Leon Springs Pediatrics

Parent Questionnaire

To help our office better serve our families with children under the age of two in the prevention of RSV, please complete this questionnaire.

Child's Name: _____

Date of Birth: _____

1. Please check any of the situations listed below that pertain to your child today or may pertain to your child in the future.

   - o My child is around other children for more than 4 hours per week.
   - o My child attends day care, either in the home, a center, church, or gym.
   - o My child lives with siblings or other children.
   - o My child may be exposed to tobacco smoke, wood burning stoves or kerosene heaters.
   - o My child lives over 30 miles from the nearest hospital.
   - o My child has GERD (gastro esophageal reflux disease).

2. Was your child born early (less than 36 weeks gestation)?

   - Yes (If yes, how many weeks?) _____
   - No

3. Was your child in the neonatal intensive care unit (NICU) after birth?

   - Yes (If yes, how many days?) _____
   - No

4. Has your child ever been hospitalized?

   - Yes (If yes, please explain) _____
   - No

5. Has your child ever had any respiratory problems, family history of asthma, or is your child using regularly or recurrently any steroids (Flovent/ Pulmicort)?

   - Yes (If yes, please explain) _____
   - Medications _____
   - No

6. Does your child have a heart condition?

   - Yes (If yes, please explain) _____
   - No

7. Does your child have a condition of the immune system?

   - Yes (If yes, please explain) _____
   - No

Parent Signature: _____ Date: _____