

2011



# Health Administration Survey for Prefectural Residents

## Questionnaire for Pregnancy and birth survey

The nuclear disaster accompanying the recent earthquake and tsunami has caused a great deal of anxiety and stress, with many people forced to lead dramatically altered lifestyles in evacuation shelters and temporary housing. In particular, pregnant women and nursing mothers have been unable to obtain adequate health care for themselves and their babies, due to changes to hospitals and clinics that prevent them from having periodical medical examinations.

The Fukushima Prefectural Government has therefore commissioned Fukushima Medical University to conduct a questionnaire of **pregnant women and nursing mothers in Fukushima** as part of the Health Administration Survey for Prefectural Residents, **with the aim of assessing their physical condition to assist in future health care delivery.**

This questionnaire booklet is being distributed to women who received a 'Maternal and Child Health Handbook' between August 1, 2010 and July 31, 2011 from a municipality in Fukushima Prefecture, and women who received a 'Maternal and Child Health Handbook' from a municipality outside of Fukushima Prefecture but who underwent an obstetric exam or gave birth after relocating or returning to Fukushima on or after March 11, 2011.

Any personal information that you provide in this questionnaire will be used by Fukushima Prefecture to administer health care and may also be shared with your local municipal government where necessary, with findings reported only as part of an aggregate analysis. However, none of this information will be disclosed in a manner that reveals your identity.

Please return your completed questionnaire form within approximately 2 weeks of receipt. Any queries should be directed to the contacts listed on the back of this booklet.

Fukushima Prefecture  
Fukushima Medical University

Please fill out all of the items below and place a tick (✓) in the appropriate box.

Date (YY/MM/DD): 2012/     /	Respondent (tick (✓) the relevant box below): <input type="checkbox"/> Yourself <input type="checkbox"/> Proxy (Relationship:                      )
Name: _____	
Date of birth (YY/MM/DD): <input type="checkbox"/> Showa <input type="checkbox"/> Heisei    ____/____/____	
Contact address (so that survey officers can contact you directly to confirm any questionnaire omissions):  Tel: _____-_____-_____ (Care of: _____) Mobile: _____-_____-_____	

**Please proceed to the questionnaire starting on the next page after completing all of the items above.**

**All of the following questions are intended for women who received a Maternal and Child Health Handbook ('Maternity Handbook') between August 1, 2010 and July 31, 2011.**

**Q1. About previous pregnancy and childbirth**

Please indicate the number of your previous pregnancies, child births, miscarriages, induced abortions, and stillbirths, not including the pregnancy for the abovementioned Maternity Handbook. Write '0' if you have not experienced any of the above.

Total of  pregnancies

including  childbirths  miscarriages  induced abortions  stillbirths

**Reference 1**

1 month pregnant: gw\* 0 – 3

2 months pregnant: gw 4 – 7

3 months pregnant: gw 8 – 11

4 months pregnant: gw 12 – 15

5 months pregnant: gw 16 – 19

6 months pregnant: gw 20 – 23

7 months pregnant: gw 24 – 27

8 months pregnant: gw 28 – 31

9 months pregnant: gw 32 – 35

10 months pregnant: gw 36 – 39

11 months pregnant: gw 40 – 43

\* gestational week

**Reference 2**

Miscarriage: termination of pregnancy before gestational week (gw) 22

Induced abortion: artificial termination of pregnancy before gw 22

Stillbirth: delivery of a deceased fetus from gw 22 onwards

Childbirth: delivery of a newborn from gw 22 onwards

Q2. 1) Describe your pregnancy corresponding to the above-mentioned Maternal Handbook

In the table below, tick (✓) the relevant boxes and fill out the necessary details regarding the course and outcome of your pregnancy as well as your primary care physician.

Type	<input type="checkbox"/> Natural pregnancy <input type="checkbox"/> Induced ovulation <input type="checkbox"/> Artificial insemination <input type="checkbox"/> In vitro fertilization		
Outcome	<input type="checkbox"/> Still pregnant	Expected delivery: YY/MM/DD:    /    / <input type="checkbox"/> Unknown	weeks
	Outcome	Date at end of pregnancy (YY/MM/DD)	Duration of pregnancy (gw)
	<input type="checkbox"/> Childbirth	/    /	weeks
	<input type="checkbox"/> Miscarriage	/    /	weeks
	<input type="checkbox"/> Abortion	/    /	weeks
	<input type="checkbox"/> Stillbirth	/    /	weeks
Hospital/ clinic listed on Maternal Handbook	Name: _____ Address: _____ Metropolis/ Prefecture Ward/ City Town/ Village		
	Complete the section below when delivering at a different hospital/clinic to that listed above. Name: _____ Address: _____ Metropolis/ Prefecture Ward/ City Town/ Village		

Respondents who ticked box 1 are requested to answer Q3-9 (where applicable) to the best of their ability.

Respondents who ticked box 2 are requested to answer all questions below.

Respondents who ticked boxes 3, 4 or 5 are requested to answer Q3-12 (where applicable) to the best of their ability.

