

Your Child's 3-Month Quality of Life Questionnaire (for parent to complete)

Child's participant ID number: (study team to write in)							
Study entry date (Day 1): (study team to write in)	D	D	1 1	Υ	Υ	Υ	Υ



INSTRUCTIONS

•	Please complete this questionnaire using black ink only.
•	Instructions are given for the questions.
•	If you have chosen to complete the questionnaire on-line via the app (this is smartphone-friendly): If you have not received an email or text or have any problems completing the online questionnaire, please contact us on or / or study email address: Please refer to the REST web app user guide (in the patient pack at recruitment) for instructions on how to use the app.
Tel	(work mobile)
Em	
Tel	(work mobile)
	nie Sadoo, Trial Research Administrator
Em	
Tel	
Kat Em	hryn Curtis, Trial Manager
Tel	

Thank you for your co-operation in helping us with this research.

Instructions: Please help us understand the impact of ear infections or fluid on your child's quality of life by ticking one box for each question below.

Thank you

Physical suffering: Ear pain, ear discomfort, ruptured ear drum, high fever, or poor balance. How much of a problem for your child during the past 4 weeks?					
Not present/no problem	Hardly a problem at all Somewhat of a problem Moderate problem	Quite a bit of a problemVery much of a problemExtreme problem			
	ring, questions must be repea ely loud. How much of a prob				
Not present/no problem	Hardly a problem at all Somewhat of a problem Moderate problem	Quite a bit of a problemVery much of a problemExtreme problem			
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?					
Not present/no problem	Hardly a problem at all Somewhat of a problem Moderate problem	Quite a bit of a problemVery much of a problemExtreme problem			
	, frustrated, sad, restless, or during the past 4 weeks beca	poor appetite. How much of use of ear infections or fluid?			
a problem for your child	during the past 4 weeks beca	use of ear infections or fluid?			
	during the past 4 weeks beca Hardly a problem at all	use of ear infections or fluid? Quite a bit of a problem			
a problem for your child	during the past 4 weeks beca Hardly a problem at all Somewhat of a problem	Quite a bit of a problem Very much of a problem			
a problem for your child	during the past 4 weeks beca Hardly a problem at all	use of ear infections or fluid? Quite a bit of a problem			
a problem for your child	during the past 4 weeks beca Hardly a problem at all Somewhat of a problem	Quite a bit of a problem Very much of a problem			
a problem for your child Not present/no problem Activity limitations: Playing	during the past 4 weeks beca Hardly a problem at all Somewhat of a problem Moderate problem , sleeping, doing things with limited have your child's acti	Quite a bit of a problem Very much of a problem Extreme problem friends/family, attending			
a problem for your child Not present/no problem Activity limitations: Playing school or day care. How	during the past 4 weeks beca Hardly a problem at all Somewhat of a problem Moderate problem , sleeping, doing things with limited have your child's action fections or fluid?	Quite a bit of a problem Very much of a problem Extreme problem friends/family, attending vities been during the past			
a problem for your child Not present/no problem Activity limitations: Playing school or day care. How 4 weeks because of ear	during the past 4 weeks beca Hardly a problem at all Somewhat of a problem Moderate problem , sleeping, doing things with limited have your child's action infections or fluid? Hardly limited at all	Quite a bit of a problem Quite a bit of a problem Very much of a problem Extreme problem friends/family, attending vities been during the past Moderately limited			
a problem for your child Not present/no problem Activity limitations: Playing school or day care. How 4 weeks because of ear	during the past 4 weeks beca Hardly a problem at all Somewhat of a problem Moderate problem , sleeping, doing things with limited have your child's action fections or fluid? Hardly limited at all Very slightly limited	Quite a bit of a problem Quite a bit of a problem Very much of a problem Extreme problem friends/family, attending vities been during the past Moderately limited Very limited			
a problem for your child Not present/no problem Activity limitations: Playing school or day care. How 4 weeks because of ear	during the past 4 weeks beca Hardly a problem at all Somewhat of a problem Moderate problem , sleeping, doing things with limited have your child's action infections or fluid? Hardly limited at all	Quite a bit of a problem Quite a bit of a problem Very much of a problem Extreme problem friends/family, attending vities been during the past Moderately limited			
a problem for your child Not present/no problem Activity limitations: Playing school or day care. How 4 weeks because of ear Not limited at all Caregiver concerns: How o	during the past 4 weeks beca Hardly a problem at all Somewhat of a problem Moderate problem Is sleeping, doing things with limited have your child's action fections or fluid? Hardly limited at all Very slightly limited Slightly limited ften have you, as a caregiver,	Quite a bit of a problem Quite a bit of a problem Very much of a problem Extreme problem friends/family, attending vities been during the past Moderately limited Very limited Severely limited			
a problem for your child Not present/no problem Activity limitations: Playing school or day care. How 4 weeks because of ear Not limited at all Caregiver concerns: How o	during the past 4 weeks beca Hardly a problem at all Somewhat of a problem Moderate problem Is sleeping, doing things with limited have your child's action fections or fluid? Hardly limited at all Very slightly limited Slightly limited ften have you, as a caregiver,	Quite a bit of a problem Quite a bit of a problem Very much of a problem Extreme problem friends/family, attending vities been during the past Moderately limited Very limited Severely limited been worried, concerned, or			
a problem for your child Not present/no problem Activity limitations: Playing school or day care. How 4 weeks because of ear Not limited at all Caregiver concerns: How o inconvenienced because	during the past 4 weeks beca Hardly a problem at all Somewhat of a problem Moderate problem I, sleeping, doing things with limited have your child's action fections or fluid? Hardly limited at all Very slightly limited Slightly limited ften have you, as a caregiver, of your child's ear infections or	Quite a bit of a problem Quite a bit of a problem Very much of a problem Extreme problem friends/family, attending vities been during the past Moderately limited Very limited Severely limited been worried, concerned, or or fluid over the past 4 weeks?			

RETURN OF CHILD'S STOOL SAMPLE (COLLECT AT 3 MONTHS AFTER STUDY ENTRY)

Once you have collected the stool sample (please follow the instruction sheet provided), please post the sample in the return addressed envelope provided in the kit as soon as possible.

QUESTIONNAIRE RETURN

- Please post the questionnaire back to us in the pre-paid envelope provided. We would be grateful if you could do this as soon as possible after completing the questionnaire.
- If you have lost the envelope, you can send it back to the following FREEPOST address:

FREEPOST RTZH-TUTT-KXSB The REST Study University of Bristol Department of Social Medicine Canynge Hall 39 Whatley Road **BRISTOL** BS8 2PS

THANK YOU!

For making a valuable contribution to health research. If you can obtain a stool sample from your child, we will send you a £5 voucher when we receive the sample.













The Runny Ear Study is funded by the National Institute for Health Research's HTA Programme HTA 16/85/01

REST study: measuring treatment contamination and adherence SOP

<u>Rationale</u>

We intend to collect data on treatment contamination in order to confirm receipt of the active intervention by study participants. We will also be collecting data on adherence of trial medication in order to confirm study participants have correctly followed the advice given to them by their GP when randomised to the trial.

We intend to ask these questions on Day 1-14 of the participant follow up. Allocation to drops will be confirmed by way of questions asking if the child has received antibiotic ear drops in the Symptom Recovery Questionnaire.

1) Contamination

Questions	asked to	parents durir	ng follow	up:		
cashing in t	the presc		THIS IS	OFFICE USE	•	ld to "wait and see" before OLLOW-UP TRACKER. DO
	Yes	1	No	2	Not applicable	7
in the pres	cription?		OFFICE L	JSE ONLY – I	•	ait and see" before cashing -UP TRACKER. DO NOT
•	S FOR OF	FICE USE ON			•	ur child was prescribed? NOT FOR ENTERING ONTO
	Yes	1	No	2	Not applicable	7

2) Adherence

Parents are asked to complete a Symptom Recovery Questionnaire where they will record the number of doses of medication their child has received each day for 14 days post-recruitment.

Suggested by MM.

Immediate:

Since this is a tds dosing I suggest two out of three doses for three days for the tablets and the first dose as you imply may not be on the day of randomisation but should be within say 24 hours of the index consultation.

Delayed

A prescription was issued at the time of the consultation and the patient ticks a box to say they were allocated to a delayed approach (need to check if we have this anywhere)

Drops

To be consistent the drops should have similar rules to the oral meds

CHILD ASSENT FORM (Age 6-16 Years)

Please circle the answer you agree witl	circle 1	tne	answer	vou	agree	With	า:
---	----------	-----	--------	-----	-------	------	----

1.	Has a doctor or nurse explained this study to you?	Yes	/	No
2.	Did you understand?	Yes	/	No
3.	Have you asked all the questions that you want?	Yes	/	No
4.	Did you understand the answers?	Yes	/	No
5.	It's okay to say no, at any time. Do you understand this?	Yes	/	No
6.	Do you want to take part?	Yes	/	No
Yo	ur name: Da	ate: 		
		ate: ate:		
Na				

<u>Paperwork management instructions</u>: Complete one copy.

- Send to Bristol Trial Centre via secure fax (or encrypted email

- Photocopy and give copy to parent (put it in the shopping bag provided in the Participant Pack).
- Scan into child's medical record and store in the REST Site File (these will be collected at the end of the study).













Your Child's Symptom and Recovery Questionnaire

(OFFICE USE ONLY)

Child's participant ID						
(recruiting clinician to	write in)					
Study entry date (Day (recruiting clinician to	•	D D M M Y	Y Y Y			
FOLLOW-UP PHONE CA	ALLS:					
Day 1 due: Comments:	# attempts:	Completed:	Ву:			
Data entered: Y/N	Date:					
Day 3 due: Comments:	# attempts:	Completed:	Ву:			
Data entered: Y/N	Date:					
Day 7 due: Comments:	# attempts:	Completed:	Ву:			
Data entered: Y/N	Date:					
Day 10 due: Comments:	# attempts:	Completed:	Ву:			
Data entered: Y/N	Date:					
Day 14 due: Comments:	# attempts:	Completed:	Ву:			
Data entered: Y/N	Date:	Parent SRQ return Voucher sent date				
6 Week Call due:		voucher sent date	•			

INSTRUCTIONS

- Please complete this questionnaire using black ink only.
- Instructions are given for each set of questions.
- **Day 1:** please answer these questions on the same day your child entered the study. We want to try to help so we will aim to telephone you within the first two days and answer any questions you may have.
- Days 2-14: please answer these questions every evening until Day 14 even if all your child's symptoms are completely better.
 - We'll also telephone you <u>2 or 3</u> times over the next two weeks, at a time convenient for you, to collect your information and offer help if needed.
- Days 7 and 14 Weekly Questions: please answer these questions even if all your child's symptoms are completely better.
 - ➤ We will telephone you on Days 7 and 14 to ask some further questions.
 - If your child's ear problem has not got better by Day 14, we'll ask if you are willing to answer some questions (by telephone call only) 6 weeks after the study entry date.
 - If the ear problem has stopped by Day 14, you will be asked to return the completed paper questionnaire in the pre-paid return envelope provided.

•	If you have chosen to complete the questionnaire on-line via the app (this is smartphone-friendly): If you
	have not received an email or text within 24 hours after entering the study or have any problems completing
	the online questionnaire, please contact us on or or study email address:
	. Please refer to the REST web app user guide (enclosed) for instructions on how to use the
	app.

Thank you for your co-operation in helping us with this research.

If you have any questions about filling in the questionnaire, please contact us:

Sue Harris, Resear	ch Nurse	
Email:		
Tel:	/	(work mobile)
Kate Rowley, Trial	Co-ordinator	
Email:	Co oramator	
Tel:	/	(work mobile)
Annia Cadaa Trial	Docoarch Admir	nictrotor
Annie Sadoo, Trial	Research Aumin	listrator
Email:		
Tel:		
Kathryn Curtis, Tri	al Manager	
Email:		l
Tel:		(work mobile)

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 1 - Day of Study Entry

Ple	Please enter today's date:							
DAY 1 (DAY OF STUDY ENTRY) QUESTIONS ONLY								
A. ABOUT YOUR CHILD Please answer these questions about your child.								
1.	Has your child ever had insertion of ventilation tubes (grommets)? (tick one box only)							
	Yes 1 No 2							
	i) If yes, how many times?							
2.	Has your child ever had any relevant surgical procedures/ ENT surgeries? (tick one box only)							
	Yes 1 No 2 If no, go to Qu.3 below							
	i) If yes, which of the following procedures/operations? (tick all that apply)							
	a) Adenoidectomy (with or without tonsillectomy) Yes 1							
	b) Tonsillectomy 1							
	c) Surgical removal of (persistent) grommets							
	d) Other surgical procedure, please tick box and describe:							
3.	Has your child ever suffered from allergic-type conditions, e.g. asthma, hay fever or eczema? (tick one box only)							
	Yes 1 No 2							
	4.a) What is the name of the antibiotic medicine your child was prescribed today? Please write name:							
	b) If your child was prescribed a medicine to take by mouth, were you told to "wait and see" before cashing in the prescription? (NB: THIS IS OFFICE USE ONLY – ENTER ON FOLLOW-UP TRACKER. DO NOT ENTER ON TRANSFORM DATABASE)							
	Yes 1 No 2 Not applicable 7							
	c) Were you given an advice sheet relevant to the antibiotic medicine your child was prescribed? (NB: THIS IS FOR OFFICE USE ONLY – ENTER ON FOLLOW-UP TRACKER. NOT FOR ENTERING ONTO TRANSFORM DATABASE)							
	Yes 1 No 2 Not applicable 7							

