

Richard W. Waguespack, MD

PEDIATRIC OTOLOGIC (Ear) QUESTIONNAIRE

Name: _____

Date: _____

Please print and complete to help us to obtain your child's history.

Please circle response:

Yes No Is there any apparent cause for your child's ear problem?

Right Left Which ear is involved? (Right and/or Left ear)

Yes No Repeated episodes of **ear infection** (otitis media)? How many times? _____
For how long? _____

Yes No Continuous **ear fluid** (effusion)? For how long? _____

Yes No Is there **smoking** in the household?

Yes No Is your child in a **day-care** setting?

Yes No Is there a personal or family history suggestive of **allergy**?

Yes No Have there been many **nasal or sinus** infections?

Yes No Is there a history of significant **snoring** or mouth-breathing?

Yes No Have there been many tonsil or **throat infections**?

Yes No Have any **x-rays** of the adenoids or sinuses been performed?
If yes, when and where were they done and what did they show? _____

Yes No Does your child go to bed with a bottle?

Yes No Is there any delay in your child's speech and **language development**?

Right Left Is there a **hearing problem**? (Right and/or Left ear)

Yes No Has your child had a hearing test? If yes, when and what were the results?

Yes No Is there any history of **family** members with hearing loss? What type? _____

Please list **all medicines** given for your child's ear problem. None

Comments: