LAWRENCE OTOLARYNGOLOGY
Child Ear Infection Questionnaire
Information must be filled out prior to being seen

Patient Name: _____ Date of Birth: _____ **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.	_____	_____	_____

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? _____