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Today's Date

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Audit serial number

Child's age: ..... years ..... months .....

**STAFF CHECK!** - Is this parent participating in an audit (OM2-13)? This is the **outcomes questionnaire** for audit. The indicators questionnaire giving standard criteria for surgical intervention (OM2-9) looks similar.

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Please affix Hospital Sticker or write Name and Hospital Number before giving to Parent for completion

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This identification must be removed after computer entry of the questionnaire so this paper version may be briefly stored as back-up



# Impact from ear and hearing problems

## OM2-13<sup>©</sup>

# Parent\* questionnaire

**\* For parents or other regular caregivers of children aged between 3<sup>rd</sup> and 8<sup>th</sup> birthdays who may have OME ("glue ear")**

- ◆ This questionnaire summarises the most common ways that ear and hearing problems can affect a child and family. Doctors can give a better service if they have this information in a standard form. It is appropriate in possible "glue ear" (otitis media with effusion) and repeated ear infections, not in permanent deafness.



### How to complete this questionnaire

- ◆ For each question, please tick **ONE** box, beside the description that *best fits* your child (even if the wording does not seem perfect, or you feel that further things could be said).
- ◆ Please be aware that the time period the question refers to is the last 3 months, and answer using your memories for this period.
- ◆ Please ignore the columns on the far right of each page "for office use only".
- ◆ To help ensure that this questionnaire will work well for all parents in future, we have put in two feedback questions at the end. Please answer them, too.

# 13 Questions we need answered about your child's health

## Section A: Physical Health

Please bear in mind, all questions refer to the last 3 months

For Office  
Use only



<b>1. Over the last three months, taking everything into account, how would you say that your child's health has been:</b>	
Very good	<input type="checkbox"/>
Good	<input type="checkbox"/>
Fair	<input type="checkbox"/>
Poor	<input type="checkbox"/>
<b>2. How many times has he/she had a cough, cold or sore throat?</b>	
Not at all	<input type="checkbox"/>
Once	<input type="checkbox"/>
2-3 times	<input type="checkbox"/>
4-5 times	<input type="checkbox"/>
6 or more times	<input type="checkbox"/>
<b>3. How many times has he/she had trouble with his/her ears?</b>	
Not at all	<input type="checkbox"/>
Once	<input type="checkbox"/>
2-3 times	<input type="checkbox"/>
4-5 times	<input type="checkbox"/>
6 or more times	<input type="checkbox"/>
<b>4. How many ear infections has he/she had? (i.e. severe pain in his/her ear, possibly with a temperature)</b>	
0	<input type="checkbox"/>
1	<input type="checkbox"/>
2-3	<input type="checkbox"/>
4 or more	<input type="checkbox"/>
Not Sure	<input type="checkbox"/>

PHYS1

PHYS1

PHYS1

PHYS1

PHYS1
Subtotal

## Section B: Developmental Impact

Please bear in mind, all questions refer to the last 3 months

For Office  
Use only



<b>5. How often does he/she seek your attention unnecessarily?</b> (e.g. asking for help for a task he/she can do themselves, demanding to be carried, demanding you to play with them, following you around)		
Less than once a month	<input type="checkbox"/>	
Once a month	<input type="checkbox"/>	
Once a week	<input type="checkbox"/>	
Once a day	<input type="checkbox"/>	
Two or three times a day	<input type="checkbox"/>	
<b>6. How often does he/she whine or moan with little reason?</b>		
Less than once a month	<input type="checkbox"/>	
Once a month	<input type="checkbox"/>	
Once a week	<input type="checkbox"/>	
Once a day	<input type="checkbox"/>	
Two or three times a day	<input type="checkbox"/>	
<b>7. When you <u>take him/her out somewhere</u>, does he/she do what you ask?</b>		
Never	<input type="checkbox"/>	
Sometimes	<input type="checkbox"/>	
Often	<input type="checkbox"/>	
Always	<input type="checkbox"/>	
<b>8. Do you think that the ear, nose or throat problems affect his/her sleep?</b>		
Nearly Always	<input type="checkbox"/>	
Sometimes	<input type="checkbox"/>	
Hardly Ever	<input type="checkbox"/>	
<b>9. If he/she is tired or listless during the day, do you think this happens at the same time as his/her ear, nose or throat condition?</b>		
Almost always	<input type="checkbox"/>	
Sometimes	<input type="checkbox"/>	
Never	<input type="checkbox"/>	
Not Applicable	<input type="checkbox"/>	

DEV1

DEV1

DEV1

insert DEV1 subtotal below

PHYS2

PHYS2

Dev1
Subtotal

PHYS2
Subtotal

**Section C: Impact on parents/regular caregiver\***

\*In this section you may also take account of impact on carers other than yourself  
Please bear in mind, all questions refer to the last 3 months

For Office Use only

<b>10. Have you often felt tired?</b>	
Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
<b>11. Has your child needed more attention than other children?</b>	
Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
<b>12. Has your child been very demanding?</b>	
Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
<b>13. Has it taken a lot of energy to cope?</b>	
Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

↓

DEV2

DEV2

DEV2

DEV2

DEV2
Subtotal

**Questionnaire feedback**

<b>A. Did you find answering these questions:</b>					
Very difficult	<input type="checkbox"/>	Quite difficult	<input type="checkbox"/>	Easy	<input type="checkbox"/>
<b>B. Would you describe your own educational qualifications as:</b>					
Left school before age 15	<input type="checkbox"/>	Usual school exams for age 15-16	<input type="checkbox"/>		
Usual school exams for age 17-18	<input type="checkbox"/>	Further qualification but not university degree	<input type="checkbox"/>		
University degree	<input type="checkbox"/>	Not applicable	<input type="checkbox"/>		

PHYS 1+ PHYS 2 +
Total

DEV1 + DEV2
Total

Information provided by: Child's Mother  Child's Father

Other (please specify).....

**Thank you for completing this questionnaire;  
all information you have given will be treated as confidential.**