Appointment Reminder

You have been scheduled for an appointment at the Smell and Taste Center for an evaluation and treatment recommendation.

Appointment Date: _________ / ______ / 2015 at 8:00 AM.
Please keep in mind that this is an 8 hour appointment!

Please make every attempt to keep this appointment and let us know if for any reason you can't.

Please mail packet back by ______ / ______ / 2015, via Fedex or UPS 2 weeks before your appointment. Please do NOT send packet back via USPS or FAX.

The Smell and Taste Center is located in The Hospital of University of Penn, 3400 Spruce Street, 5 Ravdin Building, Phila, PA 19104.
Attention: Gerry Brennan.

1. We ask that you to get only a prescription from a doctor that recommended you visit us if you can, if you cannot that is ok, it is not required. If your insurance requires a referral please make sure you obtain one through your primary care or referred physician.

2. If YOU feel that YOU would like to see an ENT here at UPenn please make sure your doctors office can have a referral ready if needed. For ENT appointments please call 215-662-2778, this is not required, but normally the ENT office is book several months in advance. We have no way to know if you will or will not need to see someone, if YOU think YOU do, then please make an appointment.

3. We do not need films, please only send copies of WRITTEN reports, if you like to bring your written reports with you please let us know, however all packets must be sent in 2 weeks before your appointment.

4. Make sure you return all filled out the entire packet and send back 2 weeks before to your appointment. We suggest you do not send by regular mail, but if you do please make a copy and bring the copies with you, DO NOT FAX or EMAIL packet. We prefer you to send back via UPS or Fed ex.

5. Please bring a lunch!!! There is no refrigeration available and you will not be permitted to leave our waiting area to go get something.

6. If you bring family or friends with you, please note that only you and the tester will be permitted in testing areas. Visitors will be escorted to another waiting area.

If you should have any questions about this packet please feel to call Gerry Brennan at 215-662-2797 Monday thru Friday, 9 am to 1 pm.
**PATIENT REGISTRATION QUESTIONNAIRE**

Update [ ] New [ ]

In order to keep your records up to date, please answer the following questions on both sides of the form.

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>PATIENT IDENTIFICATION NUMBER/MRN</th>
<th>TEMPORARY ACCT. NUMBER</th>
<th>VERIFIED BY/DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NAME OF PATIENT**

<table>
<thead>
<tr>
<th>LAST</th>
<th>FIRST</th>
<th>MIDDLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SOCIAL SECURITY NUMBER**

**DATE OF BIRTH**

SEX: M F

**EMERGENCY CONTACT**

( )

**AREA CODE**

**EMERGENCY CONTACT TELEPHONE**

**FATHER’S NAME**: **MOTHER’S NAME**: **MARRIED NAME**: **FOR MALE PATIENTS ONLY**

**RACE**

- Arab
- Asian
- Black
- Caucasian
- Hispanic
- Other

**MARITAL STATUS**

- Married
- Single
- Divorced
- Widowed
- Separated
- Other

*It is not mandatory to answer this question. However, for statistical purposes, your answers would be appreciated.

**GUARANTOR INFO (OF DIFFERENT THAN PATIENT)**

<table>
<thead>
<tr>
<th>LAST</th>
<th>FIRST</th>
<th>MIDDLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SOCIAL SECURITY NUMBER**

**DATE OF BIRTH**

SEX: M F

**FIRST LINE OF ADDRESS**

**SECOND LINE OF ADDRESS**

**CITY**

**STATE**

**ZIP**

**AREA CODE**

**HOME TELEPHONE**

( )

**AREA CODE**

**DAY TELEPHONE**

**EMAIL ADDRESS**

**PATIENT EMPLOYMENT INFORMATION**

**EMPLOYER NAME**

**FIRST LINE OF ADDRESS**

**SECOND LINE OF ADDRESS**

**CITY**

**STATE**

**ZIP**

( )

**AREA CODE**

**TELEPHONE**

**OCCUPATION**

**PRIMARY CARE/FAMILY PHYSICIAN**

**MD**

**DO**

**FIRST LINE OF ADDRESS**

**SECOND LINE OF ADDRESS**

**CITY**

**STATE**

**ZIP**

( )

**AREA CODE**

**TELEPHONE**

**COMMENTS**

________________________________________

________________________________________

A.M. 11:00 A.M.
### Patient Registration Questionnaire

**University of Pennsylvania Health System**

**Patient Name**

**Patient Identification Number/MRN**

#### Primary Insurance

- **BC/BS**: Commercial
- **HMO/PPO**: POS

**Name of Insurance Co.**

**First Line of Address**

**City**

**State**

**Zip**

**Certificate Number**

**Group Number**

**Plan Number**

**Medicare Plan?** Y or N

**Effective Date**

**Expiration Date**

**Area Code**

**Telephone**

**Subscriber Name (If Different)**

**Relationship to Subscriber**

**Subscriber’s Birthday**

**Subscriber’s Sex: M or F**

#### Medical Assistance

**Recipient Number**

**Card Issue Number**

**Managed Care/Medical Assistance Plan Name**

**Identification Number**

#### Medicare

**Please Answer Questions Below**

<table>
<thead>
<tr>
<th>Medicare Questions</th>
<th>(Please Circle Y or N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you or your spouse employed?</td>
<td>Y or N</td>
</tr>
<tr>
<td>Do you or your spouse have other insurance?</td>
<td>Y or N</td>
</tr>
<tr>
<td>Are you disabled or have end stage renal disease?</td>
<td>Y or N</td>
</tr>
<tr>
<td>Is this illness or injury the result of an auto accident?</td>
<td>Y or N</td>
</tr>
<tr>
<td>Did this illness or injury occur at work?</td>
<td>Y or N</td>
</tr>
<tr>
<td>Has treatment been authorized by the VA?</td>
<td>Y or N</td>
</tr>
<tr>
<td>Are you covered under the Black Lung Program?</td>
<td>Y or N</td>
</tr>
<tr>
<td>Is there Medigap coverage secondary to Medicare?</td>
<td>Y or N</td>
</tr>
<tr>
<td>Is there employer supplemental insurance secondary to Medicare?</td>
<td>Y or N</td>
</tr>
<tr>
<td>Is there insurance coverage primary to Medicare?</td>
<td>Y or N</td>
</tr>
</tbody>
</table>
Assignment of Benefits: I am receiving medical care and services by the physicians of the Clinical Practices of the University of Pennsylvania and/or Clinical Care Associates (System Provider(s)). In exchange for that care and treatment, I give and assign to one or more of the System Providers, as appropriate, the right to receive payment directly for all insurance and other health benefits to which I am entitled, and/or which may be payable on my behalf. I understand that this is called “assignment of benefits; and that the System Providers may be called my “assignees.” This assignment shall not be for more than the physicians charges. I understand that I may be required to pay for charges that others do not pay on my behalf under this assignment. I agree that the System Providers can sue anyone in their own names as my assignee and get payment for the charges resulting from my medical care. This amount may include charges on the bill for my care and layer’s fees resulting from collection efforts.

Medicare Benefits: I request that payment of Medicare benefits be made on my behalf to one or more of the System Providers for any medical services, care or treatment any of them may provide to me. I authorize the System Providers and their agents to give the Centers for Medicare and Medicaid Services and its agents any medical information about me (or the person I signed for) needed to determine these benefits payable for related services. I have provided accurate information about Medicare secondary payers.