2) Were you breastfeeding your baby at 11 March 2011?

<input type="checkbox"/> No <input type="checkbox"/> Yes
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3) Have you often felt sad or depressed over the past month?

<input type="checkbox"/> No <input type="checkbox"/> Yes
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4) Have you often felt disinterested in things or not able to enjoy yourself over the past month?

<input type="checkbox"/> No <input type="checkbox"/> Yes
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**Questions 3-9 below relate to matters during your pregnancy. Please answer to the best of your ability.**

Q3. How many children were you pregnant with? (i.e. delivered babies including stillbirths)

$$_1 \square \quad 1 \text{ (single pregnancy)} \quad _2 \square \quad 2 \text{ (twins)}$$

Q4. Describe your obstetric exams after the disaster.

Did you continue attending the same facility that you originally intended to visit for obstetric exams/delivery?

1 ☐ No    2 ☐ Yes

1 ☐ I changed to a different facility within Fukushima of my own accord.

2 ☐ I changed to a different facility outside Fukushima of my own accord.

3 ☐ I attended a different facility in Fukushima from before the disaster after returning to my parents/in-laws home to give birth

4 ☐ I attended a different facility outside Fukushima from before the disaster after returning to my parents/in-laws home to give birth

5 ☐ I was instructed to transfer (or was transferred) to a different facility in Fukushima for medical reasons

6 ☐ I was instructed to transfer (or was transferred) to a different facility outside Fukushima for medical reasons

Q5. Could you undergo obstetric exams as scheduled?

1 ☐ No    2 ☐ Yes

1 ☐ I could not undergo obstetric exams as scheduled and had to be hospitalized as a result

2 ☐ I could not undergo obstetric exams as scheduled, but my pregnancy proceeded without any problems

Q6. Did you ever suffer from any of the following diseases **before your pregnancy**?

1 ☐ Yes      2 ☐ No

Please specify which of the following disease(s) you had by placing a tick (✓) in all applicable boxes.

1 ☐ High blood pressure    2 ☐ Diabetes    3 ☐ Hyperlipidemia    4 ☐ Cancer  
5 ☐ Stroke (cerebral infarction/cerebral hemorrhage/subarachnoid hemorrhage)  
6 ☐ Heart disease (myocardial infarction/angina)    7 ☐ Chronic hepatitis  
8 ☐ Pneumonia    9 ☐ Thyroid disease    10 ☐ Mental illness  
11 ☐ Other ( )



**This completes the questionnaire for respondents who are still pregnant. Please return the booklet in the return envelope provided.**

**Questions 10-12 below are intended for women who delivered from gestational week (gw) 12 (4<sup>th</sup> month) onwards (including full term delivery, miscarriage before gw 22, artificial termination of pregnancy, and still/live birth from gw 22 onwards).**

**The questions relate to both yourself and your baby. Please complete the relevant sections to the best of your ability while referring to your Maternity Handbook.**

**Q10. What position was the baby delivered in?**

- ☐ <sub>1</sub> Head presentation (delivered head first)      ☐ <sub>2</sub> Pelvic presentation  
☐ <sub>3</sub> Other      ☐ <sub>4</sub> Not sure

In the case of twins, please describe the position of the second child.

- ☐ <sub>1</sub> Head presentation (delivered head first)      ☐ <sub>2</sub> Pelvic presentation  
☐ <sub>3</sub> Other      ☐ <sub>4</sub> Not sure

**Q11. What day/week of pregnancy was the baby delivered?**

☐ day, ☐ ☐ week of pregnancy

- ☐ <sub>1</sub> Natural delivery (including use of labor-inducing drugs)      ☐ <sub>2</sub> Forceps/vacuum extraction  
☐ <sub>3</sub> Caesarean section

In the case of twins, please describe the position of the second child.

- ☐ <sub>1</sub> Natural delivery (including use of labor-inducing drugs)      ☐ <sub>2</sub> Forceps/vacuum extraction  
☐ <sub>3</sub> Caesarean section



Q12. Please describe your baby's appearance and condition at delivery (refer to your Maternal Handbook for the section outlined in bold)

In the case of twins, please use the 'First child' and 'Second child' columns.

