This is a sample and cannot be used to fill out the form. There may be minor differences in the layout (e.g. margins) between this sample and the actual questionnaire that was sent to you.

Questionnaire

*We request that this questionnaire be completed by the addressee herself. If the addressee has difficulty completing the questionnaire, her parent or guardian can help or complete the questionnaire. Please send the completed questionnaire back to us using the enclosed return envelope by **September 30, 2015** (no stamp required).

This is an anonymous survey. Respondents' identities will not be disclosed. Please do not leave any personal information (e.g. your name) in any part of the questionnaire. Your answers will be used for statistical analysis only.

This questionnaire has 7 pages in total

Before you start, please check (√) the box indicating who is filling out the questionnaire.

□ Addressee by herself □ Addressee with help from her parent or guardian □ Addressee's parent or guardian

Your age:

Question 1. Please check (√) the appropriate box indicating your (the addressee's) date of birth (your daughter's date of birth when the addressee's parent or guardian is filling out the questionnaire).

□ ① 2 April 1994 - 1 April 1995 □ ② 2 April 1995 - 1 April 1996 □ ③ 2 April 1996 - 1 April 1997

□ ④ 2 April 1997 - 1 April 1998 □ ⑤ 2 April 1998 - 1 April 1999 □ ⑥ 2 April 1999 - 1 April 2000

□ ⑦ 2 April 2000 - 1 April 2001

Questions about physical symptoms:

Please tell us about symptoms that you have experienced.

Question 2. Have you experienced any of the following symptoms during the period from your 6th year of elementary school to the present?

Check (√) the "Yes" box if you have experienced a symptom and check "No" box if you have not.

If you check "Yes" for a symptom, please answer the more detailed questions about the symptom (e.g. When did the symptom start?). If you had a temporary symptom with a known cause (e.g. you had headache due to a cold), please do not tick "Yes".

*If you do not know the exact month when a symptom started, please write the year only.

Symptoms／No・Yes		When did the symptom start?	Did you see a doctor?	Do you still have the symptom?
1 Menstrual irregularity	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
2 Abnormal amounts of menstrual bleeding	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
3 Pain in the joints or other parts of the body	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
4 Severe headache	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
5 Fatigue	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
6 Poor endurance	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
7 Difficulty concentrating	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No

Symptoms／No・Yes		When did the symptom start?	Did you see a doctor?	Do you still have the symptom?
8 Abnormal field of vision (darkened, narrowed, etc.)	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
9 Abnormal sensitivity to light	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
10 Sudden vision loss	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
11 Dizziness	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
12 Cold feet	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
13 Difficulty falling asleep	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
14 Abnormally long duration of sleep	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
15 Skin problems (rashes, warts, etc.)	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
16 Hyperventilation	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
17 Memory decline	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
18 Loss of ability to do simple calculations	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
19 Loss of ability to remember simple Kanji	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
20 Involuntary uncontrollable body movement	□No □Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No

Symptoms／No・Yes			When did the symptom start?	Did you see a doctor?	Do you still have the symptom?
21 Loss of ability to walk in a normal way	□No	□Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
22 Becoming dependent on a walking stick or wheelchair	□No	□Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
23 Sudden loss of strength	□No	□Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
24 Weakness in the hands and feet	□No	□Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
25 Other symptoms（ ）	□No	□Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No
26 Other symptoms（ ）	□No	□Yes⇒	Year ____ Month ____	□Yes □No	□Always □Sometimes □Rarely □No

If you have symptoms other than the above (including 25 and 26), please describe them in detail in the space below.

Question 3. If you checked the “Yes” box for any of the above symptoms in Question 2, please answer the questions below.
Was your school life, after-school club activities, or job-hunting activities affected by the symptom(s)? Please indicate symptoms that had an effect. Please use the numbers of the symptom listed on pages 2-4

（1）Effect on learning at school

□ Affected (①-⑥: multiple answers allowed) □ Not affected

□ ① Absences (frequency: □ more than 2-3 times per week □ about once a week □ about 2-3 times per month □ less than once a month)
Causative symptom(s): ( )

□ ② Being late (frequency: □ more than 2-3 times per week □ about once a week □ about 2-3 times per month □ less than once a month)
Causative symptom(s): ( )

□ ③ Leaving early (frequency: □ more than 2-3 times per week □ about once a week □ about 2-3 times per month □ less than once a month)
Causative symptom(s): ( )

□ ④ Repeating a year in school Causative symptom(s): ( )

□ ⑤ Quitting school Causative symptom(s): ( )

□ ⑥ Changing your career path Causative symptom(s): ( )

（2）Effect on school activities other than studying (e.g. after-school club activities)

□ Affected □ Not affected Causative symptom(s): ( )

（3）Effect on job-hunting activities and employment

□ Affected □ Not affected □ No plan to find a job or be employed Causative symptom(s): ( )

Please describe the details of the effect of symptoms on your school life, after-school club activities and job-hunting activities.