Patient

Date

Patient’s spouse, parent, child or other responsible Party individually and as agent for patient

Relationship to Patient

5 Ravdin | 3400 Spruce Street | Philadelphia, PA 19104-4283 | Phone: 215.662.6580 | Fax: 215.349.5266
# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

**Patient Name (First, Middle, Last)**

<table>
<thead>
<tr>
<th>Address</th>
<th>City/State/Zip Code</th>
<th>Telephone Number</th>
</tr>
</thead>
</table>

**Date of Birth**

**Disclosed Information:** (check all items to be released)

- [ ] Entire Record
- [ ] Abstract
- [ ] Discharge Summary
- [ ] Operative Report
- [ ] Lab Reports
- [ ] Radiology Images
- [ ] Discharge Instructions
- [ ] ER Record
- [ ] EKG/ECG Tests
- [ ] Medication Records
- [ ] History and Physical
- [ ] X-Ray Reports
- [ ] Progress Notes
- [ ] Physician Orders
- [ ] Other (please specify)

Covering the period(s) of care (list applicable dates of treatment)

**Special Records:**

I understand that information related to my diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse may be released as part of my health information. Please check appropriate box(es) below.

- [ ] AIDS/HIV Information
- [ ] Psychiatric Care/Treatment
- [ ] Treatment for Drug or Alcohol use/abuse
- [ ] Yes, disclose
- [ ] Yes, disclose
- [ ] Yes, disclose
- [ ] No, do not disclose
- [ ] No, do not disclose
- [ ] No, do not disclose

**Location of Services:**

- [ ] HUP
- [ ] PAH
- [ ] PPMC
- [ ] Penn Home Care & Hospice Service (PHCHS)
- [ ] CPUP/CCA Outpatient Practice(s):
- [ ] Other:

**Information To Be Provided To:**

Name of Person or Institution

<table>
<thead>
<tr>
<th>Address</th>
<th>City/State/Zip Code</th>
<th>Telephone Number</th>
</tr>
</thead>
</table>

**Purpose/Use Of The Requested Information:**

- [ ] Personal use by patient
- [ ] Sharing with other health care providers
- [ ] Other (please describe)

**Format:**

- [ ] Paper Copy
- [ ] Electronic Copy (provided on encrypted disk)

**Authorization**

I hereby authorize Penn Medicine to disclose the health information described above.

I understand that my authorization will automatically expire one hundred eighty (180) days after the date of signature on this form.

I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing.

I understand the revocation will not apply to information that has already been released in response to this authorization.

My refusal to sign this authorization will not affect my ability to receive treatment. By signing this form, I understand that I am authorizing Penn Medicine to release information as described above.

Signature of Patient or Personal Representative

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Date</th>
</tr>
</thead>
</table>

Relationship of Personal Representative to Patient

If Authorization is signed by someone other than the patient, please state reason.

Signature or Date

---

PLEASE READ INSTRUCTIONS ON REVERSE
HIPAA

Printed Name of
Legally Authorized Representative

Legal Relationship to Patient
(e.g., parent or guardian)

GENERAL CONSENT TO
USE AND DISCLOSE PROTECTED HEALTH INFORMATION

This is a consent form. It asks you to permit us to use and disclose information about your health in keeping with both state and Federal law. This information is called "protected health information." It is any information we receive or create that identifies (or could identify) you and deals with your physical or mental health, any health care we provide you and/or payment for such health care.

By signing this form, you are consenting to our use and disclosure of your protected health information in order to carry out treatment, payment or health care operations, as further explained in our "Notice of Privacy Practices" (the "Notice").

By signing this form, you also acknowledge that you have received our Notice. This Notice describes in detail how we might use or disclose your protected health information. The Notice also discusses your rights and our duties with respect to your protected health information. You have the right to review the Notice before signing this consent.

Before releasing any information about your treatment for drug abuse, alcohol abuse or mental illness, and HIV or AIDS, other than as permitted or required by law, we will ask you to sign a separate consent form.

You also have the right to revoke this consent, in writing, except where we have previously taken action in reliance on your prior consent.

If you refuse to sign this consent form, we will not be able to treat you.
Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sadness</td>
<td>0: I do not feel sad. 1: I feel sad much of the time. 2: I am sad all the time. 3: I am so sad or unhappy that I can't stand it.</td>
</tr>
<tr>
<td>2. Pessimism</td>
<td>0: I am not discouraged about my future. 1: I feel more discouraged about my future than I used to be. 2: I do not expect things to work out for me. 3: I feel my future is hopeless and will only get worse.</td>
</tr>
<tr>
<td>3. Past Failure</td>
<td>0: I do not feel like a failure. 1: I have failed more than I should have. 2: As I look back, I see a lot of failures. 3: I feel I am a total failure as a person.</td>
</tr>
<tr>
<td>4. Loss of Pleasure</td>
<td>0: I get as much pleasure as I ever did from the things I used to enjoy. 1: I don't enjoy things as much as I used to. 2: I get very little pleasure from the things I used to enjoy. 3: I can't get any pleasure from the things I used to enjoy.</td>
</tr>
<tr>
<td>5. Guilty Feelings</td>
<td>0: I don't feel particularly guilty. 1: I feel guilty over many things I have done or should have done. 2: I feel quite guilty most of the time. 3: I feel guilty all of the time.</td>
</tr>
<tr>
<td>6. Punishment Feelings</td>
<td>0: I don't feel I am being punished. 1: I feel I may be punished. 2: I expect to be punished. 3: I feel I am being punished.</td>
</tr>
<tr>
<td>7. Self-Dislike</td>
<td>0: I feel the same about myself as ever. 1: I have lost confidence in myself. 2: I am disappointed in myself. 3: I dislike myself.</td>
</tr>
<tr>
<td>8. Self-Criticalness</td>
<td>0: I don't criticize or blame myself more than usual. 1: I am more critical of myself than I used to be. 2: I criticize myself for all of my faults. 3: I blame myself for everything bad that happens.</td>
</tr>
<tr>
<td>9. Suicidal Thoughts or Wishes</td>
<td>0: I don't have any thoughts of killing myself. 1: I have thoughts of killing myself, but I would not carry them out. 2: I would like to kill myself. 3: I would kill myself if I had the chance.</td>
</tr>
<tr>
<td>10. Crying</td>
<td>0: I don't cry anymore than I used to. 1: I cry more than I used to. 2: I cry over every little thing. 3: I feel like crying, but I can't.</td>
</tr>
</tbody>
</table>
11. Agitation
0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest
0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness
0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness
0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy
0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern
0 I have not experienced any change in my sleeping pattern.
1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.
2a I sleep a lot more than usual.
2b I sleep a lot less than usual.
3a I sleep most of the day.
3b I wake up 1-2 hours early and can't get back to sleep.

