

OMQ-14: Quality of Life in children’s ear problems

Questionnaire on impact of ear problems in children 3-9 years*

How parent/caregiver should complete this questionnaire

Some children are more affected than others, and in differing ways. Help can best be given, and improvement best assessed, when this impact is measured in a standard way that bridges these differences. The following 14 questions cover some of the most important ways in which ear problems affect children’s quality of life. For some questions an interpretation may be involved, not just an observation, so an “unsure” response is permitted. But please try to avoid this, by choosing the response that best describes just how affected your child has been over the last 3 months, and placing a tick-mark (✓). On finishing, please check that you have answered all questions. The answers will be kept confidential to the clinic or research team.

All questions refer to the period of the last 3 months.

		FOR OFFICE USE ONLY
1. Over the last three months, taking everything into account, how has your child’s health has been ?		
Very good	<input type="checkbox"/>	
Good	<input type="checkbox"/>	
Only fair, or poor	<input type="checkbox"/>	
2. How many times has he/she had trouble with his/her ears ?		
Not at all	<input type="checkbox"/>	
Once	<input type="checkbox"/>	
2-3 times	<input type="checkbox"/>	
4 or more times	<input type="checkbox"/>	
3. How many ear infections has he/she had ? <i>(i.e. severe pain in his/her ear, possibly with a temperature, smelly discharge in ear canal, or hole in eardrum)</i>		
0	<input type="checkbox"/>	
1	<input type="checkbox"/>	
2-3	<input type="checkbox"/>	
4 or more	<input type="checkbox"/>	

*. Exceptionally, the questionnaire can be used after a child becomes 9 years old (see User Manual)

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4. How many times has he/she had an earache ?	
0	<input type="checkbox"/>
1	<input type="checkbox"/>
2-3	<input type="checkbox"/>
4 or more	<input type="checkbox"/>

5. How would you describe your child's hearing ?	
Normal	<input type="checkbox"/>
Slightly below normal	<input type="checkbox"/>
Poor	<input type="checkbox"/>
Very poor	<input type="checkbox"/>
Not sure	<input type="checkbox"/>

6. Has he/she mis-heard words when not looking at you ?	
No	<input type="checkbox"/>
Rarely	<input type="checkbox"/>
Often	<input type="checkbox"/>
Always	<input type="checkbox"/>
Not sure	<input type="checkbox"/>

7. Has he/she had difficulty hearing when with a <u>group</u> of people ? (ie not one-to-one)	
No	<input type="checkbox"/>
Rarely	<input type="checkbox"/>
Often	<input type="checkbox"/>
Always	<input type="checkbox"/>
Not sure	<input type="checkbox"/>

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8. How long can he/she concentrate on a game or a task you have given him/her to do ?

Up to 2 minutes	<input type="checkbox"/>
Up to 5 minutes	<input type="checkbox"/>
5-10 minutes	<input type="checkbox"/>
10-15 minutes	<input type="checkbox"/>
More than 15 minutes	<input type="checkbox"/>

9. How often does he/she seek your attention unnecessarily ?

(e.g. in an unusually dependent way, asking for help for a task he/she can do alone, demanding to be carried, demanding you 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 more times per day	<input type="checkbox"/>

10. How often is he/she unhappy for no apparent reason ?

Less than once a month	<input type="checkbox"/>
Once a month	<input type="checkbox"/>
Once a week	<input type="checkbox"/>
Once or more per day	<input type="checkbox"/>

11. Has he/she mispronounced the beginnings or ends of words ?

No	<input type="checkbox"/>
Rarely	<input type="checkbox"/>
Often	<input type="checkbox"/>
Always	<input type="checkbox"/>

12. Has his/her speech been behind (less developed than) that of children of similar age ?

No	<input type="checkbox"/>
A little	<input type="checkbox"/>
Moderately or a lot	<input type="checkbox"/>
Not sure	<input type="checkbox"/>

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13. Have you often felt tired ?	
Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

14. Has your child needed more attention than other children ?	
Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

Responding person providing information

A. Would you describe your educational qualifications as:			
Left school before age 15 years	<input type="checkbox"/>	Usual school exams for 15-16	<input type="checkbox"/>
Usual school exams for 17-18	<input type="checkbox"/>	Further qualifications, but not university degree	<input type="checkbox"/>
University degree	<input type="checkbox"/>	Not applicable	<input type="checkbox"/>

Score 1
Score 2

B. Are you:			
Child's mother	<input type="checkbox"/>	Child's father	<input type="checkbox"/>
<input type="checkbox"/> Other (please specify).....			
Your own age.....		Age of child:.....	

Score 3

C. If any impacts from the ear problems of your child which you think important have not been covered above, please mention up to 4 here:

1.
2.
3.
4.