



Patient Name: \_\_\_\_\_  
 Date of Visit \_\_\_\_\_  
 Date of Birth \_\_\_\_\_

## Ear Infections Questionnaire

**History:**

Select all symptoms that the patient has experienced while having an ear infection.

**Scale of symptom severity:**

	1: very mild	2: mild	3: moderate	4: severe	5: very severe
Ear Fullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Discharge/Purulence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever (Acute Only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Drum Rupture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Associated Factors</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper respiratory infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EAR INFECTIONS	Six Months	One Year
How many ear infections has the patient had in the last		
How many time have antibiotics been used as treatment in the last		
How many times has the ear drum ruptured in the last		

### History of Medical Treatment:

Decogestants/Mucolytic/Antihistamines	Helped	Did not help
Sudafed or similar over the counter medications		
Robitussin or combination of robitussin		
Clarinetx/Claritin		
Allegra		
Zyrtec liq		
Tanafed DP, DMX,		
Tussi-12S		
Other: _____		
Intranasal or Oral Steroids	Helped	Did not help
Astepro/Astelin		
Flonase		
Nasonex		
Rhinocort AQ		
Nasacort AQ		
Veramyst		
Other: _____		

Antibiotics	How many Days did you take?	How many times did you take?	Did it help you?
Amoxicillin			
Augmentin			
Bactrim DS			
Biaxin			
Cedax			
Ceftin			
Cefzil			
Omnicef			
Zithromax			
Other			
IV Medications:			

### Allergy History:

Symptoms	Yes	No
Sneezing		
Clear Nasal Discharge		
Milk Allergy		
Symptoms all-year-round		
Symptoms are seasonal <input type="checkbox"/> Spring <input type="checkbox"/> Fall		

### EXPOSURE & PERSONAL HISTORY

- Is the patient exposed to cigarette smoke?  Yes  No
- Is the patient enrolled in day care or babysitting?  Yes  No
- Is the patient is a child, did the child have any complications at birth?  Yes  No
- Did the child have to be exposed to any IV medications?  Yes  No