**Table S1** Health questionnaire.

**Date filled**: \_\_\_.\_\_\_. 200\_\_\_

Patient’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Social security number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Guardian’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Operation day:** same as above no , what: \_\_\_.\_\_\_. 200\_\_\_
**Indication for the operation:** Recurrent/chronic otitis media infection yes no
 Recurrent tonsillitis yes no
 Periodic fever yes no
 Nasopharyngeal obstruction or apnea yes no
 Other, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Height:** \_\_\_\_\_\_\_ cm Weight: \_\_\_\_\_\_\_ cm

**Respiratory symptoms on the operation day:** yes no If yes: Cough yes no  Rhinitis yes no Acute otitis media yes no Pharyngitis yes no Other, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Respiratory symptoms within one month prior to the operation day:** yes no
If yes, when for the last time: Cough \_\_\_\_ days ago
 Rhinitis \_\_\_\_ days ago
 Acute otitis media \_\_\_\_ days ago
 Pharyngitis \_\_\_\_ days ago
 Expiratory breathing difficulty \_\_\_\_ days ago

Other, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ days ago

**Medical record for the last 12 months (number of illness)**

Upper respiratory infection \_\_\_\_ times, acute otitis media \_\_\_\_ times, bronchitis \_\_\_ times, expiratory breathing difficulty \_\_\_\_ times, pneumonia \_\_\_\_ times, allergic rhinitis \_\_\_ times, exacerbation of atopic eczema \_\_\_\_ times, other illness, what \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, antibiot \_\_\_\_ times, systemic corticosteroid, \_\_\_\_ times, regular (>one month) medication, what \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergic illnesses ever:**Any allergy yes no  if yes, what/which \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Allergic rhinitis yes no Doctor-diagnosed atopic eczema yes no Doctor-diagnosed asthma yes no

**Environment and family: Mother Father**Doctor-diagnosed asthma (ever) yes no yes no Allergic rhinitis yes no yes no Smoking yes no yes no Smoking, self yes no Furry pets yes no Number of children in the household \_\_\_\_ childrenDay-care: Home Family day-care Kindergarden/school