17. Irritability
0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite
0 I have not experienced any change in my appetite.
1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.
2a My appetite is much less than before.
2b My appetite is much greater than before.
3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty
0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue
0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.
Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>NOT AT ALL</th>
<th>MILDLY</th>
<th>MODERATELY</th>
<th>SEVERELY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Numbness or tingling.</td>
<td></td>
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<tr>
<td>2. Feeling hot.</td>
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<tr>
<td>3. Wobbliness in legs.</td>
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<tr>
<td>4. Unable to relax.</td>
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<tr>
<td>5. Fear of the worst happening.</td>
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<tr>
<td>6. Dizzy or lightheaded.</td>
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<tr>
<td>7. Heart pounding or racing.</td>
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<tr>
<td>8. Unsteady.</td>
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<tr>
<td>11. Feelings of choking.</td>
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<tr>
<td>14. Fear of losing control.</td>
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<tr>
<td>15. Difficulty breathing.</td>
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<tr>
<td>17. Scared.</td>
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<tr>
<td>18. Indigestion or discomfort in abdomen.</td>
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<tr>
<td>19. Faint.</td>
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<tr>
<td>20. Face flushed.</td>
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</tr>
<tr>
<td>21. Sweating (not due to heat).</td>
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<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Indicate hand preference</th>
<th>Always Left</th>
<th>Usually Left</th>
<th>No preference</th>
<th>Usually Right</th>
<th>Always Right</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To write a letter legibly</td>
<td></td>
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<tr>
<td>2. To throw a ball to hit a target</td>
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<tr>
<td>3. To play a game requiring the use of a racquet</td>
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<tr>
<td>4. At the top of a broom to sweep dust from the floor</td>
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<tr>
<td>5. At the top of a shovel to move sand</td>
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<tr>
<td>6. To hold a match when striking it</td>
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<tr>
<td>7. To hold scissors to cut paper</td>
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<tr>
<td>8. To hold thread to guide through the eye of a needle</td>
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<tr>
<td>9. To deal playing cards</td>
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<tr>
<td>10. To hammer a nail into wood</td>
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<tr>
<td>11. To hold a toothbrush while cleaning teeth</td>
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<tr>
<td>12. To unscrew the lid of a jar</td>
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</tbody>
</table>

Are were either of your (natural) parents left-handed? __ Yes ___ No If yes which? __________

How many siblings of each sex did you have? Male ___ Female ___

Which eye do you use when using only one (e.g. telescope, keyhole)? Left ___ Right ___

Have you ever suffered any severe head trauma? __ Yes ___ No

Staff Use: __________

(Adapted from: Rigg, G.G. and Nevers, R.D. 1975 Cortex, 11:232)
SMELL AND TASTE CENTER
PATIENT CONSENT FORM

Hospital of the University of Pennsylvania, 3400 Spruce Street, Ravdin Pavilion, Philadelphia, PA 19104-4283

The University of Pennsylvania Smell and Taste Center, an institution founded by the National Institutes of Health, is devoted to evaluating, treating, and better understanding of the senses of smell and taste in health and disease. The Center is an integral part of the School of Medicine and is closely affiliated with a number of medical centers in the Philadelphia area.

We seek your permission to obtain and keep on file all information regarding your medical history, smell and taste evaluations, and other pertinent data of potential medical and scientific importance to your care and the goals of the Center. We also seek your permission to utilize this information for medical and scientific purposes and to have the option to contact you in the future should any new information or studies become available that may be related to your case. Your information will be kept confidential and will only be available to appropriate professionals for medical and scientific purposes. Your information will be safeguarded according to Health Insurance Portability and Accountability Act (HIPAA) guidelines.

I, ____________________________ (print full name), have read the above and give permission to have information related to my smell and taste functioning, as well as other medical history and questionnaire data deemed appropriate for the University of Pennsylvania Smell and Taste Center registry, to be obtained, stored and analyzed for scientific and medical purposes. I understand that this information will be kept confidential and will only be available to appropriate professionals for medical, scientific, and teaching purposes. I also give permission to be contacted in the future should any studies or other information become available related to my chemosensory condition.

Signature of Patient (or Guardian) ____________________________ Date ______/____/____

Signature of University of Pennsylvania Smell and Taste Center Staff ____________________________ Date ______/____/____
SECTION I - GENERAL INFORMATION

Instructions: The following information is required so that we may better understand your taste or smell problem and similar problems in other people. We request that you complete all items to the best of your ability.

1. Name: __________________________ 2. Today’s Date: __/__/____
   (Last) (First) (Middle) (Mo.) (Day) (Year)


5. Mailing Address: ________________________________
   (Street) (city) (state) (zip) (E-mail)


9. MRN# (OFFICE USE ONLY): ______________________
   9A. SS# ____________________


12. Ethnicity: □ African American □ Asian/Pacific Islander
    □ Caucasian □ Hispanic American
    □ Native American □ Other (specify) ________

13. Highest Level of Education:
    □ No formal schooling □ Grade school (K-5)
    □ Middle school (6-8) □ High school (9-11)
    □ High school graduate (or GED) □ Some college
    □ College graduate □ Post-graduate
    □ Technical school (specify) _______________________
    □ Other (specify) ________________________________

14. Occupation Classification:
    □ Agricultural Worker □ Industrial Worker
    □ Biomedical Worker □ Legal Worker
    □ Business/Financial □ Manager
    □ Chemical Industry Worker □ Military
    □ Clerical Worker □ Retired
    □ Construction □ Sales/Service Industry
    □ Craftsman □ Student (Full time college)
    □ Engineering □ Student (High School)
    □ Home Economist □ Teacher
    □ Professional (specify) __________________________
    □ Other (specify) ________________________________
    □ Unemployed

15. Is English your primary language? □ Yes □ No
   If No: What is? ________________________________

15A. Have you ever served in the armed forces? □ Yes □ No
    If yes, which one _______ and how long _______
16. Who referred you to this clinic?

☐ General Practitioner  ☐ Dentist
☐ Neurologist  ☐ Ear, Nose & Throat Specialist
☐ Lawyer  ☐ Other (specify) ______

Fill out all relevant information for the person referring you to this clinic:

Please be advised that the results of the evaluation and/or consultation done by the Smell and Taste Center will be shared with the providers you list in this section for treatment purposes.

Name: ____________________________
If doctor: Degree (e.g., MD, DO, Ph.D., DDS, etc.): ____________________________
Specialty or Practice Name: ____________________________
Phone Number: (______) ______
Mailing Address: _______ _______ _______ ______

17. List any doctors you have visited regarding your smell and/or taste problem in addition to the referring doctor.

Name: ____________________________
If doctor: Degree (e.g., MD, DO, Ph.D., DDS, etc.): ____________________________
Specialty or Practice Name: ____________________________
Phone Number: (______) ______
Mailing Address: _______ _______ _______ ______

Name: ____________________________
If doctor: Degree (e.g., MD, DO, Ph.D., DDS, etc.): ____________________________
Specialty or Practice Name: ____________________________
Phone Number: (______) ______
Mailing Address: _______ _______ _______ ______

18. Do you observe any religious, medical or personal dietary restrictions?  ☐ Yes  ☐ No

If Yes: Explain: ____________________________

19. Do you have any physical or psychological conditions that are potentially related to specific foods or odors (e.g. allergies, fainting spells, etc.)?  ☐ Yes  ☐ No

If Yes: Explain: ____________________________
19b. Do you exercise? □ Yes □ No
   How many times per week: ___________________ and how many minutes: ___________________
   What type of exercise: ________________________________
   If you run how far: ___________________ how many minutes: ___________________
   Indoors ____________________ outdoors ____________________ both ____________________

20. How much of the following do you drink per week of:
   Coffee _______ cups Tea _______ cups
   Fruit Juices _______ 8-oz Beer _______ 12-oz
   Milk _______ 8-oz Wine _______ glasses
   Soft Drinks _______ 16-oz Liquor _______ shots

21. Do you currently smoke? □ Yes □ No
   If Yes: At what age did you start smoking?
   If you quit and restarted, how many total years have you smoked? ______
   Do you inhale? □ Yes □ No
   Have you noticed any change in smell ability due to smoking? □ Yes □ No
   How much of each do you use per day:
   Cigarettes: _______ packs
   Cigars: _______ each
   Pipes: _______ each
   If No:
   Have you ever smoked? □ Yes □ No
   If Yes: At what age did you begin smoking?
   How much of each did you use per day:
   Cigarettes: _______ packs
   Cigars: _______ each
   Pipes: _______ each
   At what age did you quit smoking? ______
   Did your smell ability change after you quit smoking? □ Yes □ No
   Explain: ________________________________

