



PARENT QUESTIONNAIRE

To help our office better serve our families with children under the age of two years in the prevention of RSV (Respiratory Syncytial Virus) (born after 10/01/2008), 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.
 - My child is around other children for more than 4 hours per week.
 - My child attends day care, either in the home, a center, church, or gym.
 - My child lives with siblings or other children.
 - My child may be exposed to tobacco smoke, wood burning stoves or kerosene heaters.
 - My child lives over 30 miles from the nearest hospital.
 - 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.) _____
 - Medication: _____
 - 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.

Printed Name of Parent/Guardian supplying information	Signature of Parent/Guardian