Needs improvement
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### Results and Recommendation

<b>Results</b>		<input type="checkbox"/> Normal A <input type="checkbox"/> Normal B <input type="checkbox"/> Observe caution <input type="checkbox"/> Needs treatment	
<b>Recommendation</b>	Dental health education needed	Follow-up management required	
	<input type="checkbox"/> Sugar intake (nutrition) <input type="checkbox"/> Oral hygiene <input type="checkbox"/> Use fluoride	<input type="checkbox"/> Detailed oral examination (e.g., radiation test, etc.) <input type="checkbox"/> Professional oral hygiene needed. <input type="checkbox"/> Special prevention (filling, coating fluoride, etc.) <input type="checkbox"/> Oral disease treatment (dental caries, etc.)	
<b>Additional recommendation</b>			
<b>Explanation of results</b>			

Dental institution code		Examining clinic		Examining dentist	(signature)
Examination date	(year)	(month)	(date)	License No.	

※ This dental health screening is designed to detect and treat cavities. Therefore, not all diseases can be identified from this screening. It is advised to consult with a dentist as recommended.

## Results of Infant/Toddler Dental Health Screening

(This result is for infants/toddlers between 42 months to 53 months of age.)

Name		Residential ID No.	- 3(4)
Address		Contact information	

### Screening test results

(Dental) medical history	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Oral health habits	Sugar intake	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Awareness about oral health	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Oral hygiene	<input type="checkbox"/> No	<input type="checkbox"/> Yes
				Use of fluoride	<input type="checkbox"/> No	<input type="checkbox"/> Yes

### Oral examination results

Section	Disease	List	Results	Note																									
<b>Tooth test</b>	<b>Dental caries (cavity)</b>	<b>Teeth condition</b>																											
		<table border="1" style="width: 100%; border-collapse: collapse; margin: 0 auto;"> <tr> <td style="width: 5%;">16</td><td style="width: 5%;">55</td><td style="width: 5%;">54</td><td style="width: 5%;">53</td><td style="width: 5%;">52</td><td style="width: 5%;">51</td><td style="width: 5%;">61</td><td style="width: 5%;">62</td><td style="width: 5%;">63</td><td style="width: 5%;">64</td><td style="width: 5%;">65</td><td style="width: 5%;">26</td> </tr> <tr> <td>46</td><td>85</td><td>84</td><td>83</td><td>82</td><td>81</td><td>71</td><td>72</td><td>73</td><td>74</td><td>75</td><td>36</td> </tr> </table>			16	55	54	53	52	51	61	62	63	64	65	26	46	85	84	83	82	81	71	72	73	74	75	36	
		16	55	54	53	52	51	61	62	63	64	65	26																
		46	85	84	83	82	81	71	72	73	74	75	36																
		<b>Indication</b>	<b>Cavity</b>	<b>● Cavity suspected</b>	<b>● Repaired</b>	<b>F Filling</b>	<b>Se</b>																						
		<b>Dental caries</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes		※ Milk tooth caries incident rate (2006/%) <table border="1" style="width: 100%; border-collapse: collapse; margin: 5px auto;"> <tr> <td></td> <td style="text-align: center;">Total</td> <td style="text-align: center;">Boy</td> <td style="text-align: center;">Girl</td> </tr> <tr> <td style="text-align: center;">2 yrs</td> <td style="text-align: center;">13</td> <td style="text-align: center;">9</td> <td style="text-align: center;">32</td> </tr> <tr> <td style="text-align: center;">3 yrs</td> <td style="text-align: center;">27</td> <td style="text-align: center;">15</td> <td style="text-align: center;">23</td> </tr> </table> (Ministry of Health and Welfare. 2006 National Oral Health Survey data in 2007) ※ List of examination ① Dental caries: tooth with cavity. ② Proximal caries suspected tooth: Interdental cavity suspected tooth. ③ Repaired tooth: Tooth repaired by capping with gold, resin, or amalgam to remedy cavity.				Total	Boy	Girl	2 yrs	13	9	32	3 yrs	27	15	23										
	Total	Boy	Girl																										
2 yrs	13	9	32																										
3 yrs	27	15	23																										
<b>Proximal caries suspected tooth</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes																												
<b>Repaired tooth</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes																												
<b>Tooth at risk of caries</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes																												
<b>Examination of other parts</b>																													
<b>Dental health test</b>	<b>Dental caries</b>	<b>Residual food and dental plaque</b>	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Needs improvement																										
<b>Results and Recommendation</b>																													
<b>Results</b>		<input type="checkbox"/> Normal A <input type="checkbox"/> Normal B <input type="checkbox"/> Observe caution <input type="checkbox"/> Needs treatment																											
<b>Recommendation</b>	Dental health education needed	Follow-up management required		Additional recommendation																									
	<input type="checkbox"/> Sugar intake(nutrition)	<input type="checkbox"/> Detailed oral examination (e.g., radiation test, etc.)																											
	<input type="checkbox"/> Oral hygiene	<input type="checkbox"/> Professional oral hygiene needed.																											
<input type="checkbox"/> Use fluoride	<input type="checkbox"/> Special prevention (filling, coating fluoride, etc.)																												
<b>Explanation of results</b>																													

Dental institution code		Examining clinic		Examining dentist	(signature)
Examination date	(year)	(month)	(date)	License No.	