21A. Do you chew gum? □ Yes □ No
   If Yes: How many do you chew per day: _______ packs _______ sticks
   What Brand: ________________________________ When Did you Begin: ____________

22. Do you currently use smokeless tobacco (e.g., snuff, chew, etc.)? □ Yes □ No
   If Yes: How much do you use per day? _______ pinches

23. Is there tobacco smoke in your immediate living and/or work environment (e.g., someone who lives with you smokes)? □ Yes □ No
   If Yes: For how many hours/day are you exposed to the smoke? _______ hrs/day
   How many months and/or years have you been exposed? _______ mo. _______ yrs.
23A. Do you receive an annual flu vaccination? □ Yes □ No
   If no, have you ever received a flu vaccination? □ Yes □ No
      If yes when?
      If yes, for how many years have you been receiving a flu vaccination? ______ years
      What type of vaccination did you receive? □ Injection □ Nasal Inhalation

SECTION II - MEDICAL HISTORY

Instructions: Please answer each of the following questions. If answer is yes, check all boxes below that apply and state the years you had the problem. If a problem re-occurred during several different years, use a comma to separate (e.g., 1983, 1989).

24. Do you have or have you ever had any nasal/sinus problems? □ Yes □ No
   Check all that apply
   □ Frequent or chronic sneezing or itchy nose
   □ Prolonged abnormal nasal discharge
   □ Frequent or chronic trouble breathing through the nose
   □ Frequent or chronic post nasal drip
   □ Sinus pain or headache
   □ Sinus infection
   □ Nasal polyps
   □ Deviated septum of the nose
   □ Frequent nosebleeds
   □ Broken nose
   □ Nasal allergy
   □ Frequent colds
   □ Other (specify)

25. Do you have or have you ever had any serious respiratory problems? □ Yes □ No
   Check all that apply
   □ Chronic coughing
   □ Wheezing or asthma
   □ Chronic or recurrent lung infections (e.g., bronchitis, pneumonia)
   □ Other (specify)

26. Do you have or have you ever had any dental or mouth problems? □ Yes □ No
   Check all that apply
   □ Sensitive or sore tongue
27. On average, how often do you get sick? _____ number of times per year

28. Do you have or have you ever had dentures? □ Yes □ No

<table>
<thead>
<tr>
<th>Check all that apply</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Partial dentures</td>
<td></td>
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<tr>
<td>□ Full dentures</td>
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<tr>
<td>□ Lower dentures</td>
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<tr>
<td>□ Upper dentures</td>
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</tbody>
</table>

29. Have you ever had any surgical operations pertaining to Ear, Nose, or Throat? □ Yes □ No

<table>
<thead>
<tr>
<th>Check all that apply</th>
<th>How many times?</th>
<th>Date(s)</th>
<th>Specific nature of operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Deviated septum repair</td>
<td></td>
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<tr>
<td>□ Nasal polypectomy</td>
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<tr>
<td>□ Sinus surgery</td>
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<td>□ Brain surgery</td>
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<tr>
<td>□ Mouth surgery</td>
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<tr>
<td>□ Wisdom tooth removal</td>
<td></td>
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</tbody>
</table>

If so, which teeth were removed?
□ Right Upper
□ Left Upper
□ Right Lower
□ Left Lower

If so, when were your wisdom teeth removed?
□ One year ago
□ Two to Five years ago
□ Five to Ten years ago
□ More than 10 years ago
□ Don't Remember
Other tooth extractions

Gum surgery

Tonsillectomy

Laryngectomy

Ear surgery:

Other surgeries (specify) 

30. Have you ever had any head or facial injuries?  □ Yes  □ No

Check all that apply

☐ Head injury
   Explain:

☐ Facial injury
   Explain:

☐ Duration of loss of consciousness due to injury:
   □ less than 2 minutes
   □ between 2 minutes and 1 hour
   □ between 1 hour and 1 day
   □ between 1 day and 1 week
   □ between 1 week and 1 month
   □ greater than 1 month

☐ Amnesia (memory loss of events surrounding injury):
   □ Less than 12 hours
   □ Between 12 hours and 24 hours
   □ More than 24 hours

31. Have you ever been given general anesthesia?  □ Yes  □ No

How many times? 

32. Do you suffer from any allergies?  □ Yes  □ No

Check all that apply

☐ Medication allergies
   Specify:

☐ Seasonal allergies
   (e.g., pollen, grass, ragweed)
   Specify:
Smell and Taste Center Questionnaire

☐ Perennial allergies
    (e.g., dust, molds, animals)
    Specify: ____________________________

☐ Food allergies
    Specify: ____________________________

☐ Other allergies
    Specify: ____________________________

33. Have you ever had any specialized radiographs of your head, neck, jaws, or sinuses?  ☐ Yes  ☐ No

    Check all that apply
    ☐ X-rays
    ☐ Computer Tomography (CT)
    ☐ Magnetic Resonance Imaging (MRI)
    ☐ Single Photon Emission Computer Tomography (SPECT)
    ☐ Positron Emission Topography (PET)
    ☐ Functional Magnetic Source Imaging (FMSI)

34. Have you ever had prolonged exposure to any of the following?  

    Check all that apply

    ☐ Acid fumes
    ☐ Formaldehyde
    ☐ Herbicides or pesticides
    ☐ Industrial solvents or cleaning products
    ☐ Metal dusts
    ☐ Paint fumes
    ☐ Wood dusts
    ☐ Other (specify) ____________________________

    Amount of Exposure (hrs., days, months, or years)

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35. Have you ever experienced any of the following conditions?

Check all that apply

☐ Alcohol abuse
☐ Alzheimer's disease
☐ Bell's palsy (facial nerve weakness or paralysis)
☐ Cancer or tumor (specify) 
☐ Cerebral Palsy
☐ Cystic fibrosis
☐ Depression
☐ Diabetes mellitus
☐ Drug abuse
☐ Frequent ear aches
☐ Gastroesophageal reflux disorder
☐ Frequent heartburn or vomiting
☐ Headaches
☐ High blood pressure
☐ Liver condition
☐ Lupus
☐ Multiple sclerosis
☐ Neurosis
☐ Vitamin or mineral deficiency
☐ Parkinson's disease
☐ Psychosis
☐ Rheumatoid arthritis
☐ Sarcoidosis
☐ Schizophrenia
☐ Seizures or epilepsy
☐ Sjogren's syndrome
☐ Stroke
☐ Thyroid problem
☐ Other (specify)

36. Has anyone in your family had a smell and/or taste problem? 

If Yes: Relationship (e.g., sibling, grandparent, etc.) 

Yes ☐ No ☐
37. Indicate below all medications (prescription or over the counter) you are currently taking or have taken within 5 years prior to your problem.

**Instructions:** Fill in the “Year began” and “Year Ended” for each medication, if you are still taking a medication, write “ongoing” in the “Year Ended” blank. Check the “Onset” box if your problem began shortly after beginning to take the medicine.

