# Defining the microorganisms in the middle ear and upper respiratory tract that lead to recurrent ear infections

## Data Collection Form

**History**

<table>
<thead>
<tr>
<th>Child's DOB __ __ / __ __ / __ __</th>
<th>I.D. Number: M G O __ __ __ __</th>
</tr>
</thead>
</table>

**Gender:**  
- [ ] Male  
- [ ] Female

**Identify with being Aboriginal or Torres Straight Islander?**  
- [ ] Yes  
- [ ] No

**Suburb** (where participant lives): ___________________________  
**Postcode:** __________

**Who is providing the information?**  
- [ ] Mother  
- [ ] Father  
- [ ] Grandparent
- [ ] Guardian  
- [ ] Foster Carer  
- [ ] Other_________________

**Is the child currently breastfed?**  
- [ ] Yes  
- [ ] No  
- [ ] N/A  
- [ ] Unknown  
  
  *If Yes:*  
  - [ ] Exclusive  
  - [ ] Partial  
  - [ ] Unknown

  **How old was child when breastfeeding ceased?** ________________  
  - [ ] Unknown

**Is the child attending day care or school?**  
- [ ] Day care  
- [ ] School  
- [ ] Neither
  
  - [ ] N/A  
  - [ ] Unknown

  *If at day care/school, how many hours/wk _________*  
  **What age (in months) did they start day care_________**

**Number of people normally living in your house**  

- **Total number** __ __  
- **Number of children (at or under 5 years of age)** __ __

**Does anyone at home smoke?**  
- [ ] Yes  
- [ ] No  
- [ ] Unknown

  *If yes:*  
  **How many people?** __ __  
  - [ ] Unknown

  *If yes:*  
  **How often do they smoke?**  
  - [ ] Occasionally  
  - [ ] Regularly  
  - [ ] Unknown

  *If yes:*  
  **Does anyone smoke inside your house?**  
  - [ ] Inside  
  - [ ] Outside only  
- [ ] Unknown
Does your child have any chronic illnesses such as:  
If Yes, describe

Ear infection
☐ Yes  ☐ No  ☐ Unknown ______________________________________________________________________

If yes, How many ear infections have they had in total? ________________ ☐ Unknown

Has your child previously had grommets inserted?  ☐ Yes  ☐ No  ☐ Unknown

Has your child previously had their adenoids removed?  ☐ Yes  ☐ No  ☐ Unknown

Asthma  ☐ Yes  ☐ No  ☐ Unknown ______________________________________________________________________

Allergy  ☐ Yes  ☐ No  ☐ Unknown ______________________________________________________________________

Chest problem  ☐ Yes  ☐ No  ☐ Unknown ______________________________________________________________________

Heart problem  ☐ Yes  ☐ No  ☐ Unknown ______________________________________________________________________

Kidney problem  ☐ Yes  ☐ No  ☐ Unknown ______________________________________________________________________

Any other illnesses  ☐ Yes  ☐ No  ☐ Unknown ______________________________________________________________________

Has your child ever been admitted to hospital for infection?  ☐ Yes  ☐ No  ☐ Unknown

Please specify (Hospital, date and site - LRTI, meningitis, gastrointestinal, UTI etc)
________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________

Antibiotic usage during the last month:  ☐ Yes  ☐ No  ☐ Unknown

If yes:  Date started__ __/ __ __/ __ __  Date finished__ __/ __ __/ __ __

Name of Antibiotic given:
☐ Penicillin   ☐ Cephalexin  ☐ Erythromycin
☐ Amoxycillin ☐ Cefaclor    ☐ Roxithromycin
☐ Augmentin   ☐ Ceftriaxone ☐ Azithromycin
☐ Flucloxacillin ☐ Cotrimoxazole ☐ Other____________

GP Name: ___________________________________________________________________________

Practice Name: ______________________________________________________________________

Address: ___________________________________________________________________________
**General health** (on day of surgery)

### Nose

**Any Nasal discharge?**
- Yes
- No
- Unknown

*If Yes, Discharge severity:*
- Mild
- Moderate
- Profuse
- Unknown

*Discharge Colour:*
- Clear
- Opaque
- Yellow/green
- Unknown

### Ear

**Any ear discharge?**
- Yes
- No
- Unknown

*If yes, which ear?*
- Left
- Right
- Both
- Unknown

### General

**Has the child been diagnosed with..**
- Cleft lip/palate?
  - Yes
  - No
  - Unknown
- Immune deficiency?
  - Yes
  - No
  - Unknown
- Any genetic syndrome?
  - Yes
  - No
  - Unknown

### Immunisation Status

Your child's current immunisation status will be checked on the Australian Childhood Immunisation Register

- ACIR checked by (researcher name): ____________________________
- Date ACIR checked __ __ / __ __/____

### Name of Research Staff: ____________________________
**Signature:** ____________________________
**Date of interview** __ __ / __ __/____