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 1 - Day of Study Entry

4.	Please describe your child's	ethnic group (ti	ck one b	ox only):				
a)	White:	British	1	Irish	2		Any other White background	3
b)	Black or Black British:	African	1	Caribbean	2		Any other Black background	3
c)	Mixed or Mixed British:	White/Black Caribbean	1	White/Black African	2		White/Asian	3
		Any other Mixe	d backgr	ound	4			
d)	Asian or Asian British:	Indian	1	Pakistani	2		Bangladeshi	3
		Chinese	4	Any other As	sian backgro	ound	5	
e)	Other Ethnic Group:	Arab	1	Any other et	thnic group	(please	describe): 2	2
f)	Prefer not to answer:	1						
5.	Does anybody living in the o	child's home smo	oke? (ticl	k one box onl	ly)			
	Yes							
i)	i) If yes, does anyone smoke in the house? (tick one box only)							
	Yes							
	B. ABOUT YOU (PARENT/GUARDIAN) Please answer these questions about yourself.							
1.	Would you describe your ed	lucational qualif	ications	as: (tick one	box only)			
	Left school before age 16 years	1	Usual so for 15-1	chool exams .6	2		Usual school exar for 17-18	ms 3
	Further qualifications but not university degree	4	Univers	ity degree	5		Not applicable	6
2.	Are you: (tick one box only)							
	Child's mother	Child's	father [2		Other,	please specify:	3

...Now go to Day 1 Daily Questions on the next page

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 1 - Day of Study Entry

Please enter today's date:	
DAY 1 (DAY OF STUDY ENTRY) - DAILY QUESTIONS Please answer all the following questions in the evening looking back over the last 24 hours. We will ask the sam your child's recovery from their ear problem – please an completely better.	ne questions every day until Day 14 so we can track
 Has your child had any ear infection-related symptoms in t Yes 1 No 2 	he last 24 hours? (tick one box only)
2. Has your child been given an antibiotic in the last 24 hours Yes	ions 1 and 2, go to Day 2 on page 7
a) If yes, how many times? Write the number in the boxes (if	none, please write " 00 ").
b) If ear drops were used, which ear(s) did you treat? (tick on Right ear	
3. Did your child take any paracetamol, e.g. Calpol®, in the la Yes, for pain 1 Yes, for high temperature i) If yes, how many times?	
4. Did your child take any ibuprofen, e.g. Nurofen®, in the las Yes, for pain 1 Yes, for high temperature i) If yes, how many times?	t 24 hours? (tick one box only) 2 Yes, for both 3 No 4 If no, go to Qu.5
 5. Did your child take any other pain-killing remedy in the last Yes	
6. Did your child take any other medicine for the ear infection Yes 1 No 2 If no, go to Qu i) If yes, please write the name of the medicine:	n in the last 24 hours? (tick one box only)

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 1 - Day of Study Entry

7.	Has your child had any ear discharg	ge in the last 2	24 hours ? (tid	ck one box	only)				
	Yes 1 No 2	→ If no	o, go to Qu.8	below					
	i) If yes, from which ear? (tick or	e box only)							
	Right ear1	Left ear	2	I	Both ears	3			
_					2.01				
8.	Has your child had any of the follow one box only to score each symptom					ver <u>all</u> tr	ie questio	ons – tick	
		0 = Normal/no problem	1 = Very little problem	2 = Slight problem	3 = Moderately bad	4 = Bad	5 = Very I bad	6 = Extremely bad	
a)	Pain	0	1	2	3	4	5	6	
b)	High temperature (fever)	0	1	2	3	4	5	6	
c)	Ear discharge	0	1	2	3	4	5	6	
d)	Being unwell	0	1	2	3	4	5	6	
e)	Disturbed sleep	0	1	2	3	4	5	6	
f)	Episodes of distress/crying	0	1	2	3	4	5	6	
g)	Eating or drinking less than normal	0	1	2	3	4	5	6	
h)	Interference with normal activities	0	1	2	3	4	5	6	

...Now go to Day 2 on the next page

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 2 Please enter today's date: **DAY 2 - DAILY QUESTIONS** Please answer all the following questions in the evening of Day 2 looking back over the last 24 hours. 1. Has your child had any ear infection-related symptoms in the last 24 hours? (tick one box only) No Yes 2. Has your child been given an antibiotic in the last 24 hours (ear drops or by mouth)? (tick one box only) No If no to Questions 1 and 2, go to Day 3 on page 9 Yes a) If yes, how many times? Write the number in the boxes (if none, please write "00") ▶ If "00", go to Qu.3 below b) If ear drops were used, which ear(s) did you treat? (tick one box only) Right ear Left ear Both ears Drops not prescribed 3. Did your child take any paracetamol, e.g. Calpol®, in the last 24 hours? (tick one box only) Yes, for pain Yes, for high temperature Yes, for both If yes, how many times? If no, go to Qu.4 4. Did your child take any ibuprofen, e.g. Nurofen®, in the last 24 hours? (tick one box only) Yes, for high temperature Yes, for pain Yes, for both If yes, how many times? If no, go to Qu.5 5. Did your child take any other pain-killing remedy today? (tick **one** box only) No ➤ If no, go to Qu.6 below Yes i) If yes, how many times?

6. Did your child take any other medicine for the ear infection in the last 24 hours? (tick one box only)

➤ If no, go to Qu.7 on the next page

ii) If yes, please write the name of the remedy:

If yes, please write the name of the medicine:

Yes

7

7.	Has your child had any ear dischar	ge? (tick one l	oox only)					
	Yes 1 No 2	→ If n	o, go to Qu.8	below				
	i) If yes, from which ear? (tick or	ne box only)						
	Right ear1	Left ear	2	į.	Both ears	3		
8.	Has your child had any of the follo box only to score each symptom a				s ? Please ansv	ver <u>all</u> th	ne quest	tions - tick one
		0 =	1 =	2 =	3 =	4 =	5 =	6 =
		Normal/no problem	Very little problem	Slight problem	Moderately bad	Bad	Very bad	Extremely bad
a)	Pain	0	1	2	3	4		5 6
b)	High temperature (fever)	0	1	2	3	4		5 6
c)	Ear discharge	0	1	2	3	4		5 6
d)	Being unwell	0	1	2	3	4		5 6
e)	Disturbed sleep	0	1	2	3	4		5 6
f)	Episodes of distress/crying	0	1	2	3	4		5 6
g)	Eating or drinking less than norma	I o	1	2	3	4		5 6
h)	Interference with normal activities	5 0	1	2	3	4		5 6

...Now go to Day 3 on the next page

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 3 Please enter today's date: **DAY 3 - DAILY QUESTIONS** Please answer all the following questions in the evening of Day 3 looking back over the last 24 hours. 1. Has your child had any ear infection-related symptoms in the last 24 hours? (tick one box only) No Yes 2. Has your child been given an antibiotic in the last 24 hours (ear drops or by mouth)? (tick one box only) No ► If no to Questions 1 & 2, go to Day 4 on page 11 Yes a) If yes, how many times? Write the number in the boxes (if none, please write "00") → If "00", go to Qu.3 below b) If ear drops were used, which ear(s) did you treat? (tick one box only) Right ear Left ear Both ears Drops not prescribed 3. Did your child take any paracetamol, e.g. Calpol®, in the last 24 hours? (tick one box only) Yes, for pain Yes, for high temperature Yes, for both If yes, how many times? If no, go to Qu.4 4. Did your child take any ibuprofen, e.g. Nurofen®, in the last 24 hours? (tick one box only) Yes, for high temperature Yes, for pain Yes, for both If yes, how many times? If no, go to Qu.5 5. Did your child take any other pain-killing remedy today? (tick **one** box only) No → If no, go to Qu.6 below Yes i) If yes, how many times? ii) If yes, please write the name of the remedy:

6. Did your child take any other medicine for the ear infection in the last 24 hours? (tick one box only)

If yes, please write the name of the medicine:

Yes

i)

► If no, go to Qu.7 on the next page

7.	Has your child had any ear discharg	ge? (tick one l	oox only)					
	Yes 1 No 2	→ If no	o, go to Qu.8	below				
	i) If yes, from which ear? (tick or	e box only)						
	Right ear 1	Left ear	2	E	Both ears	3		
8.	Has your child had any of the follow box only to score each symptom as				s ? Please ansv	ver <u>all</u> th	ie questio	ns - tick on e
		0 = Normal/no problem	1 = Very little problem	2 = Slight problem	3 = Moderately bad	4 = Bad	5 = Very E bad	6 = xtremely bad
a)	Pain	0	1	2	3	4	5	6
b)	High temperature (fever)	0	1	2	3	4	5	6
c)	Ear discharge	0	1	2	3	4	5	6
d)	Being unwell	0	1	2	3	4	5	6
e)	Disturbed sleep	0	1	2	3	4	5	6
f)	Episodes of distress/crying	0	1	2	3	4	5	6
g)	Eating or drinking less than normal	0	1	2	3	4	5	6
h)	Interference with normal activities	0	1	2	3	4	5	6

10

...Now go to Day 4 on the next page

Please enter today's date: **DAY 4 - DAILY QUESTIONS** Please answer all the following questions in the evening of Day 4 looking back over the last 24 hours. 1. Has your child had any ear infection-related symptoms in the last 24 hours? (tick one box only) No Yes 2. Has your child been given an antibiotic in the last 24 hours (ear drops or by mouth)? (tick one box only) No ► If no to Questions 1 & 2, go to Day 5 on page 13 Yes a) If yes, how many times? Write the number in the boxes (if none, please write "00") → If "00", go to Qu.3 below b) If ear drops were used, which ear(s) did you treat? (tick one box only) Right ear Left ear Both ears Drops not prescribed 3. Did your child take any paracetamol, e.g. Calpol®, in the last 24 hours? (tick one box only) Yes, for pain Yes, for high temperature Yes, for both If yes, how many times? If no, go to Qu.4 4. Did your child take any ibuprofen, e.g. Nurofen®, in the last 24 hours? (tick one box only) Yes, for high temperature Yes, for pain Yes, for both If yes, how many times? If no, go to Qu.5 5. Did your child take any other pain-killing remedy today? (tick **one** box only) No → If no, go to Qu.6 below Yes i) If yes, how many times? ii) If yes, please write the name of the remedy: 6. Did your child take any other medicine for their ear infection in the last 24 hours? (tick one box only) Yes No ➤ If no, go to Qu.7 on the next page If ves, please write the name of the medicine:

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 4

/.	Has your child had any ear discharg	ger (tick one i	oox only)					
	Yes 1 No 2	→ If no	o, go to Qu.8	below				
	i) If yes, from which ear? (tick on	e box only)						
	Right ear1	Left ear	2	1	Both ears	3		
8.	Has your child had any of the follow box only to score each symptom as				s ? Please ansv	ver <u>all</u> th	ne quest	ions - tick on
		0 =	1 =	2 =	3 =	4 =	5 =	6 =
		Normal/no problem	Very little problem	Slight problem	Moderately bad	Bad	Very bad	Extremely bad
a)	Pain	0	1	2	3	4		5 6
b)	High temperature (fever)	0	1	2	3	4		5 6
c)	Ear discharge	0	1	2	3	4		5 6
d)	Being unwell		1	2	3	4		5 6
e)	Disturbed sleep	0	1	2	3	4		5 6
f)	Episodes of distress/crying	0	1	2	3	4		5 6
g)	Eating or drinking less than normal	0	1	2	3	4		5 6
h)	Interference with normal activities	0	1	2	3	4		5 6

...Now go to Day 5 on the next page

lease enter today's date:	D D M M Y Y Y
AY 5 - DAILY QUESTIONS lease answer all the following questions in the e	vening of Day 5 looking back over the last 24 hours.
. Has your child had any ear infection-related symptom	oms in the last 24 hours? (tick one box only)
Yes 1 No 2	
. Has your child been given an antibiotic in the last 2	4 hours (ear drops or by mouth)? (tick one box only)
Yes ☐ 1 No ☐ 2 → If no to	O Questions 1 & 2, go to Day 6 on page 15
♦ a) If yes, how many times? Write the number in the b	poxes (if none, please write " 00 ")
If "00", go to Qu.3 below	
b) If ear drops were used, which ear(s) did you treat?	(tick one box only)
Right ear 1 Left ear 2	Both ears 3 Drops not prescribed 4
. Did your child take any paracetamol, e.g. Calpol®, i	n the last 24 hours? (tick one box only)
Yes, for pain 1 Yes, for high temperat	ure 2 Yes, for both 3 No 4
i) If yes, how many times?	If no, go to Qu.4
. Did your child take any ibuprofen, e.g. Nurofen®, ir	the last 24 hours? (tick one box only)
Yes, for pain 1 Yes, for high temperat	ure 2 Yes, for both 3 No 4
) If an land was 1900 2	
i) If yes, how many times?	If no, go to Qu.5
. Did your child take any other pain-killing remedy to	day? (tick one box only)
Yes	go to Qu.6 below
i) If yes, how many times?	
ii) If yes, please write the name of the remedy:	
· · ·	
. Did your child take any other medicine for the ear i	nfection in the last 24 hours? (tick one box only)
Yes	go to Qu.7 on the next page
i) If yes, please write the name of the medicine:	

7.	Has your child had any ear discharg	ge? (tick one k	oox only)					
	Yes 1 No 2	→ If no	o, go to Qu.8	below				
	i) If yes, from which ear? (tick on	e box only)						
	Right ear	Left ear	2	E	Both ears	3		
8.	Has your child had any of the follow box only to score each symptom as				s ? Please ansv	ver <u>all</u> th	ie questio	ns - tick on e
		0 = Normal/no problem	1 = Very little problem	2 = Slight problem	3 = Moderately bad	4 = Bad	5 = Very E bad	6 = xtremely bad
a)	Pain	0	1	2	3	4	5	6
b)	High temperature (fever)	0	1	2	3	4	5	6
c)	Ear discharge	0	1	2	3	4	5	6
d)	Being unwell	0	1	2	3	4	5	6
e)	Disturbed sleep	0	1	2	3	4	5	6
f)	Episodes of distress/crying	0	1	2	3	4	5	6
g)	Eating or drinking less than normal	0	1	2	3	4	5	6
h)	Interference with normal activities	0	1	2	3	4	5	6