**Current Medications**

<table>
<thead>
<tr>
<th>Name</th>
<th>Milligrams</th>
<th>How often</th>
<th>Start</th>
<th>Ended</th>
<th>Reason for use</th>
<th>Onset</th>
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</table>

**Past Medications**

<table>
<thead>
<tr>
<th>Name</th>
<th>Milligrams</th>
<th>How often</th>
<th>Start</th>
<th>Ended</th>
<th>Reason for use</th>
<th>Onset</th>
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</table>

Please list any over the counter Antacids you have taken

<table>
<thead>
<tr>
<th>What brand</th>
<th>How often</th>
<th>How many</th>
<th>How long</th>
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10
38. Please describe in your own words the nature of the problem you are seeking treatment for, and the way in which you feel these symptoms may have developed. Include all symptoms that you feel are related to the problem and indicate when each began and whether each symptom is constant or if it has changed since the problem started. Also, please indicate what treatment(s), if any, you have received for this problem and whether you feel they have been effective or not. Please include dates as closely as possible. Be concise but complete and accurate as possible. Please write legibly.

Thank you.

39. Do you suffer, or have you ever suffered from any endocrine dysfunction, abnormality or change which brought you to the attention of a physician or other medical professional (for example, problems with the sex organs, the thyroid gland, the adrenal gland, puberty, fertility, change in life)? □ Yes □ No

If Yes: Explain:

40. Have you ever had an operation involving your sex organs (e.g. hysterectomy, castration, ovariectomy)? □ Yes □ No
Questions 41-50 are to be filled out by women only.
If you are male or postmenopausal please go to question 51.

41. Do you currently take oral contraceptives? □ Yes □ No
   If Yes: How long have you been taking them? ______ days ______ mo. ______ yrs.
   What brand are you currently using?
   Are the oral contraceptives being taken for reasons other than birth control? □ Yes □ No
   If Yes: Explain:

42. Are you currently taking oral contraceptives? □ Yes □ No
   Have you ever taken oral contraceptives? □ Yes □ No
   If Yes: How long ago did you take them? ______ mo. ______ yrs.
   How long did you take them? ______ mo. ______ yrs.
   What brands did you use?
   Was there a particular medical or personal reason for discontinuing their use? □ Yes □ No
   If Yes: Explain:

43. Have you ever kept a temperature chart or other count of your menstrual cycle? □ Yes □ No

44. Is your menstrual cycle regular (i.e., does the period of bleeding start every 28 days, every 29 days, every 30 days, etc. without or rarely without fail?) □ Yes □ No

45. Approximately what day of your cycle is it today? (day 1 = first day of menstrual bleeding) ______ (day) of ______ (length of cycle)

46. How long, on average, does your period of menstrual bleeding last? ______ days

47. Have you ever experienced any acute or partially disabling medical or psychological symptom as a result of the menstrual cycle or as a result of taking oral contraceptives? □ Yes □ No
   If Yes: Explain:

48. Around the time of ovulation (i.e., mid-cycle or about day 14 in a regular 28 day
cycle, where $I =$ first day of menstrual bleeding), do you ever notice intermittent cramping pains on one or both sides of the lower abdomen lasting for about a day (termed "Mittelschmerz")?  □ Yes □ No

If Yes: Explain:  

---

49. At what age did you experience your first period of menstrual bleeding?  

50. Have you noticed changes in your ability to smell or taste during the menstrual cycle?  □ Yes □ No

If Yes: Was your ability increased during:

□ Menses
□ Mid-cycle
□ Premenstrual
□ None of these

Was your ability decreased during:

□ Menses
□ Mid-cycle
□ Premenstrually
□ None of these

---

SECTION III - SMELL AND NASAL INFORMATION

51. Check each of the following statements that apply to you now:

□ My sense of smell is distorted, that is things smell peculiar.
□ I experience a smell when nothing is there (phantom smell).
□ My sense of smell is heightened (hypersensitive).
□ My sense of smell is diminished (partial loss).
□ My sense of smell is absent (complete loss).
□ My main complaint is an abnormal body odor.
□ My sense of smell is normal.  <- If you checked this box please go to question 98, Section IV - Taste and Oral Information.

52. Is one or both sides of your nose obstructed?  □ Yes □ No

If Yes: Circle the number related to the amount of obstruction for each nostril:

Left side:  (no obstruction) 1 2 3 4 5 6 7 8 9 10 (complete obstruction)
Right side: (no obstruction) 1 2 3 4 5 6 7 8 9 10 (complete obstruction)

53. Do you experience excessive nasal secretions or mucus?  □ Yes □ No

If Yes: Explain:  

---
54. Do you experience dryness or crustiness in the nose? □ Yes □ No
   If Yes: Explain:

55. Does your smell problem change over time? □ Yes □ No
   If Yes:
   Check all that apply
   □ Before meals (specify which meals)
   □ After meals (specify which meals)
   □ Before going to sleep
   □ After waking up
   □ Certain time of the day (specify the time)
   □ Other (specify exactly what and when)
   Explain:

56. Does your smell return to normal periodically? □ Yes □ No

57. Is your smell problem increased by anything? □ Yes □ No
   □ Exercising
   □ Certain foods or beverages (specify)
   □ When taking medication (specify)
   □ Other (specify)
   □ Never increases

58. Is your smell problem decreased by anything? □ Yes □ No
   □ Exercising
   □ Certain foods or beverages (specify)
   □ When taking medication (specify)
   □ Other (specify)

59. Do you sometimes perceive a smell or food flavor when you first encounter an item but find that the sensation disappears rapidly? □ Yes □ No

60. Does your smell problem interfere with eating? □ Yes □ No
   If Yes: Has it changed your appetite? □ Yes □ No
   Have you suffered weight or appetite loss as a result of your smell problem?
   □ Yes □ No
   If Yes: How much weight loss? ______ lbs.
   Explain:
   If No: Have you experienced any other physical changes as a result of your smell problem? □ Yes □ No
   If Yes: Explain:

61. Does your smell problem interfere with your everyday functioning? □ Yes □ No
   If Yes: Explain:
62. Has your smell problem affected your psychological well-being?  □ Yes  □ No
   If Yes: Explain:

63. Did your smell problem occur gradually over time?  □ Yes  □ No
   If Yes: How long did it take for you to lose your sense of smell?
   □ Less than 1 month
   □ Between 1 and 6 months
   □ Between 6 months and 1 year
   □ Between 1 and 5 years
   □ Longer than 5 years
   Did you notice any abnormal smell sensations during that time?  □ Yes  □ No
   If Yes: Explain:

64. Did your smell problem begin with (check all that apply):
   □ Accident (specify)
   □ Allergy or sensitivity (specify)
   □ Chemotherapy
   □ Exposure (chemicals, smoke, etc.) (specify)
   □ Illness (specify)
   □ Medication (specify)
   □ Nasal disease (sinusitis, polyps, etc.) (specify)
   □ Pregnancy
   □ Radiation therapy
   □ Stroke (specify)
   □ Surgery (specify)
   □ Upper respiratory infection (specify)
   □ Other (specify)
   □ Unknown
   □ Present since birth

65. Has your ability to detect odors changed?  □ Yes  □ No
   If Not: Go to Question 74. If Yes: Go to question 66.

66. Have you lost all your ability to detect odors?  □ Yes  □ No
67. Have you lost part but not all of your ability to detect odors?
   □ Yes  □ No
   If Yes: Explain:

68. How long have you experienced a smell problem?  ___ mo. ___ yrs.
69. Can you determine about when your smell problem began?  □ Yes  □ No
   If Yes: When?  /  /  
      (Mo) (Day) (Year)

70. Do you feel that your smell problem is on one or both sides of your nose?
   □ One  □ Both
   If One: Which side?  □ Right  □ Left

71. Before your loss of smell, did you experience any strange smell sensations?  □ Yes  □ No
   If Yes: Explain: __________________________

