

NAME (optional): _____

Date: _____

OTITIS MEDIA QUALITY OF LIFE SURVEY

Instructions: Please help us understand the impact of ear infections on your child's quality of life by checking one box [x] for each question below. Thank You!

1. **PHYSICAL SUFFERING:** Ear pain, ear discomfort, ear discharge, ruptured ear drum, high fever, or poor balance. How much of a problem for your child during the past 4 weeks?

- | | | |
|---|---|--|
| <input type="checkbox"/> Not present / no problem | <input type="checkbox"/> Hardly a problem at all
<input type="checkbox"/> Somewhat of a problem
<input type="checkbox"/> Moderate problem | <input type="checkbox"/> Quite a bit of a problem
<input type="checkbox"/> Very much of a problem
<input type="checkbox"/> Extreme problem |
|---|---|--|

2. **HEARING LOSS:** Difficulty hearing, question must be repeated, frequently says "what," or television is excessively loud. How much of a problem for your child during the past 4 weeks?

- | | | |
|---|---|--|
| <input type="checkbox"/> Not present / no problem | <input type="checkbox"/> Hardly a problem at all
<input type="checkbox"/> Somewhat of a problem
<input type="checkbox"/> Moderate problem | <input type="checkbox"/> Quite a bit of a problem
<input type="checkbox"/> Very much of a problem
<input type="checkbox"/> Extreme problem |
|---|---|--|

3. **SPEECH IMPAIRMENT:** Delayed speech, poor pronunciation, difficult to understand, or unable to repeat words clearly. How much of a problem for your child during the past 4 weeks?

- | | | |
|---|---|--|
| <input type="checkbox"/> Not present / no problem | <input type="checkbox"/> Hardly a problem at all
<input type="checkbox"/> Somewhat of a problem
<input type="checkbox"/> Moderate problem | <input type="checkbox"/> Quite a bit of a problem
<input type="checkbox"/> Very much of a problem
<input type="checkbox"/> Extreme problem |
|---|---|--|

4. **EMOTIONAL DISTRESS:** Irritable, frustrated, sad, restless, or poor appetite. How much of a problem for your child during the past 4 weeks as a result of ear infections or fluid?

- | | | |
|---|---|--|
| <input type="checkbox"/> Not present / no problem | <input type="checkbox"/> Hardly a problem at all
<input type="checkbox"/> Somewhat of a problem
<input type="checkbox"/> Moderate problem | <input type="checkbox"/> Quite a bit of a problem
<input type="checkbox"/> Very much of a problem
<input type="checkbox"/> Extreme problem |
|---|---|--|

5. **ACTIVITY LIMITATIONS:** Playing, sleeping, doing things with friends / family, attending school or day care. How limited have your child's activities been during the past 4 weeks because of ear infections or fluid?

- | | | |
|---|---|--|
| <input type="checkbox"/> Not present / no problem | <input type="checkbox"/> Hardly a problem at all
<input type="checkbox"/> Somewhat of a problem
<input type="checkbox"/> Moderate problem | <input type="checkbox"/> Quite a bit of a problem
<input type="checkbox"/> Very much of a problem
<input type="checkbox"/> Extreme problem |
|---|---|--|

6. **CAREGIVER CONCERNS:** How often have you, as a caregiver, been worried, concerned, or inconvenienced because of your child's ear infections or fluid over the past 4 weeks?

- | | | |
|---|---|--|
| <input type="checkbox"/> Not present / no problem | <input type="checkbox"/> Hardly a problem at all
<input type="checkbox"/> Somewhat of a problem
<input type="checkbox"/> Moderate problem | <input type="checkbox"/> Quite a bit of a problem
<input type="checkbox"/> Very much of a problem
<input type="checkbox"/> Extreme problem |
|---|---|--|