

LAWRENCE OTOLARYNGOLOGY
Child Ear Infection Questionnaire

Patient Name _____

Date _____

1) How do you know when your child has an infection? **(Circle all that apply)**

- A. fussy
- B. pulls at ear(s)
- C. won't eat
- D. runny nose
- E. visible drainage out of ear
- G. fever
- H. none of the above; the doctor tells me
- I. other _____

2) What do you do when your child has an infection?

- A. give a cold medicine
- B. get an antibiotic
- C. other _____

3) Please list the antibiotics you have given your child for ear infections in the last year.

	Name of Medication	Date Started	Date Ended
A.	_____	_____	_____
B.	_____	_____	_____
C.	_____	_____	_____
D.	_____	_____	_____
E.	_____	_____	_____
F.	_____	_____	_____
G.	_____	_____	_____
H.	_____	_____	_____
I.	_____	_____	_____

4) Do you believe your child's hearing is affected? Yes / No

5) Do you believe your child's speech is affected? Yes / No

6) Has your child's eardrum ruptured? Yes / No

7) Does your child have nasal blockage? **(Circle all that apply)**

- A. No
- B. Yes, with snoring
- C. Yes, with mouth breathing
- D. Yes, with snoring and stopping breathing at night

8) Does your child go to sleep with a bottle or pacifier at night or nap time? Yes/No

9) Is your child exposed to tobacco smoke? Yes/No

10) What other family members have had problems with ear infections? **(Circle all that apply)**

- A. mom
- B. dad
- C. sister or brother
- D. aunt
- E. uncle
- F. grandparents

11) Is your child in daycare? Yes/No
How many other children are enrolled? _____