...Now go to Day 6 on the next page

Ple	Please enter today's date:	D D M I	M / Y	YYY
	DAY 6 - DAILY QUESTIONS Please answer all the following questions in the <u>evenir</u>	ng of Day 6 looking b	oack over <u>the</u>	e last 24 hours.
1.	1. Has your child had any ear infection-related symptoms ir	the last 24 hours? (t	ick one box or	nly)
	Yes No 2			
2.	2. Has your child been given an antibiotic in the last 24 hou	rs (ear drops or by mo	outh)? (tick o n	e box only)
	Yes	stions 1 & 2, go to Da	y 7 on page 1	7
a)	a) If yes, how many times? Write the number in the boxes	(if none, please write	" 00 ")	
	→ If "00", go to Qu.3 below			
b)	b) If ear drops were used, which ear(s) did you treat? (tick of	one box only)		
	Right ear 1 Left ear 2 Both	n ears	Drops not pre	escribed4
3.	3. Did your child take any paracetamol, e.g. Calpol®, in the	last 24 hours? (tick or	ie box only)	
	Yes, for pain 1 Yes, for high temperature	2 Yes, for b	oth 3	No
	i) If yes, how many times?			↓ If no, go to Qu.4
4.	4. Did your child take any ibuprofen, e.g. Nurofen®, in the l	ast 24 hours? (tick on	e box only)	
	Yes, for pain 1 Yes, for high temperature	Yes, for b	oth 3	No 🔲 4
	i) If yes, how many times?			If no, go to Qu.5
5.	5. Did your child take any other pain-killing remedy today?	(tick one box only)		
	Yes \square 1 No \square 2 \longrightarrow If no, go to	Qu.6 below		
	i) If yes, how many times?			
	ii) If yes, please write the name of the remedy:			
6.	6. Did your child take any other medicine for the ear infecti	on in the last 24 hour	s? (tick one bo	ox only)
	Yes \square_1 No \square_2 \longrightarrow If no, go to \square_2	Qu.7 on the next page	<u> </u>	
	i) If yes, please write the name of the medicine:			

7.	Has your child had any ear discharg	ge? (tick one l	oox only)					
	Yes 1 No 2	→ If no	o, go to Qu.8	below				
	i) If yes, from which ear? (tick on	e box only)						
	Right ear1	Left ear	2	I	Both ears	3		
8.	Has your child had any of the follow box only to score each symptom as				s ? Please ansv	ver <u>all</u> th	ne questi	ons - tick one
		0 = Normal/no problem	1 = Very little problem	2 = Slight problem	3 = Moderately bad	4 = Bad	5 = Very l bad	6 = Extremely bad
a)	Pain	0	1	2	3	4	5	6
b)	High temperature (fever)	0	1	2	3	4	5	6
c)	Ear discharge	0	1	2	3	4	5	6
d)	Being unwell	0	1	2	3	4	5	6
e)	Disturbed sleep	0	1	2	3	4	5	6
f)	Episodes of distress/crying	0	1	2	3	4	5	6
g)	Eating or drinking less than normal	0	1	2	3	4	5	6
h)	Interference with normal activities	0	1	2	3	4	5	6

...Now go to Day 7 on the next page

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 7 Please enter today's date:

	Y 7 - DAILY QUESTIONS ease answer all the following questions in the <u>evening of Day 7</u> looking back over <u>the last 24 hours</u> .
 L.	Has your child had any ear infection-related symptoms in the last 24 hours? (tick one box only)
	Yes 1 No 2
2.	Has your child been given an antibiotic in the last 24 hours (ear drops or by mouth)? (tick one box only) Yes 1
a)	If yes, how many times? Write the number in the boxes (if none, please write "00") If "00", go to Qu.3 below
b)	If ear drops were used, which ear(s) did you treat? (tick one box only) Right ear
3.	Did your child take any paracetamol, e.g. Calpol®, in the last 24 hours ? (tick one box only) Yes, for pain 1 Yes, for high temperature 2 Yes, for both 3 No 4
	i) If yes, how many times? If no, go to Qu.4
1.	Did your child take any ibuprofen, e.g. Nurofen®, in the last 24 hours? (tick one box only) Yes, for pain 1 Yes, for high temperature 2 Yes, for both 3 No 4 i) If yes, how many times? If no, go to Qu.5
5.	Did your child take any other pain-killing remedy today? (tick one box only) Yes
ō.	Did your child take any other medicine for the ear infection in the last 24 hours? (tick one box only) Yes 1 No 2 House places write the name of the medicine.

7.	Has your child had any ear discharg	ge? (tick one b	oox only)					
	Yes 1 No 2	→ If no	o, go to Qu.8	below				
	i) If yes, from which ear? (tick on Right ear	Left ear	2	E	Both ears	3		
8.	Has your child had any of the follow box only to score each symptom as				s ? Please ansv	ver <u>all</u> th	ne questio	ons - tick on e
		0 = Normal/no problem	1 = Very little problem	2 = Slight problem	3 = Moderately bad	4 = Bad	5 = Very l bad	6 = Extremely bad
a)	Pain	0	1	2	3	4	5	6
b)	High temperature (fever)	0	1	2	3	4	5	6
c)	Ear discharge	0	1	2	3	4	5	6
d)	Being unwell	0	1	2	3	4	5	6
e)	Disturbed sleep	0	1	2	3	4	5	6
f)	Episodes of distress/crying	0	1	2	3	4	5	6
g)	Eating or drinking less than normal	0	1	2	3	4	5	6
h)	Interference with normal activities	0	1	2	3	4	5	6

...Now go to End of Week 1 Questions on the next page —

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 7 – End of Week 1 Questions

Please enter today's date:	D D	М	М	Υ	Υ	Υ	Υ	
Please complete the following questions at the end o	f the week or	n Day 7	'.					
 A. NEW OR WORSENING SYMPTOMS 1.a) Did your child experience, on one or more days in the symptom (or symptoms) other than the ones you have 		-	nptom,	or wo	rsenin	g of a	pre-e	xisting
Yes 1 No 2 If no, go to b) If yes, please tell us what it was and if it was mild, more	Section B belo		Mi	ld	Mod	lerate	S	evere
when at its worst:				7	Г			
i) ii)				1 	L	2		3
iii)			<u> </u>	_] 1 □	L	2		3
iv)			┨ ├	1 □ _	L	2		3
v)			┦	_	L	2		3
vi)			┨┝	_] 1 □ _1	L T	2		3
vii)			┨┝	$\frac{1}{1}$	L	2		3
viii)			┨╞	_	Г			3
					L		ļ	
 B. HEALTH SERVICES Please tell us about any other health services your child has have used NHS services for other health problems <u>not</u> to do about them. 1. Has your child had to see a GP again in the last 7 days by Yes i) If yes, how many times? 	o with your chil	d's ear	probler	n, you	<u>do no</u>	<u>t</u> need	l to te	•
 2. Have you had a GP telephone appointment for your children box only) Yes	ild in the last 7	' days b	ecause	of the	ir ear ¡	oroble	m? (ti	ck one
3. Has your child seen a GP practice nurse in the last 7 day Yes	ys because of to Qu.4 on the n			m? (tio	ck one	box o	nly)	

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 7 – End of Week 1 Questions

4.	Have you used the NHS telephone service 111 in the last 7 days because of your child's ear problem? (tick one box only)
	Yes If no, go to Qu.5 below
	i) If yes, how many times?
5.	Has your child attended an A&E department in the last 7 days because of their ear problem? (tick one box only)
	Yes I No 2 If no, go to Qu.6 below i) If yes, how many times?
	i) If yes, how many times?
6.	Has your child attended a hospital outpatient department in the last 7 days because of their ear problem? (tick one box only)
	Yes I No 2 If no, go to Qu.7 below i) If ves. how many times?
	i) If yes, how many times?
7.	Has your child stayed overnight in hospital in the last 7 days because of their ear problem? (tick one box only)
	Yes I No 2 If no, go to Qu.8 below i) If ves. how many nights?
	i) If yes, how many nights?
8.	Did your child receive any additional treatment in the last 7 days because of their ear problem? (tick one box only)
	Yes If no, go to Section C on the next page
	i) If yes, please tell us what treatment they received:
	a)
	b)
	c)

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 7 – End of Week 1 Questions

C. PRESCRIPTION MEDICINES

Please tell us about **ALL** medicines and remedies a doctor/nurse has prescribed **in the last 7 days** to treat your child's ear problem. If any medicines/remedies have been prescribed for **other** health problems **not** to do with your child's ear problem, you **do not** need to tell us about them.

1.	 Has your child been prescribed any medicines or remedies by a doctor/nurse for their ear problem in the last 7 days? (tick one box only) 							
	Yes	No	If no, go to D	ay 8 on the next page				
i) If yes, please tell us which medicine or remedy was prescribed (tick all that apply):								
			Yes	No				
	a)	Paracetamol, e.g. Calpol®						
	b)	Ibuprofen, e.g. Nurofen®						
	c)	Other pain-killing remedy, please tick box and write name:						
		please tick box and write name.						
	d)	Other medicine for ear problem,						
		e.g. new antibiotic, please tick box and write name:						
				Now go to Day 8 on the next page	•			

Ple	ease enter today's date:
	AY 8 - DAILY QUESTIONS ease answer all the following questions in the <u>evening of Day 8</u> looking back over <u>the last 24 hours.</u>
1.	Has your child had any ear infection-related symptoms in the last 24 hours? (tick one box only)
	Yes 1 No 2
2.	Has your child been given an antibiotic in the last 24 hours (ear drops or by mouth)? (tick one box only)
	Yes No 2 If no to Questions 1 & 2, go to Day 9 on page 24
a)	If yes, how many times? Write the number in the boxes (if none, please write "00")
	If "00", go to Qu.3 below
b)	If ear drops were used, which ear(s) did you treat? (tick one box only)
	Right ear 1 Left ear 2 Both ears 3 Drops not prescribed 4
3.	Did your child take any paracetamol, e.g. Calpol®, in the last 24 hours? (tick one box only)
	Yes, for pain 1 Yes, for high temperature 2 Yes, for both 3 No 4
	i) If yes, how many times? If no, go to Qu.4
4.	Did your child take any ibuprofen, e.g. Nurofen®, in the last 24 hours? (tick one box only)
	Yes, for pain 1 Yes, for high temperature 2 Yes, for both 3 No 4
	i) If yes, how many times? If no, go to Qu.5
5.	Did your child take any other pain-killing remedy today? (tick one box only)
	Yes ☐ 1 No ☐ 2 → If no, go to Qu.6 below
	i) If yes, how many times?
	ii) If yes, please write the name of the remedy:
6.	Did your child take any other medicine for the ear infection in the last 24 hours? (tick one box only)
	Yes 1 No 2 If no, go to Qu.7 on the next page
	i) If yes, please write the name of the medicine:

7.	Has your child had any ear discharg	ge? (tick one k	oox only)						
	Yes 1 No 2	→ If no	o, go to Qu.8	below					
	i) If yes, from which ear? (tick on	e box only)							
	Right ear1	Left ear	2	į.	Both ears	3			
8.	Has your child had any of the follow box only to score each symptom as				s ? Please ansv	wer <u>all</u> th	ie questic	ons - tick o n	16
		0 = Normal/no problem	1 = Very little problem	2 = Slight problem	3 = Moderately bad	4 = Bad	5 = Very E bad	6 = Extremely bad	
a)	Pain	0	1	2	3	4	5	6	
b)	High temperature (fever)	0	1	2	3	4	5	6	
c)	Ear discharge	0	1	2	3	4	5	6	
d)	Being unwell	o	1	2	3	4	5	6	
e)	Disturbed sleep	0	1	2	3	4	5	6	
f)	Episodes of distress/crying	0	1	2	3	4	5	6	
g)	Eating or drinking less than normal	0	1	2	3	4	5	6	
h)	Interference with normal activities	0	1	2	3	4	5	6	

...Now go to Day 9 on the next page

Please enter today's date:	D D M M Y Y Y
DAY 9 - DAILY QUESTIONS Please answer all the following questions in the <u>ev</u>	vening of Day 9 looking back over the last 24 hours.
1. Has your child had any ear infection-related sympto	ms in the last 24 hours? (tick one box only)
Yes 1 No 2	
2. Has your child been given an antibiotic in the last 24	hours (ear drops or by mouth)? (tick one box only)
Yes \square 1 No \square 2 If no to	Questions 1 & 2, go to Day 10 on page 26
a) If yes, how many times? Write the number in the b	oxes (if none, please write " 00 ")
→ If "00", go to Qu.3 below	
b) If ear drops were used, which ear(s) did you treat?	(tick one box only)
Right ear 1 Left ear 2	Both ears
3. Did your child take any paracetamol, e.g. Calpol®, in	the last 24 hours? (tick one box only)
Yes, for pain 1 Yes, for high temperatu	re 2 Yes, for both 3 No 4
i) If yes, how many times?	If no, go to Qu.4
4. Did your child take any ibuprofen, e.g. Nurofen®, in	the last 24 hours? (tick one box only)
Yes, for pain 1 Yes, for high temperatu	re 2 Yes, for both 3 No 4
i) If yes, how many times?	↓ If no, go to Qu.5
5. Did your child take any other pain-killing remedy too	day? (tick one box only)
Yes ☐ 1 No ☐ 2 → If no, g	o to Qu.6 below
i) If yes, how many times?	
ii) If yes, please write the name of the remedy:	
6. Did your child take any other medicine for the ear ir	fection in the last 24 hours? (tick one box only)
Yes \square_1 No \square_2 \longrightarrow If no, go	o to Qu.7 on the next page
i) If yes, please write the name of the medicine:	