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## Results of Infant/Toddler Dental Health Screening

(This result is for infants/toddlers between 54 months to 65 months of age.)

Name		Residential ID No.	- 3(4)
Address		Contact information	

Screening test results						
(Dental) medical history	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Oral health habits	Sugar intake	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Awareness about oral health	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Oral hygiene	<input type="checkbox"/> No	<input type="checkbox"/> Yes
				Use of fluoride	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Oral examination results						

Section	Disease	List	Results	Note																																																	
<b>Tooth test</b>	<b>Dental caries (cavity)</b>	<b>Teeth condition</b>																																																			
					<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td></td><td></td><td></td><td></td><td style="text-align: center;">12</td><td style="text-align: center;">11</td><td style="text-align: center;">21</td><td style="text-align: center;">22</td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: center;">16</td><td style="text-align: center;">55</td><td style="text-align: center;">54</td><td style="text-align: center;">53</td><td style="text-align: center;">52</td><td style="text-align: center;">51</td><td style="text-align: center;">61</td><td style="text-align: center;">62</td><td style="text-align: center;">63</td><td style="text-align: center;">64</td><td style="text-align: center;">65</td><td style="text-align: center;">26</td> </tr> <tr> <td style="text-align: center;">46</td><td style="text-align: center;">85</td><td style="text-align: center;">84</td><td style="text-align: center;">83</td><td style="text-align: center;">82</td><td style="text-align: center;">81</td><td style="text-align: center;">71</td><td style="text-align: center;">72</td><td style="text-align: center;">73</td><td style="text-align: center;">74</td><td style="text-align: center;">75</td><td style="text-align: center;">36</td> </tr> <tr> <td></td><td></td><td></td><td></td><td style="text-align: center;">42</td><td style="text-align: center;">41</td><td style="text-align: center;">31</td><td style="text-align: center;">32</td><td></td><td></td><td></td><td></td> </tr> </table>					12	11	21	22					16	55	54	53	52	51	61	62	63	64	65	26	46	85	84	83	82	81	71	72	73	74	75	36					42	41	31	32				
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		46	85	84	83	82	81	71	72	73	74	75	36																																								
				42	41	31	32																																														
<b>Indication</b>	<b>Cavity</b>	●	<b>Cavity suspected</b>	●	<b>Repaired</b>	<b>F</b>	<b>Filling</b>	<b>Se</b>																																													
<b>Dental caries</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	※ Milk tooth caries incident rate (2006/%)																																																		
<b>Proximal caries suspected tooth</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td></td><td style="text-align: center;">Total</td><td style="text-align: center;">Boy</td><td style="text-align: center;">Girl</td> </tr> <tr> <td style="text-align: center;">2 yrs</td><td style="text-align: center;">13</td><td style="text-align: center;">9</td><td style="text-align: center;">32</td> </tr> <tr> <td style="text-align: center;">3 yrs</td><td style="text-align: center;">27</td><td style="text-align: center;">15</td><td style="text-align: center;">23</td> </tr> </table>					Total	Boy	Girl	2 yrs	13	9	32	3 yrs	27	15	23																																			
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3 yrs	27	15	23																																																		
<b>Repaired tooth</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(Ministry of Health and Welfare. 2006 National Oral Health Survey data in 2007)																																																		
<b>Tooth at risk of caries</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	※ List of examination																																																		
<b>Examination of other parts</b>																																																					
<b>Dental health test</b>	<b>Dental caries</b>	<b>Residual food and dental plaque</b>	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Needs improvement																																																		
Results and Recommendation																																																					
<b>Results</b>			<input type="checkbox"/> Normal A <input type="checkbox"/> Normal B <input type="checkbox"/> Observe caution <input type="checkbox"/> Needs treatment																																																		
<b>Recommendation</b>	Dental health education needed	Follow-up management required			Additional recommendation																																																
	<input type="checkbox"/> Sugar intake (nutrition) <input type="checkbox"/> Oral hygiene <input type="checkbox"/> Use fluoride	<input type="checkbox"/> Detailed oral examination (e.g., radiation test, etc.) <input type="checkbox"/> Professional oral hygiene needed. <input type="checkbox"/> Special prevention (filling, coating fluoride, etc.) <input type="checkbox"/> Oral disease treatment (dental caries, etc.)																																																			
<b>Explanation of results</b>																																																					

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