Questions about vaccinations that you have received.

Question 4. Have you received any of the following vaccinations during the period from your 6th year of elementary school to the present? Please check (√) either the "No" or "Yes" box to tell us whether you got vaccinated against the following diseases. If you check "Yes", please indicate the time when you received the vaccination (please see the list of vaccinations attached).

Type of vaccination／No · Yes	Time of immunization *If you do not know the exact month, please write the year only.
1 Cervical cancer □No □Yes⇒	First: Year ＿＿＿ Month ＿＿＿ □Not sure Second: Year ＿＿＿ Month ＿＿＿ □Not sure Third: Year Month □Not sure
2 Japanese encephalitis □No □Yes⇒	First: Year ＿＿＿ Month ＿＿＿ □Not sure Second: Year ＿＿＿ Month ＿＿＿ □Not sure Third: Year Month □Not sure
3 Diphtheria-tetanus combination (DT vaccine) □No □Yes⇒	Year ＿＿＿ Month ＿＿＿ □Not sure
4 Measles-rubella combination (MR vaccine) □No □Yes⇒	Year ＿＿＿ Month ＿＿＿ □Not sure
5 Measles □No □Yes⇒	Year ＿＿＿ Month ＿＿＿ □Not sure
6 Rubella □No □Yes⇒	Year ＿＿＿ Month ＿＿＿ □Not sure
7 Influenza (most recent flu shot) □No □Yes⇒	Year ＿＿＿ Month ＿＿＿ □Not sure □ Almost every year
8 Others (name of vaccines:) □No □Yes⇒	Year ＿＿＿ Month ＿＿＿ □Not sure
9 A vaccine that I can't remember the name of (most recent) □No □Yes⇒	Year ＿＿＿ Month ＿＿＿ □Not sure

Question 5. If you checked the “Yes” box for the cervical cancer vaccination, please answer the following questions.

（1）There are two types of cervical cancer vaccines. Which one did you receive?

□ ① Cervarix (bivalent vaccine)

□ ② Gardasil (quadrivalent)

□ ③ Not sure *Please see the attached document for a description of these two types of vaccines.

（2）If you decided not to complete the vaccination schedule after first or second injection, why did you not complete the vaccination schedule (multiple answers allowed)?

□ ① The injection was more painful than I expected.

□ ② I had side effects (adverse reactions) after the injection.

□ ③ I heard about side effects (adverse reactions) and became concerned.

□ ④ Others（ ）

Question 6. If you would like to leave any comments, please do so in the space below:

This is the end of the questionnaire. Thank you for your cooperation.

*Results of this survey will be released in December 2015

For any inquiries about this questionnaire, please contact:

Nagoya City Immunization Telephone Support: 052-972-3969

Open: 9 a.m.-5:30 p.m. (closed Saturdays, Sundays, national holidays, and year-end/New Year holidays)

*This is an anonymous survey, so Nagoya City cannot contact you regarding the content of the completed questionnaire. Please contact to the nearest public health center if you would like to discuss any issues such as adverse events.

Chikusa Public Health Center 052-753-1982
Higashi Public Health Center 052-934-1218
Kita Public Health Center 052-917-6552
Nishi Public Health Center 052-523-4618
Nakamura Public Health Center 052-481-2295
Naka Public Health Center 052-265-2262
Showa Public Health Center 052-735-3964
Mizuho Public Health Center 052-837-3264
Atsuta Public Health Center 052-683-9683
Nakagawa Public Health Center 052-363-4463
Minato Public Health Center 052-651-6537
Minami Public Health Center 052-614-2814
Moriyama Public Health Center 052-796-4623
Midori Public Health Center 052-891-3623
Meito Public Health Center 052-778-3114
Tempaku Public Health Center 052-807-3912

Open: 8:45 a.m. - 5:15 p.m. (closed Saturdays, Sundays, national holidays, and year-end/New Year holidays)