7.	Has your child had any ear discharg	ge? (tick one k	oox only)					
	Yes 1 No 2	→ If no	o, go to Qu.8	below				
	i) If yes, from which ear? (tick on	e box only)						
	Right ear	Left ear	2	E	Both ears	3		
8.	Has your child had any of the follow box only to score each symptom as				s? Please ansv	ver <u>all</u> th	ne questio	ons - tick one
		0 = Normal/no problem	1 = Very little problem	2 = Slight problem	3 = Moderately bad	4 = Bad	5 = Very I bad	6 = Extremely bad
a)	Pain	0	1	2	3	4	5	6
b)	High temperature (fever)	0	1	2	3	4	5	6
c)	Ear discharge	0	1	2	3	4	5	6
d)	Being unwell	0	1	2	3	4	5	6
e)	Disturbed sleep	0	1	2	3	4	5	6
f)	Episodes of distress/crying	0	1	2	3	4	5	6
g)	Eating or drinking less than normal	0	1	2	3	4	5	6
h)	Interference with normal activities	0	1	2	3	4	5	6

...Now go to Day 10 on the next page

Please enter today's date:	
DAY 10 - DAILY QUESTIONS Please answer all the following questions in the <u>eve</u>	ning of Day 10 looking back over the last 24 hours.
1. Has your child had any ear infection-related symptom	s in the last 24 hours? (tick one box only)
Yes 1 No 2	
2. Has your child been given an antibiotic in the last 24 h	nours (ear drops or by mouth)? (tick one box only)
Yes ☐ 1 No ☐ 2 → If no to Q	uestions 1 & 2, go to Day 11 on page 28
a) If yes, how many times? Write the number in the box	kes (if none, please write " 00 ")
→ If "00", go to Qu.3 below	
b) If ear drops were used, which ear(s) did you treat? (t Right ear 1 Left ear 2 B	oth ears 3 Drops not prescribed 4
3. Did your child take any paracetamol, e.g. Calpol®, in tl Yes, for pain 1 Yes, for high temperature	
i) If yes, how many times?	If no, go to Qu.4
4. Did your child take any ibuprofen, e.g. Nurofen®, in th	e last 24 hours? (tick one box only)
Yes, for pain 1 Yes, for high temperature	Yes, for both 3 No 4
i) If yes, how many times?	↓ If no, go to Qu.5
5. Did your child take any other pain-killing remedy toda	y? (tick one box only)
Yes 1 No 2 If no, go	to Qu.6 below
i) If yes, how many times?	
ii) If yes, please write the name of the remedy:	
6. Did your child take any other medicine for the ear infe	ection in the last 24 hours? (tick one box only)
Yes 1 No 2 If no, go t	to Qu.7 on the next page
i) If yes, please write the name of the medicine:	

7.	Has your child had any ear discharg	ge? (tick one b	oox only)						
	Yes 1 No 2	→ If no	o, go to Qu.8	below					
	i) If yes, from which ear? (tick on	e box only)							
	Right ear1	Left ear	2	E	Both ears	3			
8.	Has your child had any of the follow box only to score each symptom as				s? Please ansv	ver <u>all</u> th	ie quest	ions - tick on	E
		0 =	1 =	2 =	3 =	4 =	5 =	6 =	
		Normal/no problem	Very little problem	Slight problem	Moderately bad	Bad	Very bad	Extremely bad	
a)	Pain	0	1	2	3	4		5 6	
b)	High temperature (fever)	0	1	2	3	4		5 6	
c)	Ear discharge	0	1	2	3	4		5 6	
d)	Being unwell	0	1	2	3	4		5 6	
e)	Disturbed sleep	0	1	2	3	4		5 6	
f)	Episodes of distress/crying	0	1	2	3	4		5 6	
g)	Eating or drinking less than normal	0	1	2	3	4		5 6	
h)	Interference with normal activities	0	1	2	3	4		5 6	

...Now go to Day 11 on the next page

Please enter today's date:	D D M M Y Y Y
DAY 11 - DAILY QUESTIONS Please answer all the following questions in the <u>eve</u>	ening of Day 11 looking back over the last 24 hours
 Has your child had any ear infection-related sympton Yes 1 No 2 	ns in the last 24 hours ? (tick one box only)
$\overline{\downarrow}$	Questions 1 & 2, go to Day 12 on page 30
a) If yes, how many times? Write the number in the bo	oxes (if none, please write " 00 ")
b) If ear drops were used, which ear(s) did you treat? (Right ear 1 Left ear 2	tick one box only) Both ears 3 Drops not prescribed 4
3. Did your child take any paracetamol, e.g. Calpol®, in and Yes, for pain 1 Yes, for high temperatur i) If yes, how many times?	
4. Did your child take any ibuprofen, e.g. Nurofen®, in t Yes, for pain 1 Yes, for high temperatur i) If yes, how many times?	
 Did your child take any other pain-killing remedy tod. Yes	ay? (tick one box only) o to Qu.6 below
6. Did your child take any other medicine for the ear inf Yes 1 No 2 If no, go i) If yes, please write the name of the medicine:	to Qu.7 on the next page

7. Has your child had any ear discharge? (tick **one** box only)

	Yes 1 No 2	→ If no	o, go to Qu.8	below				
	i) If yes, from which ear? (tick or	ne box only)						
	Right ear1	Left ear	2	E	Both ears	3		
8.	Has your child had any of the follow box only to score each symptom as				s? Please ansv	ver <u>all</u> th	e questi	ons - tick on
		0 = Normal/no problem	1 = Very little problem	2 = Slight problem	3 = Moderately bad	4 = Bad	5 = Very bad	6 = Extremely bad
a)	Pain	0	1	2	3	4		5 6
b)	High temperature (fever)	0	1	2	3	4	5	6
c)	Ear discharge	0	1	2	3	4	5	6
d)	Being unwell	0	1	2	3	4		6
e)	Disturbed sleep	0	1	2	3	4		6
f)	Episodes of distress/crying	0	1	2	3	4		5 6
g)	Eating or drinking less than normal	I 0	1	2	3	4		5 6
h)	Interference with normal activities	0	1	2	3	4		5 6

...Now go to Day 12 on the next page

Please enter today's date:	D D M M Y Y Y
DAY 12 - DAILY QUESTIONS Please answer all the following questions in the <u>ev</u>	rening of Day 12 looking back over the last 24 hours.
 Has your child had any ear infection-related symptor Yes 1 No 2 	ns in the last 24 hours ? (tick one box only)
 Has your child been given an antibiotic in the last 24 Yes	hours (ear drops or by mouth)? (tick one box only) Questions 1 & 2, go to Day 13 on page 32
a) If yes, how many times? Write the number in the bo	oxes (if none, please write " 00 ")
b) If ear drops were used, which ear(s) did you treat? (tick one box only) Both ears 3 Drops not prescribed 4
3. Did your child take any paracetamol, e.g. Calpol®, in Yes, for pain 1 Yes, for high temperatur i) If yes, how many times?	
4. Did your child take any ibuprofen, e.g. Nurofen®, in t Yes, for pain 1 Yes, for high temperatur i) If yes, how many times?	
 Did your child take any other pain-killing remedy tod Yes	day? (tick one box only) o to Qu.6 below
6. Did your child take any other medicine for the ear in Yes 1 No 2 If no, go i) If yes, please write the name of the medicine:	fection in the last 24 hours? (tick one box only) to Qu.7 on the next page

7. Has your child had any ear discharge? (tick **one** box only)

	Yes	→ If no	o, go to Qu.8	below					
	i) If yes, from which ear? (tick on	e box only)							
	Right ear1	Left ear	2	E	Both ears	3			
8.	Has your child had any of the follow box only to score each symptom as				s ? Please ansv	wer <u>all</u> th	e questic	ons - tick on	i€
		0 = Normal/no problem	1 = Very little problem	2 = Slight problem	3 = Moderately bad	4 = Bad	5 = Very E bad	6 = Extremely bad	
a)	Pain	0	1	2	3	4	5	6	
b)	High temperature (fever)	0	1	2	3	4	5	6	
c)	Ear discharge	0	1	2	3	4	5	6	
d)	Being unwell	0	1	2	3	4	5	6	
e)	Disturbed sleep	0	1	2	3	4	5	6	
f)	Episodes of distress/crying	0	1	2	3	4	5	6	
g)	Eating or drinking less than normal	0	1	2	3	4	5	6	
h)	Interference with normal activities	0	1	2	3	4	5	6	

...Now go to Day 13 on the next page -

Please enter today's date:	D M M Y Y Y
DAY 13 - DAILY QUESTIONS Please answer all the following questions in the evening of	Day 13 looking back over the last 24 hours
1. Has your child had any ear infection-related symptoms in the	last 24 hours? (tick one box only)
Yes 1 No 2	
2. Has your child been given an antibiotic in the last 24 hours (e	ear drops or by mouth)? (tick one box only)
Yes 1 No 2 If no to Question	ns 1 & 2, go to Day 14 on page 34
a) If yes, how many times? Write the number in the boxes (if n	one, please write " 00 ")
→ If "00", go to Qu.3 below	
b) If ear drops were used, which ear(s) did you treat? (tick one Right ear	
3. Did your child take any paracetamol, e.g. Calpol®, in the last 2	24 hours? (tick one box only)
Yes, for pain 1 Yes, for high temperature 2	Yes, for both 3 No 4
i) If yes, how many times?	If no, go to Qu.4
4. Did your child take any ibuprofen, e.g. Nurofen®, in the last 2	4 hours? (tick one box only)
Yes, for pain 1 Yes, for high temperature 2	Yes, for both 3 No 4
i) If yes, how many times?	If no, go to Qu.5
5. Did your child take any other pain-killing remedy today? (tick	one box only)
Yes \square 1 No \square 2 \longrightarrow If no, go to Qu.6	below
i) If yes, how many times?	
ii) If yes, please write the name of the remedy:	
6. Did your child take any other medicine for the ear infection ir	the last 24 hours? (tick one box only)
Yes	on the next page
i) If yes, please write the name of the medicine:	

7.	Has your child had any ear discharg	e? (tick one k	oox only)					
	Yes I 1 No 2	→ If no	o, go to Qu.8	below				
	i) If yes, from which ear? (tick on	e box only)						
	Right ear 1	Left ear	2	E	Both ears	3		
8.	Has your child had any of the follow box only to score each symptom as				s ? Please ansv	ver <u>all</u> th	ne questio	ns - tick one
		0 =	1 =	2 =	3 =	4 =	5 =	6 =
		Normal/no problem	Very little problem	Slight problem	Moderately bad	Bad	Very E bad	xtremely bad
a)	Pain	0	1	2	3	4	5	6
b)	High temperature (fever)	0	1	2	3	4	5	6
c)	Ear discharge	0	1	2	3	4	5	6
d)	Being unwell	0	1	2	3	4	5	6
e)	Disturbed sleep	o	1	2	3	4	5	6
f)	Episodes of distress/crying	0	1	2	3	4	5	6
g)	Eating or drinking less than normal	0	1	2	3	4	5	6
h)	Interference with normal activities	0	1	2	3	4	5	6

...Now go to Day 14 on the next page —

Please er	nter today's date:	D D M M	Y Y Y
	DAILY QUESTIONS nswer all the following questions in the even	ing of Day 14 looking bac	k over <u>the last 24 hours</u> .
1. Has yo	rour child had any ear infection-related symptoms 1 No 2	in the last 24 hours? (tick o	ne box only)
Yes	our child been given an antibiotic in the last 24 ho 1 No 2 If no to Qu 5, how many times? Write the number in the boxe If "00", go to Qu.3 below	estions 1 & 2, go to End of \	Week 2 Questions on page 36
•	r drops were used, which ear(s) did you treat? (tick		os not prescribed 4
Yes, fo	our child take any paracetamol, e.g. Calpol®, in th for pain 1 Yes, for high temperature If yes, how many times?		
Yes, fo	our child take any ibuprofen, e.g. Nurofen®, in the for pain 1 Yes, for high temperature If yes, how many times?		
Yes [our child take any other pain-killing remedy today 1 No 2 If no, go to the injury of the remedy:	? (tick one box only) o Qu.6 below	
6. Did yo	our child take any other medicine for the ear infec	ction in the last 24 hours? (ti	ick one box only)

7.	Has your child had any ear discharg	ge? (tick one k	oox only)						
	Yes 1 No 2	→ If no	o, go to Qu.8	below					
	i) If yes, from which ear? (tick on	e box only)							
	Right ear 1	Left ear	2	I	Both ears	3			
8.	Has your child had any of the follow box only to score each symptom as				s ? Please ansv	ver <u>all</u> th	ne quest	ions - tick or	16
	, , , , ,	0 =	1 =	2 =	3 =	4 =	5 =	6 =	
		Normal/no problem	Very little problem	Slight problem	Moderately bad	Bad	Very bad	Extremely bad	
a)	Pain	0	1	2	3	4		5 6	
b)	High temperature (fever)	0	1	2	3	4		5 6	
c)	Ear discharge	0	1	2	3	4		5 6	
d)	Being unwell	0	1	2	3	4		5 6	
e)	Disturbed sleep	0	1	2	3	4		5 6	
f)	Episodes of distress/crying	0	1	2	3	4		5 6	
g)	Eating or drinking less than normal	0	1	2	3	4		5 6	
h)	Interference with normal activities	0	1	2	3	4		5 6	

...Now go to End of Week 2 Questions on the next page —

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 14 – End of Week 2 Questions

Please enter today's date:	D D	М	М	ΥΥ	Υ
Please complete the following questions at the end of	the week o	n Day 1	. 4.		
A. NEW OR WORSENING SYMPTOMS					
1.a) Did your child experience, on one or more days in the last symptom (or symptoms) other than the ones you have a	•		mptom, or wc	orsening of a pr	re-existing
Yes \square 1 No \square 2 If no, go to	Section B bel	low			
b) If yes, please tell us what it was and if it was mild, mod when at its worst:	lerate or seve	ere	Mild	Moderate	Severe
i)			1	2	3
ii)			1	2	3
iii)			1	2	3
iv)			1	2	3
v)			1	2	3
vi)			1	2	3
vii)			1	2	3
viii)			1	2	3
 B. HEALTH SERVICES Please tell us about any other health services your child has have used NHS services for other health problems <u>not</u> to do about them. 1. Has your child had to see a GP again in the last 7 days b Yes	with your ch	ild's ear	problem, you	ı <u>do not</u> need t	•
2. Have you had a GP telephone appointment for your chil box only)		7 days b	ecause of the	eir ear problem	? (tick one
Yes 1 No 2 If no, go to i) If yes, how many calls?	Qu.3 below				
3. Has your child seen a GP practice nurse in the last 7 day Yes				ick one box onl	(y)

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 14 – End of Week 2 Questions

4.	Have you used the NHS telephone service 111 in the last 7 days because of your child's ear problem? (tick one box only)
	Yes If no, go to Qu.5 below
	i) If yes, how many times?
5.	Has your child attended an A&E department in the last 7 days because of their ear problem? (tick one box only)
	Yes I No 2 If no, go to Qu.6 below i) If yes, how many times?
	i) If yes, how many times?
6.	Has your child attended a hospital outpatient department in the last 7 days because of their ear problem? (tick one box only)
	Yes I No 2 If no, go to Qu.7 below i) If ves. how many times?
	i) If yes, how many times?
7.	Has your child stayed overnight in hospital in the last 7 days because of their ear problem? (tick one box only)
	Yes I No 2 If no, go to Qu. 8 below i) If ves. how many nights?
	i) If yes, how many nights?
8.	Did your child receive any additional treatment in the last 7 days because of their ear problem? (tick one box only)
	Yes If no, go to Section C on the next page
	i) If yes, please t please tell us what treatment they recived?
	a)
	b)
	c)

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 14 – End of Week 2 Questions

C. PRESCRIPTION MEDICINES

Please tell us about **ALL** medicines and remedies a doctor/nurse has prescribed **in the last 7 days** to treat your child's ear problem. If any medicines/remedies have been prescribed for **other** health problems **not** to do with your child's ear problem, you **do not** need to tell us about them.