72. Are the majority of odors you detect:
   □ Pleasant
   □ Neutral
   □ Unpleasant

73. Indicate with a check whether your perception of each of the following odors is currently normal, diminished, absent, distorted or heightened (enter “?” if unsure):

<table>
<thead>
<tr>
<th>Odor</th>
<th>Normal</th>
<th>Diminished</th>
<th>Absent</th>
<th>Distorted</th>
<th>Heightened</th>
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<tbody>
<tr>
<td>Ammonia/Vinegar</td>
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<tr>
<td>Body odors</td>
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<tr>
<td>Cigarette smoke</td>
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<tr>
<td>Flowers</td>
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<td>Food flavors</td>
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<td>Household gas</td>
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<td>Perfumes</td>
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<td>Smoke</td>
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<td>Spoiled food</td>
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<td>Vicks/Menthol</td>
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74. Do you experience any strange or distorted odors?  □ Yes  □ No
   If No: Go to question 84. If Yes: Go to question 75

75. Does your strange or distorted odor require you to sniff something?  □ Yes  □ No

76. How long have you had this smell problem?  _____ mo. _____ yrs.

77. Can you determine about when your smell problem began?  □ Yes  □ No
   If Yes: When?  /  /  
      (Mo) (Day) (Year)
78. Can you tell in which nostril(s) you experience smell distortions?  □ Yes □ No
   □ the right nostril only
   □ the left nostril only
   □ both nostrils

79. Are there any odors that continue to smell normal to you?  □ Yes □ No
   If Yes: Specify: ____________________________

80. Do all of the odors you experience as being distorted smell the same to you?
   □ No, different odors still smell differently; they just do not have the same quality they used to.
   □ Yes, they all smell the same.

81. Are the majority of strange or distorted odors you detect: □ Pleasant
   □ Neutral
   □ Unpleasant

82. Has there been a change in the quality of the strange or distorted odor since you first noticed it?
   □ Yes □ No
   If Yes: Explain: ____________________________

83. The kinds of odors that smell distorted (peculiar) to you are (Check all that apply):
   □ Foods/beverages (specify): ________________________________
   □ Perfumes (specify): ________________________________
   □ Tobacco products (specify): ________________________________
   □ Other (specify): ________________________________

84. Do you detect a persistent odor that others can't smell (phantosmia)?  □ Yes □ No
   If No: Go to question 98. If yes: please continue with question 85.

85. Do you experience more than one type of phantom smell sensation?  □ Yes □ No
   If Yes: Explain: ____________________________

86. How long have you had this smell problem?    months    years.

87. Can you determine about when your phantom smell began?  □ Yes □ No
   If Yes: When?  (Mo) (Day) (Year)

88. Do you experience the phantom smell(s):
   □ in the right nostril only.
   □ in the left nostril only.
   □ in both nostrils.
89. Can other people smell the phantom odor(s) you smell?
   □ No, I don’t think so.
   □ Yes, I think so, but no one has commented on it.
   □ Yes, I have been told so by others.

90. Does the phantom odor occur:
   □ While breathing in
   □ While breathing out
   □ While breathing in and out
   □ At all times
   □ Unsure

91. How frequent is the recurring phantom odor?
   □ Always present
   □ Occurs several times per day (how many?) ____
   □ Weekly
   □ Monthly
   □ Varies (specify) ____________________________

92. How long does the phantom odor usually last?
   □ Fleeting
   □ Minutes
   □ Hours
   □ All day

93. Does the phantom odor begin with a certain event?  □ Yes  □ No
   If Yes: Explain: ______________________________________

94. What does the odor(s) smell like? (check all that apply)
   □ Infected tissue or mucus
   □ Smoky or burnt
   □ Fecal
   □ Rotten
   □ Musty
   □ Moldy
   □ Metallic
   □ Salty, sour, sweet, or bitter
   □ Pleasant, flower-like (specify) _________________________
   □ Pleasant, candy-like (specify) _________________________
95. Has the phantom odor changed in quality since you first noticed it?

- [ ] Yes
- [ ] No

If Yes: Explain:

96. Does anything cause a variation in the phantom odor?  

- [ ] Yes
- [ ] No

If Yes: Does the phantom odor increase with: (check all that apply)

- [ ] Crying
- [ ] Putting head down
- [ ] Tickling the inside of the nose
- [ ] Nasal congestion
- [ ] Sleep or rest
- [ ] Exposure to strong odors
- [ ] Other (specify)
- [ ] Unknown
- [ ] Never increases

Does the phantom odor decrease with: (check all that apply)

- [ ] Crying
- [ ] Putting head down
- [ ] Tickling the inside of the nose
- [ ] Nasal congestion
- [ ] Sleep or rest
- [ ] Exposure to strong odors
- [ ] Other (specify)
- [ ] Unknown
- [ ] Never decreases

97. On average, what is the strength of the phantom odor?

- [ ] Weak
- [ ] Moderate
- [ ] Strong

SECTION IV - TASTE AND ORAL INFORMATION

98. Check all each of the following statements that apply to you now:

- [ ] My sense of taste is distorted, that is, things taste peculiar.
- [ ] I experience a taste when nothing is there (phantom taste).
Smell and Taste Center Questionnaire

99. Have you noticed food tasting different as a result of your problem?  □ Yes  □ No
   If Yes: What month and year did it begin tasting different?  /
   How does it taste different?

100. Has your appetite changed as a result of your taste problem?  □ Yes  □ No
     If Yes: Explain:

101. Are there certain foods you avoid since your taste problem began?  □ Yes  □ No
     If Yes: Specify:

102. Are there certain foods you have begun craving since your taste problem began?  □ Yes  □ No
     If Yes: List:

103. Are there any fluctuations in your taste problem?  □ Yes  □ No
     If Yes: Does it increase:
         □ Before meals (specify which meals)
         □ After meals (specify which meals)
         □ Before going to sleep
         □ After waking up
         □ Certain time of the day (specify time)
         □ Other (specify exactly what and when)
     Does it decrease:
         □ Before meals (specify which meals)
         □ After meals (specify which meals)
         □ Before going to sleep
         □ After waking up
         □ Certain time of the day (specify time)
         □ Other (specify exactly what and when)

104. Has the amount of your saliva changed?  □ Yes  □ No
     If Yes: What month and year did this begin?  /
     How has it changed?
         □ More
         □ Less
         □ Different (specify)

105. Is your taste problem increased by:
         □ Rinsing with
         □ Chewing
         □ Eating
         □ Heat or cold
Smell and Taste Center Questionnaire

106. Is your taste problem reduced by:

- [ ] Certain foods (specify)
- [ ] Other (specify)
- [ ] Never increases

107. Do you have any pain or soreness in your mouth?  
[ ] Yes  [ ] No

If Yes:  Where does the pain or soreness come from? (check all that apply)

- [ ] Whole mouth
- [ ] Throat
- [ ] Gums
- [ ] Roof of mouth
- [ ] Tongue (specify area)
- [ ] Other (specify)
- [ ] Not sure

How intense is the pain or soreness?

