Hepatitis B (B 型肝炎) vaccine: Vaccination Register and Screening Questionnaire													
Address		北区											
Patient's name				л Da	Date of birth:								
			F	Aç	ge:	years	mor	nths	対象年齢				
Parent/guardian name			Pho	one					-				
Vaccination history First vaccination received (years months)													
Please fill in the question items in the bold box below and circle one of the answer columns. Body temperature before intervi										riew			°C
Questionnaire for Vaccination									Ans	swer	Doct		
Have you read the document (sent to you previously from your city) about the vaccination that will be administered today?									No	Yes	001111	non.	
Was your child born to a mother who tested positive for hepatitis B virus?								Yes*	No				
Please answer about your child's development history.													
Birth weight () gram Did the child have abnormal findings at delivery?										Yes	No		
	Did the child have any abnormal findings after birth?									Yes	No		
Have you ever been told any abnormal findings at an infant health check?									Yes	No			
4 1	Is the child sick today? 4. Is the child sick today?									Yes	No		
	If so, describe the specific symptoms. (163	NO		
5. [Did the child have a disease within the last one month? Name of disease (Yes	No		
6. H	Has any family member or friend of the child had disease such as measles, rubella, chickenpox or mumps within one month?									Yes	No		
١	Name of disease: (
7. H	. Has the child been vaccinated in the past month?									Yes	No		
1	Name of vaccination (Date of vaccination; /)												
8. Does the child have a congenital anomaly, heart, kidney, liver, central nerve disease, immune deficiency, or any other diseases for which you										Yes	No		
h	have consulted a doctor? Name of disease (
ŀ	Has the doctor treating disease told you that the child could have the vaccination today?										No		
9. A	Are you currently taking any special medication, such as steroids or immunosuppressants									Yes	No		
10. H	10. Has the child had a seizure (spasm or fit) in the past? If Yes: age () years old.								Yes	No			
Did the child have a fever at that time?									Yes	No			
11. H	11. Has the child ever had a rash or hives or become ill because of the medications or food?									Yes	No		
12. Does the child have a family member or relative with a congenital immunodeficiency?									Yes	No			
13. H	3. Has the child ever become ill after the vaccination?									Yes	No		
14. H	4. Has any family member or relative of the child had a serious reaction to a vaccination in the past?								Yes	No			
15. [Do you have any question about the vaccination?									Yes	No		
医 2	2 * に該当する場合	合、母子感染予防に係る保険診療のため、定期予防	接種の)対象外で	であるこ	ことを説明しまし	 ,た。						
師の	保護者に対して、予	予防接種の効果、副反応及び予防接種健康被害救済	制度に	ついて、	説明を	をしました。							
入 [*]	以上の問診及び診察	冬の結果、今日の予防接種は (実施できる ・	見合				ンます。						
欄													
2 my column for parcing daratam								所・接種	重医師名				
I have been interviewed and explained by the doctor. I have understood the benefit, objectives, and risk of serious side effects, and also the Relief				(注)有効期限が切れていないか要確認									
							#B 5 2 -						
System for Health Damage by Vaccination. Now, I confirm my intent on taking vaccination as follows.				□ビームゲン 0.25mL 実施機関名・伯□ビームゲン 0.5mL 〒114-0003					幾関名・住所・電 114-0003	・电砧笛写			
(Agree · Not agree)				□ヘプタバックス-II 東京都北区					京都北区豊島 5	島 5-5-5-107			
This screening questionnaire is used to improve the safety of vaccination.				ロヘプタバックフ(されいご) 0.25)					しま町クリニッ	ク			
		nd agree that this questionnaire can be submitted		電話 03-3927-3						78			
la, , , , , , , , , , , , , , , , , , ,					(注)有効期限が切れていないかを要確認 接種医 接種部位				医師名				
		·		左・右	·····	上腕・カ	大腿	接種	(予診) 年月日		年	月	日