1.		s your child been ys ? (tick one box	prescribed any med only)	licines or remedie	s by a docto	or/nurse for their ea	ar problem in th o	e last 7
	Yes	S 1	No	→ If no, go to S	ection D be	low		
i)	If	f yes, please tell ι	ıs which medicine oı	r remedy was pre	scribed (tick	all that apply):		
				Yes	No			
	a)	Paracetamol, e.	g. Calpol®					
	b)	Ibuprofen, e.g. I	Nurofen®					
	c)	Other pain-killin please tick box a	- '					
	d)	Other medicine e.g. new antibio and write name	tic, please tick box					
D.	PA	RENT'S SATISFA	ACTION WITH TREA	ATMENT				
1.	Ov	erall, how satisfie	d were you with the	treatment your	child receive	ed for their ear prol	olem? (tick one b	oox only)
Ex	trei	1 = mely satisfied	2 = Satisfied	3 = Neither sat or dissatis		4 = Not satisfied	5 = Extremely di	ssatisfied
		1	2	s	3	4		5
	If	f your child has no	ot recovered by Day	14 and still has 6	ear-related	symptoms and taki	ing antibiotics o	r pain-
		killing medicine	es, we would like to	call you again in	6 weeks' tir	me to ask about yo	ur child's recove	ery.

You have now completed the questionnaire. Thank you!

There are no further questions to complete in this booklet.

END OF QUESTIONNAIRE INSTRUCTIONS

RETURN OF CHILD'S STOOL SAMPLE (COLLECT ON DAY 14)

• Once you have collected the stool sample on Day 14 (please follow the instruction sheet provided), please post the sample in the return addressed envelope provided in the kit as soon as possible.

DIARY RETURN

- Please post the questionnaire back to us in the pre-paid envelope provided. We would be grateful if you could do
 this as soon as possible after completing the questionnaire but not before the final follow-up phone call from the
 study team.
- If you have lost the envelope, you can send it back to the following FREEPOST address:

FREEPOST RTZH-TUTT-KXSB
The REST Study
University of Bristol
Department of Social Medicine
Canynge Hall
39 Whatley Road
BRISTOL
BS8 2PS

THANK YOU!

For making a valuable contribution to health research. We will send you a £10 High Street Voucher by post as a token of our thanks for the valuable time you have given to help us with this research. If you can obtain a stool sample from your child, we will send you a further £5 voucher when we receive the sample.















Your Child's Symptom and Recovery Questionnaire (for parent to complete)

Child's participant ID number: (recruiting clinician to write in)

Study entry date (Day 1): (recruiting clinician to write in)





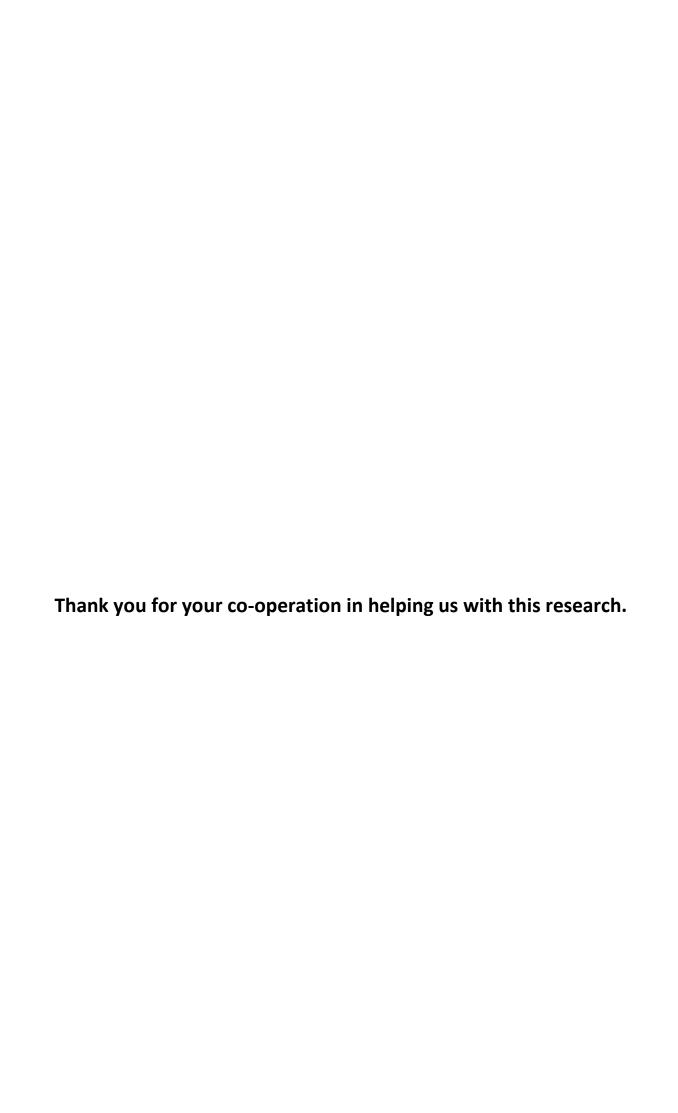
INSTRUCTIONS

- Please complete this questionnaire using black ink only.
- Instructions are given for each set of questions.
- **Day 1:** please answer these questions on the same day your child entered the study. We want to try to help so we will aim to telephone you within the first two days and answer any questions you may have.
- Days 2-14: please answer these questions every evening until Day 14 even if all your child's symptoms are completely better.
 - We'll also telephone you <u>2 or 3</u> times over the next two weeks, at a time convenient for you, to collect your information and offer help if needed.
- Days 7 and 14 Weekly Questions: please answer these questions even if all your child's symptoms are completely better.
 - We will telephone you on Days 7 and 14 to ask some further questions.
 - If your child's ear problem has not got better by Day 14, we'll ask if you are willing to answer some questions (by telephone call only) 6 weeks after the study entry date.
 - If the ear problem has stopped by Day 14, you will be asked to return the completed paper questionnaire in the pre-paid return envelope provided.

•	If you have chosen to complete the questionnaire on-line via the app (this is smartphone-friendly): If you
	have not received an email or text within 24 hours after entering the study or have any problems completing
	the online questionnaire, please contact us on or / or study email address:
	. Please refer to the REST web app user guide (enclosed) for instructions on how to use the
	app.

If you have any questions about filling in the questionnaire, please contact us:

Sue Harris, Res Email:	earch Nurse	_
Tel:	/	(work mobile)
Kate Rowley, T	rial Co-ordina	tor
Email:		
Tel:	/	(work mobile)
Annie Sadoo, T	rial Research	Administrator
Email:		
Tel:		
Kathryn Curtis,	Trial Manage	er
Email:		
Tel·	/	(work mobile)



YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 1 - Day of Study Entry

Please enter today's date:	D	D	/	M	M		Υ	Υ	Υ	ĺ
•			•			•				1

DAY 1 (DAY OF STUDY ENTRY) QUESTIONS ONLY

	ABOUT YOUR CHILD case answer these question	ons about y	our child.				
L.	Has your child ever had insertion of ventilation tubes (grommets)? (tick one box only)						
	Yes 1 No [2	→ If no, g	go to Qu.2 be	elow		
	i) If yes, how many times	?					
2.	Has your child ever had any	relevant su	rgical proce	dures/ ENT si	urgeries? (tick one k	oox only)	
	Yes 1 No	2	→ If no, g	go to Qu.3 be	elow		
	i) If yes, which of the follo	owing proced	dures/opera	ations? (tick a	all that apply) Yes		
	a) Adenoidectomy (with o	or without to	nsillectomy))		1	
	b) Tonsillectomy					1	
	c) Surgical removal of (pe	rsistent) gro	mmets			1	
	d) Other surgical procedu	re, please tic	k box and d	escribe:		1	
•	Harris abild a second frame	d £ allana		J:#:			h l\
3.	Has your child ever suffered		ic-type cond	aitions, e.g. a	strima, nay rever or	eczemar (tick one i	oox only)
	Yes 1 No	2					
1.	What is the name of the an	tibiotic medi	icine your cl	hild was pres	cribed today? Pleas	e write name:	
							•••••
5.	Please describe your child's	s ethnic grou	p (tick one l	box only):			
a)	White:	British	1	Irish	2	Any other White [background	3
o)	Black or Black British:	African	1	Caribbean	2	Any other Black [background	3
:)	Mixed or Mixed British:	White/Blac Caribbean	k 1	White/Blacl African	k ₂	White/Asian	3
		Any other N	Mixed backg	round	4		
(k	Asian or Asian	Indian	1	Pakistani	2	Bangladeshi	3
	British:	Chinese	4	Any other A	Asian background	5	
<u> </u>	Other Ethnic Group:	Arab	1	Any other e	ethnic group (please	describe): 2	
:)	Prefer not to answer						

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 1 - Day of Study Entry

6.	Does anybody living in	the child's home smo	oke? (tick one box only)	
	Yes I	No 2	If no, go to Section B below	
i)	▼ If yes, does anyone s	smoke in the house ? ((tick one box only)	
	Yes 1	No 2		
	ABOUT YOU (PAREN	•	self.	
1.	Would you describe yo	our educational qualif	ications as: (tick one box only)	
	Left school before age 16 years	1	Usual school exams 2 for 15-16	Usual school exams 3 for 17-18
	Further qualifications but not university degr	ree 4	University degree 5	Not applicable 6
2.	Are you: (tick one box	only)		
	Child's mother1	Child's	father 2	Other, please specify: 3

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 1 - Day of Study Entry

Please enter today's date:	
DAY 1 (DAY OF STUDY ENTRY) - DAILY QUESTIONS Please answer all the following questions in the evening looking back over the last 24 hours. We will ask the sar your child's recovery from their ear problem – please as completely better.	me questions every day until Day 14 so we can track
 Has your child had any ear infection-related symptoms in Yes 1 No 2 	the last 24 hours? (tick one box only)
 Has your child been given an antibiotic in the last 24 hour Yes 1 No 2 If no to Ques 	rs (ear drops or by mouth)? (tick one box only) tions 1 and 2, go to Day 2 on page 8
a) If yes, how many times? Write the number in the boxes (If "00", go to Qu.3 below	if none, please write " 00 ").
b) If ear drops were used, which ear(s) did you treat? (tick o Right ear 1 Left ear 2 Both	ears 3 Drops not prescribed 4
3. Did your child take any paracetamol, e.g. Calpol®, in the late of the late	
4. Did your child take any ibuprofen, e.g. Nurofen®, in the la Yes, for pain 1 Yes, for high temperature i) If yes, how many times?	st 24 hours? (tick one box only) Yes, for both 3 No 4 If no, go to Qu.5
 5. Did your child take any other pain-killing remedy in the late Yes	, , , , , , , , , , , , , , , , , , , ,
6. Did your child take any other medicine for the ear infection Yes 1 No 2 If no, go to Q	on in the last 24 hours? (tick one box only)

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 1 - Day of Study Entry

7.	Has your child had any ear discharg	ge in the last a	24 hours ? (tid	ck one box	only)			
	Yes 1 No 2	→ If no	o, go to Qu.8	below				
	i) If yes, from which ear? (tick on	e box only)						
	Right ear1	Left ear	2	I	Both ears	3		
8.	Has your child had any of the follow one box only to score each symptom					ver <u>all</u> th	ne questi	ons – tick
		0 =	1 =	2 =	3 =	4 =	5 =	6 =
		Normal/no	Very little	Slight	Moderately	Bad	•	Extremely
		problem	problem	problem	bad		bad	bad
a)	Pain	0	1	2	3	4		6
b)	High temperature (fever)	0	1	2	3	4	5	6
c)	Ear discharge	0	1	2	3	4	5	6
d)	Being unwell	0	1	2	3	4		6
e)	Disturbed sleep	0	1	2	3	4		6
f)	Episodes of distress/crying	0	1	2	3	4		5 6
g)	Eating or drinking less than normal	0	1	2	3	4		5 6
h)	Interference with normal activities	0	1	2	3	4		6