- [ ] Weak
- [ ] Moderate
- [ ] Strong
- [ ] Excruciating

108. Do you believe your taste problem began with (check all that apply):

- [ ] Accident (specify)
- [ ] Allergy or sensitivity (specify)
- [ ] Anesthesia (specify)
- [ ] Chemotherapy
- [ ] Chronic condition (e.g., allergy, nasal problems, etc.) (specify)
- [ ] Dental problems, restorations, or appliances (specify)
- [ ] Exposure (chemicals, smoke, etc.) (specify)
- [ ] Illness (specify)
- [ ] Medication (specify)
- [ ] Oral herpes
- [ ] Oral infections (Candidosis, herpes, fever blisters) (specify)
- [ ] Otitis media
- [ ] Pregnancy
- [ ] Radiation therapy
- [ ] Surgery (specify)
Smell and Taste Center Questionnaire

109. Has your ability to detect sweet, sour, salty, and/or bitter sensations changed in relation to what it used to be? □ Yes □ No

If No: Go to question 112. If yes: Go to question 110:

110. Has your ability to detect sweet, sour, salty, and/or bitter sensations:
□ Increased
□ Decreased
□ Varies
□ Can't detect at all
□ Unsure

111. Compare your ability to detect sweet, sour, salty, and/or bitter sensations in relation to what they used to be:

<table>
<thead>
<tr>
<th>Taste</th>
<th>Better</th>
<th>Same</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sour</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bitter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metallic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

112. Do you have any taste distortion(s)? (e.g., recurring sweet, salty, sour, or bitter sensations for no reason)? □ Yes □ No

If No: Go to question 120. If Yes: Go to question 113

113. Are the taste distortion(s) present at all times or just during eating and drinking?
□ At all times
□ Only while eating or drinking
□ Other; Explain: ________________________________

114. About how frequently do your taste distortion(s) occur?
□ Less than once a week
□ Once a week
□ Several times a week
□ Once a day
□ Several times a day
115. Describe and rate your ability to taste in relation to what it used to be:

<table>
<thead>
<tr>
<th>Taste</th>
<th>Stronger</th>
<th>Same</th>
<th>Weaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sour</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bitter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metallic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

116. Aside from your taste distortion, does anything taste normal to you?  □ Yes □ No
   If Yes: Specify:

117. Does everything you perceive to be distorted now taste the same to you?
   □ No, different things taste differently; they just do not have the same quality they used to have.
   □ Yes, they all taste the same.

118. What specific things taste distorted to you? (Check all that apply)
   □ Everything tastes distorted
   □ Foods/beverages (specify):
   □ Tobacco products (specify):
   □ Other (specify):

119. Do you believe your taste distortion arises from your? (Check all that apply)
   □ Throat
   □ Gums
   □ Dentures or caps
   □ Roof of mouth
   □ Saliva
   □ Post-nasal drip
   □ Reflux (secretion of the stomach)
   □ Whole mouth
   □ Tongue (specify area)
   □ Other (specify)
   □ Not sure

120. Do you experience a phantom taste or burning sensation in your mouth when nothing is there?
   □ Yes □ No

121. Have you experienced more than one type of oral phantom sensation?  □ Yes □ No
    If Yes: Explain:
122. Can you determine about when your taste phantom began? □ Yes □ No
   If Yes: When? __ / __ / __
               (Mo.) (Day) (Year)

123. Do you currently experience more than one type of oral phantom sensation?
    □ Yes □ No
    If Yes: Explain:

124. Where do you believe your oral phantom comes from? (Check all that apply)
    □ Throat
    □ Gums
    □ Dentures or caps
    □ Roof of mouth
    □ Saliva
    □ Post-nasal drip
    □ Reflux (secretion of the stomach)
    □ Whole mouth
    □ Tongue (specify area)
    □ Other (specify)
    □ Not sure

125. Has the oral phantom changed in quality since you first noticed it?
    □ Yes □ No
    If Yes: Explain:

126. How frequently do you experience your oral phantom?
    □ Always present
    □ Occurs several times per day (how many?) __
    □ Weekly
    □ Monthly
    □ Varies (specify)

127. What is the typical duration of the oral phantom?
    □ Fleeting
    □ Minutes
    □ Hours
    □ All day

128. Does the phantom taste begin with a certain event? □ Yes □ No
    If Yes: Explain:

129. On average, what is the strength of the oral phantom?
    □ Weak
    □ Moderate
    □ Strong
The Hospital of the University of Pennsylvania is close to several hotels. Below is a partial list. When making reservations as a patient or family member, be sure to ask for the hospital room rate. Note: Please be aware that this list is not a complete listing of Philadelphia area hotels and that inclusion on this list does not necessarily imply endorsement by the University of Pennsylvania Health System.

<table>
<thead>
<tr>
<th>Hotel</th>
<th>Hospital Room Rate</th>
<th>Hotel</th>
<th>Hospital Room Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comfort Inn</td>
<td>4 miles from HUP. Located at Penn's Landing.</td>
<td>Marriott Residence Inn</td>
<td>Near Phila. International Airport; 5 miles from HUP</td>
</tr>
<tr>
<td>100 N. Christopher</td>
<td></td>
<td>Studio Suites</td>
<td></td>
</tr>
<tr>
<td>Columbus Drive</td>
<td></td>
<td>4630 Island Ave.</td>
<td></td>
</tr>
<tr>
<td>(215) 627-7900 or (800) 228-5150</td>
<td></td>
<td>(215) 492-1611</td>
<td></td>
</tr>
<tr>
<td>Taxi (215) 627-0809</td>
<td></td>
<td>Fax: (215) 492-1665</td>
<td></td>
</tr>
<tr>
<td>Clarion Suites</td>
<td>Approx. 2.5 miles from HUP in Center City.</td>
<td>Embassy Suites Hotel</td>
<td>Near Phila. International Airport; 5 miles from HUP</td>
</tr>
<tr>
<td>10th and Arch Sts.</td>
<td></td>
<td>9000 Bartram Ave.</td>
<td></td>
</tr>
<tr>
<td>(215) 922-1730</td>
<td></td>
<td>(215) 365-4500 or 1-(800) EMBASSY</td>
<td></td>
</tr>
<tr>
<td>Taxi Fax: (215) 922-6258</td>
<td></td>
<td>Fax: (215) 365-3195</td>
<td></td>
</tr>
<tr>
<td>Divine Tracy Hotel</td>
<td>4.5 Blocks from HUP.</td>
<td>Sheraton University City</td>
<td>In University City, 5 blocks from HUP</td>
</tr>
<tr>
<td>20 S. 36th St.</td>
<td></td>
<td>36th and Chestnut Streets</td>
<td></td>
</tr>
<tr>
<td>(215) 382-4310</td>
<td></td>
<td>(215) 387-8000 or (877) 459-1146</td>
<td></td>
</tr>
<tr>
<td>Taxi Fax: (215) 387-0157</td>
<td></td>
<td>Fax: (215) 387-5339</td>
<td></td>
</tr>
<tr>
<td>Double Tree Hotel</td>
<td>In Center City, 2 miles from HUP</td>
<td>Radisson Plaza Warwick Hotel</td>
<td>In Center City, 2 miles from HUP</td>
</tr>
<tr>
<td>Broad and Locust Streets</td>
<td></td>
<td>1701 Locust St.</td>
<td></td>
</tr>
<tr>
<td>(215) 893-1900</td>
<td></td>
<td>(215) 790-7781 or (800) 523-4210</td>
<td></td>
</tr>
<tr>
<td>Taxi Fax: (215) 853-1604</td>
<td></td>
<td>Fax: (215) 790-6105</td>
<td></td>
</tr>
<tr>
<td>Four Seasons Hotel</td>
<td>Approx. 2 miles from HUP in Center City.</td>
<td>Best Western</td>
<td>4.5 miles from HUP</td>
</tr>
<tr>
<td>One Logan Square</td>
<td></td>
<td>501 N.22nd Street</td>
<td></td>
</tr>
<tr>
<td>(215) 963-1500</td>
<td></td>
<td>Philadelphia, Pa. 19130</td>
<td></td>
</tr>
<tr>
<td>Taxi Fax: (215) 963-9507</td>
<td></td>
<td>(215) 568-8300</td>
<td></td>
</tr>
<tr>
<td>Holiday Inn Express</td>
<td>In Center City, 2 miles from HUP</td>
<td>The Windsor</td>
<td>Valet parking $22.00/day with in and out privileges</td>
</tr>
<tr>
<td>Midtown 1305 Walnut Street</td>
<td></td>
<td>700 Ben Franklin Parkway</td>
<td></td>
</tr>
<tr>
<td>Philadelphia, Pa. 19102</td>
<td></td>
<td>(215) 981-9678 Fax: (215) 981-5684</td>
<td></td>
</tr>
<tr>
<td>(215) 735-9300 or (800) 564-3869</td>
<td></td>
<td>Fax: (215) 557-9448</td>
<td></td>
</tr>
<tr>
<td>Taxi Fax: (215) 732-2598</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Inn at Penn</td>
<td>On Penn campus, 4 blocks from HUP</td>
<td>Hawthorn Suites</td>
<td>Self-Parking $17/day; Valet parking $21.00/day</td>
</tr>
<tr>
<td>3600 Sansom St.</td>
<td></td>
<td>1100 Vine Street</td>
<td></td>
</tr>
<tr>
<td>(215) 222-0200</td>
<td></td>
<td>(215) 829-8300 or (800) 527-1133</td>
<td></td>
</tr>
<tr>
<td>Fax: (215) 222-4600</td>
<td></td>
<td>Fax: (215) 282-1806</td>
<td></td>
</tr>
<tr>
<td>Latham Hotel</td>
<td>In Center City, 2 miles from HUP</td>
<td>The Ritz Carlton</td>
<td>4 miles from HUP</td>
</tr>
<tr>
<td>17th and Walnut Sts.</td>
<td></td>
<td>10 Avenue of the Arts</td>
<td></td>
</tr>
<tr>
<td>(215) 563-7474</td>
<td></td>
<td>(215) 735-7700</td>
<td></td>
</tr>
<tr>
<td>Fax: (215) 568-0110</td>
<td></td>
<td>Fax: (215) 735-7710</td>
<td></td>
</tr>
</tbody>
</table>
DIRECTIONS