First child		Second child	
Sex  _1 <input type="checkbox"/> Male  _2 <input type="checkbox"/> Female		Sex  _1 <input type="checkbox"/> Male  _2 <input type="checkbox"/> Female	
Weight  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> g	Height  <input type="text"/> <input type="text"/> . <input type="text"/> cm	Weight  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> g	Height  <input type="text"/> <input type="text"/> . <input type="text"/> cm
Chest circumference  <input type="text"/> <input type="text"/> . <input type="text"/> cm	Head circumference  <input type="text"/> <input type="text"/> . <input type="text"/> cm	Chest circumference  <input type="text"/> <input type="text"/> . <input type="text"/> cm	Head circumference  <input type="text"/> <input type="text"/> . <input type="text"/> cm
Neonatal asphyxia  _1 <input type="checkbox"/> Yes    _2 <input type="checkbox"/> No  If yes, was the baby resuscitated?  _1 <input type="checkbox"/> Yes    _2 <input type="checkbox"/> No    _3 <input type="checkbox"/> Not sure		Neonatal asphyxia  _1 <input type="checkbox"/> Yes    _2 <input type="checkbox"/> No  If yes, was the baby resuscitated?  _1 <input type="checkbox"/> Yes    _2 <input type="checkbox"/> No    _3 <input type="checkbox"/> Not sure	
Congenital deformity/abnormality  _1 <input type="checkbox"/> Yes    _2 <input type="checkbox"/> No  If yes, please specify below:  _1 <input type="checkbox"/> Cataract  _2 <input type="checkbox"/> Cardiac malformation  _3 <input type="checkbox"/> Kidney/urinary tract malformation  _4 <input type="checkbox"/> Spina bifida (disease involving a hole in the spine)  _5 <input type="checkbox"/> Microcephaly  _6 <input type="checkbox"/> Hydrocephalus  _7 <input type="checkbox"/> Cleft lip/palate  _8 <input type="checkbox"/> Intestinal atresia (esophagus/duodenum/ileum)  _9 <input type="checkbox"/> Imperforate anus  _10 <input type="checkbox"/> Polydactylism/syndactylism  _11 <input type="checkbox"/> Other  ( )		Congenital deformity/abnormality  _1 <input type="checkbox"/> Yes    _2 <input type="checkbox"/> No  If yes, please specify below:  _1 <input type="checkbox"/> Cataract  _2 <input type="checkbox"/> Cardiac malformation  _3 <input type="checkbox"/> Kidney/urinary tract malformation  _4 <input type="checkbox"/> Spina bifida (disease involving a hole in the spine)  _5 <input type="checkbox"/> Microcephaly  _6 <input type="checkbox"/> Hydrocephalus  _7 <input type="checkbox"/> Cleft lip/palate  _8 <input type="checkbox"/> Intestinal atresia (esophagus/duodenum/ileum)  _9 <input type="checkbox"/> Imperforate anus  _10 <input type="checkbox"/> Polydactylism/syndactylism  _11 <input type="checkbox"/> Other  ( )	

**This completes the questionnaire for women who suffered a miscarriage, abortion, or stillbirth.  
Please return the booklet in the return envelope provided.**

**Women who gave birth should proceed to the next page.**

**The following questions are for women who gave birth.**

Q13. How have you fed your baby up until now? (i.e. until starting solids)

1 ☐ Breast milk only      2 ☐ Mixture of breast milk & infant formula      3 ☐ Infant formula only



1) For women who used infant formula, please state the reason why you chose it?

1 ☐ Insufficient breast milk  
 2 ☐ Fear of radioactive contamination of breast milk  
 3 ☐ Other reason (Please specify: \_\_\_\_\_ )

2) What type of water do you use to prepare the infant formula?

1 ☐ Tap water      2 ☐ Mineral water      3 ☐ Other ( \_\_\_\_\_ )

Q14. Were you unable to provide proper nutrition to your baby as a result of the disasters? (e.g. reduced breast milk production due to inadequate nutritional intake, or difficulty obtaining infant formula due to supply shortages)

1 ☐ Yes      2 ☐ No      3 ☐ Not sure

Q15. This question is for women who have undergone their 1-month post-natal health check.

Please describe your baby's development.

In the case of twins, please use the 'First child' and 'Second child' columns.

First child		Second child	
Underwent 1-month post-natal health check at <input type="text"/> <input type="text"/> days, <input type="text"/> months after birth		Underwent 1-month post-natal health check at <input type="text"/> <input type="text"/> days, <input type="text"/> months after birth	
Weight <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> g	Height <input type="text"/> <input type="text"/> . <input type="text"/> cm	Weight <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> g	Height <input type="text"/> <input type="text"/> . <input type="text"/> cm
Chest circumference <input type="text"/> <input type="text"/> . <input type="text"/> cm	Head circumference <input type="text"/> <input type="text"/> . <input type="text"/> cm	Chest circumference <input type="text"/> <input type="text"/> . <input type="text"/> cm	Head circumference <input type="text"/> <input type="text"/> . <input type="text"/> cm
Nutritional status: 1 <input type="checkbox"/> Good    2 <input type="checkbox"/> Need guidance    3 <input type="checkbox"/> Poor		Nutritional status: 1 <input type="checkbox"/> Good    2 <input type="checkbox"/> Need guidance    3 <input type="checkbox"/> Poor	

**Please provide any comments or requests you may have regarding this survey in the box below.**

A large, empty rectangular box with a thin black border, occupying the upper half of the page. It is intended for the respondent to place the completed questionnaire and the return envelope.

**This completes the questionnaire. Please return the booklet in the return envelope provided.**

## Queries

Radiology Resident Health Care Center, Fukushima Medical University  
Tel: 024-549-5180 (Office hours: 9:00 a.m. - 5:00 p.m.)

## Health Administration Survey for Prefectural Residents



Fukushima Prefectural Government & Fukushima Medical University