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 2 Please enter today's date: **DAY 2 - DAILY QUESTIONS** Please answer all the following questions in the evening of Day 2 looking back over the last 24 hours. 1. Has your child had any ear infection-related symptoms in the last 24 hours? (tick one box only) No Yes 2. Has your child been given an antibiotic in the last 24 hours (ear drops or by mouth)? (tick one box only) If no to Questions 1 and 2, go to Day 3 on page 10 Yes No a) If yes, how many times? Write the number in the boxes (if none, please write "00") ▶ If "00", go to Qu.3 below b) If ear drops were used, which ear(s) did you treat? (tick one box only) Right ear Left ear Both ears Drops not prescribed 3. Did your child take any paracetamol, e.g. Calpol®, in the last 24 hours? (tick one box only) Yes, for pain Yes, for high temperature Yes, for both If yes, how many times? If no, go to Qu.4 4. Did your child take any ibuprofen, e.g. Nurofen®, in the last 24 hours? (tick one box only) Yes, for high temperature Yes, for pain Yes, for both If yes, how many times? If no, go to Qu.5 5. Did your child take any other pain-killing remedy today? (tick **one** box only) No ➤ If no, go to Qu.6 below Yes

i) If yes, how many times?
ii) If yes, please write the name of the remedy:
6. Did your child take any other medicine for the ear infection in the last 24 hours? (tick one box only)
Yes 1 No 2 If no, go to Qu.7 on the next page
i) If yes, please write the name of the medicine:

/.	Has your child had any ear discharg	ger (tick one t	ox only)						
	Yes 1 No 2		o, go to Qu.8	below					
	i) If yes, from which ear? (tick on	e box only)							
	Right ear 1	Left ear	2	E	Both ears	3			
8.	Has your child had any of the follow box only to score each symptom as				s ? Please ansv	ver <u>all</u> th	ne quest	tions - tick one	
		0 =	1 =	2 =	3 =	4 =	5 =	6 =	
		Normal/no	Very little	Slight	Moderately	Bad	Very	Extremely	
		problem	problem	problem	bad		bad	bad	
a)	Pain	0	1	2	3	4		5 6	
b)	High temperature (fever)	0	1	2	3	4		5 6	
c)	Ear discharge	0	1	2	3	4		5 6	
d)	Being unwell	0	1	2	3	4		5 6	
e)	Disturbed sleep	0	1	2	3	4		5 6	
f)	Episodes of distress/crying	0	1	2	3	4		5 6	
g)	Eating or drinking less than normal	0	1	2	3	4		5 6	
h)	Interference with normal activities	0	1	2	3	4		5 6	

...Now go to Day 3 on the next page ——

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 3 Please enter today's date: **DAY 3 - DAILY QUESTIONS** Please answer all the following questions in the evening of Day 3 looking back over the last 24 hours. 1. Has your child had any ear infection-related symptoms in the last 24 hours? (tick one box only) Yes No 2. Has your child been given an antibiotic in the last 24 hours (ear drops or by mouth)? (tick one box only) No ► If no to Questions 1 & 2, go to Day 4 on page 12 Yes a) If yes, how many times? Write the number in the boxes (if none, please write "00") → If "00", go to Qu.3 below b) If ear drops were used, which ear(s) did you treat? (tick one box only) Right ear Left ear Both ears Drops not prescribed 3. Did your child take any paracetamol, e.g. Calpol®, in the last 24 hours? (tick one box only) Yes, for pain Yes, for high temperature Yes, for both If yes, how many times? If no, go to Qu.4 4. Did your child take any ibuprofen, e.g. Nurofen®, in the last 24 hours? (tick one box only) Yes, for high temperature Yes, for pain Yes, for both If yes, how many times? If no, go to Qu.5 5. Did your child take any other pain-killing remedy today? (tick **one** box only) No → If no, go to Qu.6 below Yes i) If yes, how many times? ii) If yes, please write the name of the remedy:

6. Did your child take any other medicine for the ear infection in the last 24 hours? (tick one box only)

If yes, please write the name of the medicine:

Yes

i)

If no, go to Qu.7 on the next page

7.	Has your child had any ear discharg	ge? (tick one k	oox only)					
	Yes I 1 No 2		o, go to Qu.8	below				
	i) If yes, from which ear? (tick on	e box only)						
	Right ear 1	Left ear	2	E	Both ears	3		
3.	Has your child had any of the follow box only to score each symptom as				s ? Please answ	ver <u>all</u> th	ne quest	ions - tick one
		0 =	1 =	2 =	3 =	4 =	5 =	6 =
		Normal/no problem	Very little problem	Slight problem	Moderately bad	Bad	Very bad	Extremely bad
a)	Pain	0	1	2	3	4		5 6
o)	High temperature (fever)	0	1	2	3	4		5 6
:)	Ear discharge	0	1	2	3	4		5 6
(k	Being unwell	0	1	2	3	4		5 6
9)	Disturbed sleep	0	1	2	3	4		5 6
)	Episodes of distress/crying	0	1	2	3	4		5 6
g)	Eating or drinking less than normal	0	1	2	3	4		5 6
1)	Interference with normal activities	0	1	2	3	4		5 6

...Now go to Day 4 on the next page

Please enter today's date: **DAY 4 - DAILY QUESTIONS** Please answer all the following questions in the evening of Day 4 looking back over the last 24 hours. 1. Has your child had any ear infection-related symptoms in the last 24 hours? (tick one box only) Yes No 2. Has your child been given an antibiotic in the last 24 hours (ear drops or by mouth)? (tick one box only) If no to Questions 1 & 2, go to Day 5 on page 14 Yes No a) If yes, how many times? Write the number in the boxes (if none, please write "00") → If "00", go to Qu.3 below b) If ear drops were used, which ear(s) did you treat? (tick one box only) Right ear Left ear Both ears Drops not prescribed 3. Did your child take any paracetamol, e.g. Calpol®, in the last 24 hours? (tick one box only) Yes, for pain Yes, for high temperature Yes, for both If yes, how many times? If no, go to Qu.4 4. Did your child take any ibuprofen, e.g. Nurofen®, in the last 24 hours? (tick one box only) Yes, for high temperature Yes, for pain Yes, for both If yes, how many times? If no, go to Qu.5 5. Did your child take any other pain-killing remedy today? (tick **one** box only) No → If no, go to Qu.6 below Yes i) If yes, how many times? ii) If yes, please write the name of the remedy: 6. Did your child take any other medicine for their ear infection in the last 24 hours? (tick one box only) Yes ➤ If no, go to Qu.7 on the next page No If yes, please write the name of the medicine:

/.	Has your child had any ear discharg	ger (tick one t	ox only)					
	Yes I 1 No 2	→ If no	o, go to Qu.8	below				
	i) If yes, from which ear? (tick on	e box only)						
	Right ear 1	Left ear	2	ĺ	Both ears	3		
8.	Has your child had any of the follow box only to score each symptom as				s ? Please ansv	ver <u>all</u> th	ie questi	ons - tick one
		0 =	1 =	2 =	3 =	4 =	5 =	6 =
		Normal/no	Very little	Slight	Moderately	Bad	-	Extremely
		problem	problem	problem	bad		bad	bad
a)	Pain	0	1	2	3	4		6
b)	High temperature (fever)	0	1	2	3	4	5	6
c)	Ear discharge	0	1	2	3	4	5	6
d)	Being unwell	0	1	2	3	4		6
e)	Disturbed sleep	0	1	2	3	4		6
f)	Episodes of distress/crying	0	1	2	3	4		5 6
g)	Eating or drinking less than normal	0	1	2	3	4		5 6
h)	Interference with normal activities	0	1	2	3	4		5 6

...Now go to Day 5 on the next page

Please enter today's date:	D D M M Y Y Y Y
DAY 5 - DAILY QUESTIONS Please answer all the following questions in the <u>ev</u>	ening of Day 5 looking back over the last 24 hours.
 Has your child had any ear infection-related sympton Yes 1 No 2 	ms in the last 24 hours ? (tick one box only)
 Yes	hours (ear drops or by mouth)? (tick one box only) Questions 1 & 2, go to Day 6 on page 16
a) If yes, how many times? Write the number in the bo	oxes (if none, please write " 00 ")
b) If ear drops were used, which ear(s) did you treat? (Right ear 1 Left ear 2	tick one box only) Both ears 3 Drops not prescribed 4
3. Did your child take any paracetamol, e.g. Calpol®, in Yes, for pain 1 Yes, for high temperature i) If yes, how many times?	
4. Did your child take any ibuprofen, e.g. Nurofen®, in the Yes, for pain 1 Yes, for high temperature i) If yes, how many times?	
 Did your child take any other pain-killing remedy too Yes	lay? (tick one box only) o to Qu.6 below
6. Did your child take any other medicine for the ear in Yes 1 No 2 If no, go i) If yes, please write the name of the medicine:	fection in the last 24 hours? (tick one box only) to Qu.7 on the next page

/٠	rias your crillo riad arry ear discriars	ge: (tick one i	JOX Office						
	Yes 1 No 2	→ If no	o, go to Qu.8	below					
	i) If yes, from which ear? (tick on	e box only)							
	Right ear 1	Left ear	2	I	Both ears	3			
8.	Has your child had any of the follow box only to score each symptom as				s ? Please ansv	ver <u>all</u> th	ne quest	ions - tick on	e
		0 =	1 =	2 =	3 =	4 =	5 =	6 =	
		Normal/no	Very little	Slight	Moderately	Bad	Very	Extremely	
		problem	problem	problem	bad		bad	bad	
a)	Pain	0	1	2	3	4		5 6	
b)	High temperature (fever)	0	1	2	3	4		5 6	
c)	Ear discharge	0	1	2	3	4		5 6	
d)	Being unwell	0	1	2	3	4		5 6	
e)	Disturbed sleep	0	1	2	3	4		5 6	
f)	Episodes of distress/crying	0	1	2	3	4		5 6	
g)	Eating or drinking less than normal	0	1	2	3	4		5 6	
h)	Interference with normal activities	0	1	2	3	4		5 6	

...Now go to Day 6 on the next page

Ple	ease enter today's date:
	Y 6 - DAILY QUESTIONS case answer all the following questions in the <u>evening of Day 6</u> looking back over the last 24 hours.
1.	Has your child had any ear infection-related symptoms in the last 24 hours? (tick one box only)
	Yes 1 No 2
2.	Has your child been given an antibiotic in the last 24 hours (ear drops or by mouth)? (tick one box only)
	Yes 1 No 2 If no to Questions 1 & 2, go to Day 7 on page 18
a)	If yes, how many times? Write the number in the boxes (if none, please write "00")
	→ If "00", go to Qu.3 below
b)	If ear drops were used, which ear(s) did you treat? (tick one box only) Right ear 1 Left ear 2 Both ears 3 Drops not prescribed 4
	Right ear 1 1 Left ear 2 Both ears 3 Drops not prescribed 4
3.	Did your child take any paracetamol, e.g. Calpol®, in the last 24 hours ? (tick one box only) Yes, for pain
	i) If yes, how many times? If no, go to Qu.4
4.	Did your child take any ibuprofen, e.g. Nurofen®, in the last 24 hours? (tick one box only)
	Yes, for pain 1 Yes, for high temperature 2 Yes, for both 3 No 4
	i) If yes, how many times? If no, go to Qu.5
5.	Did your child take any other pain-killing remedy today? (tick one box only)
	Yes No 2 If no, go to Qu.6 below
	i) If yes, how many times?
	ii) If yes, please write the name of the remedy:
6.	Did your child take any other medicine for the ear infection in the last 24 hours? (tick one box only)
	Yes 1 No 2 → If no, go to Qu.7 on the next page
	i) If yes, please write the name of the medicine:

7.	Has your child had any ear discharg	ge? (tick one k	oox only)					
	Yes 1 No 2	→ If no	o, go to Qu.8	below				
	i) If yes, from which ear? (tick on	e box only)						
	Right ear	Left ear	2	I	Both ears	3		
8.	Has your child had any of the follow box only to score each symptom as				s ? Please answ	ver <u>all</u> th	ne ques	tions - tick one
		0 =	1 =	2 =	3 =	4 =	5 =	6 =
		Normal/no problem	Very little problem	Slight problem	Moderately bad	Bad	Very bad	Extremely bad
		problem	problem	problem	Dau		Dau	bau
a)	Pain	0	1	2	3	4		5 6
b)	High temperature (fever)	0	1	2	3	4		5 6
c)	Ear discharge	0	1	2	3	4		5 6
d)	Being unwell	0	1	2	3	4		5 6
e)	Disturbed sleep	0	1	2	3	4		5 6
f)	Episodes of distress/crying	0	1	2	3	4		5 6
g)	Eating or drinking less than normal	0	1	2	3	4		5 6
h)	Interference with normal activities	0	1	2	3	4		5 6

...Now go to Day 7 on the next page

Please enter today's date:	D D M M Y Y Y
DAY 7 - DAILY QUESTIONS Please answer all the following questions in the <u>ev</u>	ening of Day 7 looking back over the last 24 hours.
 Has your child had any ear infection-related sympton Yes 1 No 2 	ns in the last 24 hours ? (tick one box only)
2. Has your child been given an antibiotic in the last 24 Yes 1 No 2 If no to 0 a) If yes , how many times? Write the number in the bo	Questions 1 & 2, go to End of Week 1 Questions on page 20
b) If ear drops were used, which ear(s) did you treat? (to Right ear 1 Left ear 2	cick one box only) Both ears 3 Drops not prescribed 4
3. Did your child take any paracetamol, e.g. Calpol®, in Yes, for pain 1 Yes, for high temperatur i) If yes, how many times?	
4. Did your child take any ibuprofen, e.g. Nurofen®, in t Yes, for pain 1 Yes, for high temperatur i) If yes, how many times?	
 Did your child take any other pain-killing remedy tod Yes	ay? (tick one box only) o to Qu.6 below
6. Did your child take any other medicine for the ear information of the ear information of the medicine:	fection in the last 24 hours? (tick one box only) to Qu.7 on the next page