FROM NORTHEASTERN AREAS
From I-95 South, take the Vine Street/Center City Exit, stay left to 676 West (Vine Street Expressway). Follow 676 West to the I-76 East Exit 1, International Airport. Follow I-76 East (Schuylkill Expressway) to Exit 346A, South Street (left exit), and turn right on South Street. Make a left on 34th Street. The Hospital of the University of Pennsylvania is on the right and Penn Tower and the Perelman Center for Advanced Medicine are on the left. See "PARKING."

FROM THE WEST & MONTGOMERY COUNTY
Take the Pennsylvania Turnpike to Exit 3. Follow the Black Horse Pike (Route 168 North) for one mile to I-295 South. Go one mile to Exit 26 for I-76 West to the Walt Whitman Bridge. Cross the Bridge to take I-76 West (Schuylkill Expressway) to Exit 346A, South Street (left exit), and turn left on South Street. Turn left on 34th Street. The Hospital of the University of Pennsylvania is on the right and Penn Tower and the Perelman Center for Advanced Medicine are on the left. See "PARKING."

FROM THE NORTH
Take I-476 (Northeast Extension) South to Exit 20, Mid-County. Pay the toll and continue south on I-476 to Exit 16A, I-76 East. Follow I-76 East (Schuylkill Expressway) approximately 17 miles to Exit 346A, South Street (left exit), and turn right on South Street. Turn left on 34th Street. The Hospital of the University of Pennsylvania is on the right and Penn Tower and the Perelman Center for Advanced Medicine are on the left. See "PARKING."

FROM THE SOUTH/PHILADELPHIA INTERNATIONAL AIRPORT
Take I-95 North to Exit 13, PA-291 toward I-76 West/Valley Forge (Schuylkill Expressway). Merge right. Cross Girard Point Bridge and turn left at right on 26th Street. Merge on I-76 West to Exit 346A, South Street (left exit), and turn left on South Street. Turn left on 34th Street. The Hospital of the University of Pennsylvania is on the right and Penn Tower and the Perelman Center for Advanced Medicine are on the left. See "PARKING."

FROM NEW JERSEY
Take I-295 to the Walt Whitman Bridge. Follow signs for I-76 West (Schuylkill Expressway) and take Exit 346A, South Street (left). Turn left on South Street and turn left on 34th Street. The Hospital of the University of Pennsylvania is on the right and Penn Tower and the Perelman Center for Advanced Medicine are on the left. See "PARKING."

Alternate Route from New Jersey and points East
Take the New Jersey Turnpike to Exit 3. Follow the Black Horse Pike (Route 168 North) for one mile to I-295 South. Go one mile to Exit 26 for I-76 West to the Walt Whitman Bridge. Cross the Bridge to take I-76 West (Schuylkill Expressway) to Exit 346A, South Street (left exit), and turn left on South Street. Turn left on 34th Street. The Hospital of the University of Pennsylvania is on the right and Penn Tower and the Perelman Center for Advanced Medicine are on the left. See "PARKING.

PARKING
Parking garages are available at the front entrances of the Hospital of the University of Pennsylvania (right turn from 34th Street), and the Perelman Center for Advanced Medicine (left turn from Civic Center Boulevard).

Parking is available at the front entrances of the Hospital of the University of Pennsylvania (right turn from 34th Street), and the Perelman Center for Advanced Medicine (left turn from Civic Center Boulevard).

PARKING COSTS

<table>
<thead>
<tr>
<th>GARAGE</th>
<th>VALET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Non-patient</td>
</tr>
<tr>
<td>Up to 3 hrs.</td>
<td>$10</td>
</tr>
<tr>
<td>3-7 hrs.</td>
<td>$20</td>
</tr>
<tr>
<td>7-24 hrs.</td>
<td>$30</td>
</tr>
</tbody>
</table>

Rates Vary

Patients and guests 62 years and older are eligible for a senior discount. ($1 off, up to 3 hrs. / $2 off, 3 hrs. or over)

DIRECTIONS TO PENN PRESBYTERIAN MEDICAL CENTER
Take the 30th Street Exit from I-76 East or West, and continue West on Market Street to 38th Street. Turn right on 38th Street to enter the Penn Presbyterian campus.

DIRECTIONS TO PENNSYLVANIA HOSPITAL
Take I-76 West to 676 East. Follow I-676 (Vine Street Expressway) to the Eighth Street Exit. Follow Eighth Street to Spruce Street to reach the Hospital. Parking is available in the garage on Delancey Street.
The Hospital of the University of Pennsylvania campus consists of the Hospital of the University of Pennsylvania (HUP), the Ruth and Raymond Perelman Center for Advanced Medicine and Penn Tower. Bridges connect all three buildings at the first floor.

**DINING**

1. **HUP Cafeteria** (6 am to 7 pm)
   - Founders Building, 2nd Floor
2. **Jazz & Java Coffee**
   - Founders Building, 2nd Floor
3. **Potbelly Sandwich Works**
   - Penn Tower
   - Main Entrance, Ground Floor
4. **Coffee Classics** (6 am to 2:30 pm)
   - Penn Tower
   - Main Entrance, Ground Floor
5. **Gia Pronto Cafe**
   - Perelman Center
   - West Atrium, Ground Floor
6. **Gia Pronto Coffee Cart**
   - Perelman Center
   - Atrium, First Floor