7.	Has your child had any ear discharg	ge? (tick one k	oox only)					
	Yes I No 2	→ If no	o, go to Qu.8	below				
	i) If yes, from which ear? (tick on	e box only)						
	Right ear 1	Left ear	2	E	Both ears	3		
3.	Has your child had any of the follow box only to score each symptom as	•			s ? Please answ	ver <u>all</u> th	ne quest	ions - tick one
		0 =	1 =	2 =	3 =	4 =	5 =	6 =
		Normal/no problem	Very little problem	Slight problem	Moderately bad	Bad	Very bad	Extremely bad
a)	Pain	0	1	2	3	4		5 6
o)	High temperature (fever)	0	1	2	3	4		5 6
:)	Ear discharge	0	1	2	3	4		5 6
(k	Being unwell	0	1	2	3	4		5 6
<u>e</u>)	Disturbed sleep	0	1	2	3	4		5 6
)	Episodes of distress/crying	0	1	2	3	4		5 6
g)	Eating or drinking less than normal	0	1	2	3	4		5 6
1)	Interference with normal activities	0	1	2	3	4		5 6

...Now go to End of Week 1 Questions on the next page

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 7 – End of Week 1 Questions

Please enter today's date:	D D	М	M	Υ	Υ	Υ	Υ	
Please complete the following questions at the end o	f the week or	n Day 7	'.					
 A. NEW OR WORSENING SYMPTOMS 1.a) Did your child experience, on one or more days in the symptom (or symptoms) other than the ones you have 		-	nptom,	or wo	rsenin	g of a _l	pre-e>	kisting
<u> </u>	Section B belo		M	114	Mod	lerate	ا د	
b) If yes, please tell us what it was and if it was mild, mod when at its worst:	uerate or sever	e 	IVI	lia	IVIOC	ierate	36	evere
i)				1		2		3
ii)				1		2		3
iii)				1		2		3
iv)				1		2		3
v)				1		2		3
vi)				1		2		3
vii)				1		2		3
viii)				1		2		3
 B. HEALTH SERVICES Please tell us about any other health services your child has have used NHS services for other health problems not to do about them. 1. Has your child had to see a GP again in the last 7 days to Yes i) If yes, how many times? 	o with your chil	d's ear	probler	n, you	<u>do no</u>	<u>t</u> need	to te	
 2. Have you had a GP telephone appointment for your children box only) Yes	ld in the last 7 Qu.3 below	days b	ecause	of the	ir ear p	oroblei	m? (ti	ck one
3. Has your child seen a GP practice nurse in the last 7 day Yes 1 No 2 If no, go to i) If yes, how many times?	-			m? (tio	ck one	box o	nly)	

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 7 – End of Week 1 Questions

4. Have you used the NHS telephone service 111 in the last 7 days because of your child's ear problem? (tick on only)							
Yes In No 2 If no, go to Qu.5 below							
i) If yes, how many times?							
Has your child attended an A&E department in the last 7 days because of their ear problem? (tick one box only)							
Yes I 1 No 2 If no, go to Qu.6 below i) If yes, how many times?							
i) If yes, how many times?							
Has your child attended a hospital outpatient department in the last 7 days because of their ear problem? (tick one box only)							
Yes I No 2 If no, go to Qu.7 below i) If ves. how many times?							
i) If yes, how many times?							
Has your child stayed overnight in hospital in the last 7 days because of their ear problem? (tick one box only)							
Yes I No 2 If no, go to Qu.8 below i) If yes, how many nights?							
i) If yes, how many nights?							
Did your child receive any additional treatment in the last 7 days because of their ear problem? (tick one box only)							
Yes If no, go to Section C on the next page							
i) If yes, please tell us what treatment they received:							
a)							
b)							
c)							

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 7 – End of Week 1 Questions

C. PRESCRIPTION MEDICINES

Please tell us about **ALL** medicines and remedies a doctor/nurse has prescribed **in the last 7 days** to treat your child's ear problem. If any medicines/remedies have been prescribed for **other** health problems **not** to do with your child's ear problem, you **do not** need to tell us about them.

1.	Has your child been prescribed any medicines or remedies by a doctor/nurse for their ear problem in the last 7 days? (tick one box only)					
	Yes	\bigcap_1 No \bigcap_2 \longrightarrow If	no, go to Day	8 on the next page		
i)	If	yes, please tell us which medicine or reme	dy was presci	ibed (tick all that apply):		
			Yes	No		
	a)	Paracetamol, e.g. Calpol®				
	b)	Ibuprofen, e.g. Nurofen®				
	c)	Other pain-killing remedy, please tick box and write name:				
	d)	Other medicine for ear problem, e.g. new antibiotic, please tick box and write name:				

Please enter today's date:	
DAY 8 - DAILY QUESTIONS Please answer all the following questions in the	evening of Day 8 looking back over the last 24 hours.
1. Has your child had any ear infection-related symptons	oms in the last 24 hours? (tick one box only)
Yes 1 No 2	
2. Has your child been given an antibiotic in the last	24 hours (ear drops or by mouth)? (tick one box only)
Yes ☐ 1 No ☐ 2 → If no t	to Questions 1 & 2, go to Day 9 on page 25
a) If yes, how many times? Write the number in the	boxes (if none, please write " 00 ")
If "00", go to Qu.3 below	ı
b) If ear drops were used, which ear(s) did you treat	? (tick one box only)
Right ear 1 Left ear 2	Both ears Drops not prescribed 4
3. Did your child take any paracetamol, e.g. Calpol®,	in the last 24 hours? (tick one box only)
Yes, for pain 1 Yes, for high temperate	ture 2 Yes, for both 3 No 4
i) If yes, how many times?	↓ If no, go to Qu.4
4. Did your child take any ibuprofen, e.g. Nurofen®, i	n the last 24 hours? (tick one box only)
Yes, for pain 1 Yes, for high temperate	ture 2 Yes, for both 3 No 4
i) If yes, how many times?	If no, go to Qu.5
Did your child take any other pain-killing remedy t	oday? (tick one box only)
Yes ☐ 1 No ☐ 2 → If no,	go to Qu.6 below
i) If yes, how many times?	
ii) If yes, please write the name of the remedy:	
, yes, prease write the halfe of the remedy.	
6. Did your child take any other medicine for the ear	infection in the last 24 hours? (tick one box only)
Yes \square_1 No \square_2 \longrightarrow If no,	go to Qu.7 on the next page
i) If yes, please write the name of the medicine:	
	

<i>/</i> .	Has your child had any ear discharg	ger (tick one t	ox only)						
	Yes 1 No 2 i) If yes, from which ear? (tick on		o, go to Qu.8	below					
	Right ear1	Left ear	2	E	Both ears	3			
8.	Has your child had any of the follow box only to score each symptom as				s ? Please answ	ver <u>all</u> th	ne quest	tions - tick one	9
		0 =	1 =	2 =	3 =	4 =	5 =	6 =	
		Normal/no	Very little	Slight	Moderately	Bad	Very	Extremely	
		problem	problem	problem	bad		bad	bad	
a)	Pain	0	1	2	3	4		5 6	
b)	High temperature (fever)	0	1	2	3	4		5 6	
c)	Ear discharge	0	1	2	3	4		5 6	
d)	Being unwell	0	1	2	3	4		5 6	
e)	Disturbed sleep	0	1	2	3	4		5 6	
f)	Episodes of distress/crying	0	1	2	3	4		5 6	
g)	Eating or drinking less than normal	0	1	2	3	4		5 6	
h)	Interference with normal activities	0	1	2	3	4		5 6	

...Now go to Day 9 on the next page

Please enter today's date:	D D M M Y Y Y
DAY 9 - DAILY QUESTIONS Please answer all the following questions in the <u>eve</u>	ening of Day 9 looking back over the last 24 hours.
1. Has your child had any ear infection-related sympton	ns in the last 24 hours? (tick one box only)
Yes 1 No 2	
2. Has your child been given an antibiotic in the last 24	hours (ear drops or by mouth)? (tick one box only)
Yes \square 1 No \square 2 If no to 0	Questions 1 & 2, go to Day 10 on page 27
♦a) If yes, how many times? Write the number in the bo	xes (if none, please write " 00 ")
→ If "00", go to Qu.3 below	
b) If ear drops were used, which ear(s) did you treat? (tick one box only)
Right ear 1 Left ear 2	Both ears 3
3. Did your child take any paracetamol, e.g. Calpol®, in t	he last 24 hours? (tick one box only)
Yes, for pain 1 Yes, for high temperature	Yes, for both 3 No 4
<u> </u>	
i) If yes, how many times?	If no, go to Qu.4
4. Did your child take any ibuprofen, e.g. Nurofen®, in t	ne last 24 hours? (tick one box only)
Yes, for pain 1 Yes, for high temperature	Yes, for both 3 No 4
, , , , , , , , , , , , , , , , , , ,	
i) If yes, how many times?	If no, go to Qu.5
5. Did your child take any other pain-killing remedy tod	ay? (tick one box only)
Yes ☐ 1 No ☐ 2 → If no, go	to Qu.6 below
i) If yes, how many times?	
ii) If yes, please write the name of the remedy:	
6. Did your child take any other medicine for the ear inf	ection in the last 24 hours? (tick one box only)
Yes \square_1 No \square_2 If no, go	to Qu.7 on the next page
i) If yes, please write the name of the medicine:	

/ .	Has your child had any ear discharg	ge? (tick one b	oox only)					
	Yes 1 No 2	→ If no	o, go to Qu.8	below				
	i) If yes, from which ear? (tick on	e box only)						
	Right ear 1	Left ear	2	E	Both ears	3		
3.	Has your child had any of the follow box only to score each symptom as				s ? Please answ	/er <u>all</u> th	ne quest	ions - tick one
		0 =	1 =	2 =	3 =	4 =	5 =	6 =
		Normal/no problem	Very little problem	Slight problem	Moderately bad	Bad	Very bad	Extremely bad
a)	Pain	0	1	2	3	4		5 6
o)	High temperature (fever)	0	1	2	3	4		5 6
:)	Ear discharge	0	1	2	3	4		5 6
d)	Being unwell	0	1	2	3	4		5 6
<u>e</u>)	Disturbed sleep	0	1	2	3	4		5 6
)	Episodes of distress/crying	0	1	2	3	4		5 6
g)	Eating or drinking less than normal	0	1	2	3	4		5 6
1)	Interference with normal activities	0	1	2	3	4		5 6

...Now go to Day 10 on the next page

Please enter today's date:	D D M M Y Y Y
DAY 10 - DAILY QUESTIONS Please answer all the following questions in the <u>ev</u>	vening of Day 10 looking back over the last 24 hours.
Has your child had any ear infection-related sympto	ms in the last 24 hours? (tick one box only)
Yes 1 No 2	
2. Has your child been given an antibiotic in the last 24	hours (ear drops or by mouth)? (tick one box only)
Yes ☐ 1 No ☐ 2 → If no to	Questions 1 & 2, go to Day 11 on page 29
a) If yes, how many times? Write the number in the b	oxes (if none, please write " 00 ")
If "00", go to Qu.3 below	
b) If ear drops were used, which ear(s) did you treat? Right ear	(tick one box only) Both ears 3 Drops not prescribed 4
3. Did your child take any paracetamol, e.g. Calpol®, in Yes, for pain	
i) If yes, how many times?	If no, go to Qu.4
4. Did your child take any ibuprofen, e.g. Nurofen [®] , in	the last 24 hours? (tick one box only)
Yes, for pain 1 Yes, for high temperatu	re 2 Yes, for both 3 No 4
i) If yes, how many times?	↓ If no, go to Qu.5
5. Did your child take any other pain-killing remedy to	day? (tick one box only)
Yes 1 No 2	o to Qu.6 below
i) If yes, how many times?	
ii) If yes, please write the name of the remedy:	
6. Did your child take any other medicine for the ear in	fection in the last 24 hours? (tick one box only)
Yes ☐ 1 No ☐ 2 → If no, g	o to Qu.7 on the next page
i) If yes, please write the name of the medicine:	

7.	Has your child had any ear discharg	ge? (tick one b	oox only)					
	Yes 1 No 2 i) If yes, from which ear? (tick on		o, go to Qu.8	below				
	Right ear 1	Left ear	2	I	Both ears	3		
8.	Has your child had any of the follow box only to score each symptom as				s ? Please answ	ver <u>all</u> th	ie questi	ions - tick one
		0 =	1 =	2 =	3 =	4 =	5 =	6 =
		Normal/no	Very little	Slight	Moderately	Bad	•	Extremely
		problem	problem	problem	bad		bad	bad
a)	Pain	0	1	2	3	4		5 6
b)	High temperature (fever)	0	1	2	3	4		6
c)	Ear discharge	0	1	2	3	4		6
d)	Being unwell	0	1	2	3	4		6
e)	Disturbed sleep	0	1	2	3	4		6
f)	Episodes of distress/crying	0	1	2	3	4		5 6
g)	Eating or drinking less than normal	0	1	2	3	4		5 6
h)	Interference with normal activities	0	1	2	3	4		5 6

...Now go to Day 11 on the next page

Please enter today's date:	
DAY 11 - DAILY QUESTIONS Please answer all the following questions in the <u>eve</u>	ning of Day 11 looking back over the last 24 hours.
 Has your child had any ear infection-related symptom Yes 1 No 2 	s in the last 24 hours ? (tick one box only)
2. Has your child been given an antibiotic in the last 24 h Yes	uestions 1 & 2, go to Day 12 on page 31
b) If ear drops were used, which ear(s) did you treat? (t	oth ears 3 Drops not prescribed 4
3. Did your child take any paracetamol, e.g. Calpol®, in t l Yes, for pain 1 Yes, for high temperature i) If yes, how many times?	
4. Did your child take any ibuprofen, e.g. Nurofen®, in th Yes, for pain 1 Yes, for high temperature i) If yes, how many times?	
 Did your child take any other pain-killing remedy toda Yes	y? (tick one box only) to Qu.6 below
6. Did your child take any other medicine for the ear inference of the ear inference of the medicine:	ection in the last 24 hours? (tick one box only) to Qu.7 on the next page

7.	Has your child had any ear discharg	ge? (tick one k	oox only)					
	Yes If yes, from which ear? (tick on		o, go to Qu.8	below				
	Right ear 1	Left ear	2	I	Both ears	3		
8.	Has your child had any of the follow box only to score each symptom as	0 , .			s ? Please answ	ver <u>all</u> th	ne questi	ons - tick one
		0 =	1 =	2 =	3 =	4 =	5 =	6 =
		Normal/no	Very little	Slight	Moderately	Bad	•	Extremely
		problem	problem	problem	bad		bad	bad
a)	Pain	0	1	2	3	4	5	6
b)	High temperature (fever)	0	1	2	3	4	5	6
c)	Ear discharge	0	1	2	3	4	5	6
d)	Being unwell	0	1	2	3	4	5	6
e)	Disturbed sleep	0	1	2	3	4	5	6
f)	Episodes of distress/crying	0	1	2	3	4	5	6
g)	Eating or drinking less than normal	0	1	2	3	4	5	6
h)	Interference with normal activities	0	1	2	3	4	5	6

...Now go to Day 12 on the next page

Please enter today's date:	D D M M Y Y Y
DAY 12 - DAILY QUESTIONS Please answer all the following questions in the <u>eve</u>	ening of Day 12 looking back over the last 24 hours.
 Has your child had any ear infection-related sympton Yes 1 No 2 	ns in the last 24 hours ? (tick one box only)
 Has your child been given an antibiotic in the last 24 Yes 1 No 2 If no to 0 	hours (ear drops or by mouth)? (tick one box only) Questions 1 & 2, go to Day 13 on page 33
a) If yes, how many times? Write the number in the bo	xes (if none, please write " 00 ")
b) If ear drops were used, which ear(s) did you treat? (t Right ear	ick one box only) Both ears 3 Drops not prescribed 4
3. Did your child take any paracetamol, e.g. Calpol®, in to Yes, for pain 1 Yes, for high temperature i) If yes, how many times?	
4. Did your child take any ibuprofen, e.g. Nurofen®, in t Yes, for pain 1 Yes, for high temperature i) If yes, how many times?	
 Did your child take any other pain-killing remedy todal Yes	ay? (tick one box only) o to Qu.6 below
6. Did your child take any other medicine for the ear inf Yes 1 No 2 If no, go i) If yes, please write the name of the medicine:	to Qu.7 on the next page

7.	Has your child had any ear discharg	ge? (tick one k	oox only)						
	Yes I No 2	→ If no	o, go to Qu.8	below					
	i) If yes, from which ear? (tick on	e box only)							
	Right ear1	Left ear	2	I	Both ears	3			
3.	Has your child had any of the follow box only to score each symptom as				s ? Please answ	ver <u>all</u> th	ne quest	ions - tick	one
		0 =	1 =	2 =	3 =	4 =	5 =	6 =	
		Normal/no	Very little	Slight	Moderately	Bad	Very	Extreme	ly
		problem	problem	problem	bad —		bad	bad	
a)	Pain	0	1	2	3	4		5	6
o)	High temperature (fever)	0	1	2	3	4		5	6
:)	Ear discharge	0	1	2	3	4		5	6
d)	Being unwell	0	1	2	3	4		5	6
<u>=</u>)	Disturbed sleep	0	1	2	3	4		5	6
)	Episodes of distress/crying	0	1	2	3	4		5	6
g)	Eating or drinking less than normal	0	1	2	3	4		5	6
1)	Interference with normal activities	0	1	2	3	4		5	6

...Now go to Day 13 on the next page

Please enter today's date:	
DAY 13 - DAILY QUESTIONS Please answer all the following questions in the <u>ever</u>	ning of Day 13 looking back over the last 24 hours.
Has your child had any ear infection-related symptoms	in the last 24 hours? (tick one box only)
Yes 1 No 2	
2. Has your child been given an antibiotic in the last 24 h	ours (ear drops or by mouth)? (tick one box only)
Yes ☐ 1 No ☐ 2 If no to Q	uestions 1 & 2, go to Day 14 on page 35
a) If yes, how many times? Write the number in the box	es (if none, please write " 00 ")
→ If "00", go to Qu.3 below	
b) If ear drops were used, which ear(s) did you treat? (ti	ck one box only)
Right ear 1 Left ear 2 Bo	oth ears 3
3. Did your child take any paracetamol, e.g. Calpol®, in th	e last 24 hours? (tick one box only)
Yes, for pain 1 Yes, for high temperature	Yes, for both 3 No 4
i) If yes, how many times?	↓ If no, go to Qu.4
4. Did your child take any ibuprofen, e.g. Nurofen®, in th	e last 24 hours? (tick one box only)
Yes, for pain 1 Yes, for high temperature	yes, for both 3 No 4
i) If yes, how many times?	↓ If no, go to Qu.5
5. Did your child take any other pain-killing remedy today	/? (tick one box only)
Yes 1 No 2 If no, go t	to Qu.6 below
i) If yes, how many times?	
ii) If yes, please write the name of the remedy:	
6. Did your child take any other medicine for the ear infe	ction in the last 24 hours? (tick one box only)
Yes ☐ 1 No ☐ 2 → If no, go to	o Qu.7 on the next page
i) If yes, please write the name of the medicine:	

7.	Has your child had any ear discharg	ge? (tick one k	oox only)					
	Yes 1 No 2		o, go to Qu.8	below				
	i) If yes, from which ear? (tick on	e box only)						
	Right ear1	Left ear	2	1	Both ears	3		
8.	Has your child had any of the follow box only to score each symptom as				s? Please answ	ver <u>all</u> th	ne questi	ions - tick one
		0 =	1 =	2 =	3 =	4 =	5 =	6 =
		Normal/no	Very little	Slight	Moderately	Bad	Very	Extremely
		problem	problem	problem	bad		bad	bad
a)	Pain	0	1	2	3	4		5 6
b)	High temperature (fever)	0	1	2	3	4		6
c)	Ear discharge	0	1	2	3	4		6
d)	Being unwell	0		2	3	4		6
e)	Disturbed sleep	0	1	2	3	4		6
f)	Episodes of distress/crying	0	1	2	3	4		5 6
g)	Eating or drinking less than normal	0	1	2	3	4		5 6
h)	Interference with normal activities	0	1	2	3	4		5 6

Please enter today's date:	D D M M Y Y Y
DAY 14 - DAILY QUESTIONS Please answer all the following questions in the <u>eve</u>	ening of Day 14 looking back over the last 24 hours.
 Has your child had any ear infection-related symptom Yes 1 No 2 	ns in the last 24 hours ? (tick one box only)
$\overline{\downarrow}$	Questions 1 & 2, go to End of Week 2 Questions on page 3
a) If yes, how many times? Write the number in the box If "00", go to Qu.3 below	xes (if none, please write " 00 ")
b) If ear drops were used, which ear(s) did you treat? (t Right ear	ick one box only) Both ears 3 Drops not prescribed 4
3. Did your child take any paracetamol, e.g. Calpol®, in t Yes, for pain 1 Yes, for high temperature i) If yes, how many times?	
4. Did your child take any ibuprofen, e.g. Nurofen®, in tl Yes, for pain 1 Yes, for high temperature i) If yes, how many times?	
 5. Did your child take any other pain-killing remedy todal Yes	ay? (tick one box only) to Qu.6 below
6. Did your child take any other medicine for the ear inf Yes 1 No 2 If no, go i) If yes, please write the name of the medicine:	ection in the last 24 hours? (tick one box only) to Qu.7 on the next page

7.	Has your child had any ear discharg	ge? (tick one k	oox only)						
	Yes 1 No 2 i) If yes, from which ear? (tick on		o, go to Qu.8	below					
	ii yes, from which ear? (tick of	<u> </u>	_			_			
	Right ear 1	Left ear	2	E	Both ears	3			
3.	Has your child had any of the follow box only to score each symptom as				s ? Please answ	ver <u>all</u> th	ne questi	ons - tick one	;
		0 =	1 =	2 =	3 =	4 =	5 =	6 =	
		Normal/no	Very little	Slight	Moderately	Bad	•	Extremely	
		problem	problem	problem	bad ——		bad	bad	
a)	Pain	0	1	2	3	4		5 6	
o)	High temperature (fever)	0	1	2	3	4		5 6	
:)	Ear discharge	0	1	2	3	4	5	6	
d)	Being unwell	0	1	2	3	4		5 6	
e)	Disturbed sleep	0	1	2	3	4		5 6	
·)	Episodes of distress/crying	0	1	2	3	4		5 6	
g)	Eating or drinking less than normal	0	1	2	3	4		5 6	
1)	Interference with normal activities	0	1	2	3	4		5 6	

...Now go to End of Week 2 Questions on the next page

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 14 – End of Week 2 Questions

Please enter today's date:	D D	М	М	ΥΥ	Υ
Please complete the following questions at the end of	the week o	n Day 1	. 4.		
A. NEW OR WORSENING SYMPTOMS					
1.a) Did your child experience, on one or more days in the last symptom (or symptoms) other than the ones you have a	•		mptom, or wc	orsening of a p	re-existing
Yes \square 1 No \square 2 If no, go to	Section B bel	low			
b) If yes, please tell us what it was and if it was mild, mod when at its worst:	lerate or seve	ere	Mild	Moderate	Severe
i)			1	2	3
ii)			1	2	3
iii)			1	2	3
iv)			1	2	3
v)			1	2	3
vi)			1	2	3
vii)			1	2	3
viii)			1	2	3
 B. HEALTH SERVICES Please tell us about any other health services your child has have used NHS services for other health problems <u>not</u> to do about them. 1. Has your child had to see a GP again in the last 7 days b Yes	with your ch	ild's ear	problem, you	ı <u>do not</u> need t	•
2. Have you had a GP telephone appointment for your chil box only)		7 days b	ecause of the	eir ear problem	? (tick one
Yes 1 No 2 If no, go to i) If yes, how many calls?	Qu.3 below				
3. Has your child seen a GP practice nurse in the last 7 day Yes				ick one box onl	(y)

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 14 – End of Week 2 Questions

4.	Have you used the NHS telephone service 111 in the last 7 days because of your child's ear problem? (tick one box only)
	Yes 1 No 2 If no, go to Qu.5 below
	i) If yes, how many times?
5.	Has your child attended an A&E department in the last 7 days because of their ear problem? (tick one box only)
	Yes I No 2 If no, go to Qu.6 below i) If yes, how many times?
	i) If yes, how many times?
6.	Has your child attended a hospital outpatient department in the last 7 days because of their ear problem? (tick one box only)
	Yes I No 2 If no, go to Qu.7 below i) If yes, how many times?
	i) If yes, how many times?
7.	Has your child stayed overnight in hospital in the last 7 days because of their ear problem? (tick one box only)
	Yes I No 2 If no, go to Qu. 8 below i) If yes, how many nights?
	i) If yes, how many nights?
8.	Did your child receive any additional treatment in the last 7 days because of their ear problem? (tick one box only)
	Yes If no, go to Section C on the next page
	i) If yes, please t please tell us what treatment they recived?
	a)
	b)
	c)

YOUR CHILD'S DAILY SYMPTOM AND RECOVERY QUESTIONNAIRE: DAY 14 – End of Week 2 Questions

C. PRESCRIPTION MEDICINES

Please tell us about **ALL** medicines and remedies a doctor/nurse has prescribed **in the last 7 days** to treat your child's ear problem. If any medicines/remedies have been prescribed for **other** health problems **not** to do with your child's ear problem, you **do not** need to tell us about them.

. Has your child been prescribed any medicines or remedies by a doctor/nurse for their ear problem in the last 7 days? (tick one box only)							
Ye	S I 1	No 2	→ If no, go to Se	ction D bel	ow		
i) If yes, please tell us which medicine or remedy was prescribed (tick all that apply):							
			Yes	No			
a)) Paracetamol, e.g. Calpol®						
b)	Ibuprofen, e.g. N	Nurofen®					
c)	Other pain-killin please tick box a	-					
d)	Other medicine for ear problem, e.g. new antibiotic, please tick box and write name:						
D. PARENT'S SATISFACTION WITH TREATMENT							
1. Overall, how satisfied were you with the treatment your child received for their ear problem? (tick one box only)							
Extre	1 = 2 = Extremely satisfied Satisfied		3 = Neither satisfied or dissatisfied		4 = Not satisfied	5 Extremely (
	1	2	3		4		5
If your child has not recovered by Day 14 and still has ear-related symptoms and taking antibiotics or pain-killing medicines, we would like to call you again in 6 weeks' time to ask about your child's recovery.							

You have now completed the questionnaire. Thank you!

There are no further questions to complete in this booklet.

END OF QUESTIONNAIRE INSTRUCTIONS

RETURN OF CHILD'S STOOL SAMPLE (COLLECT ON DAY 14)

• Once you have collected the stool sample on Day 14 (please follow the instruction sheet provided), please post the sample in the return addressed envelope provided in the kit as soon as possible.

QUESTIONNAIRE RETURN

- Please post the questionnaire back to us in the pre-paid envelope provided. We would be grateful if you could do
 this as soon as possible after completing the questionnaire but not before the final follow-up phone call from the
 study team.
- If you have lost the envelope, you can send it back to the following FREEPOST address:

FREEPOST RTZH-TUTT-KXSB
The REST Study
University of Bristol
Department of Social Medicine
Canynge Hall
39 Whatley Road
BRISTOL
BS8 2PS

THANK YOU!

For making a valuable contribution to health research. We will send you a £10 High Street Voucher by post as a token of our thanks for the valuable time you have given to help us with this research. If you can obtain a stool sample from your child, we will send you a further £5 voucher when we receive the sample.











IRAS ID: 229293

