Appointment Reminder

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

Appointment Date: ____________ / ______ / 2017, at 8:00 AM. Please keep in mind that this is an 8 hour appointment!

Please mail packet back by ____________ / ______ / 2017, via FedEx or UPS.
Please do NOT send packet back via USPS or FAX.

The Smell and Taste Center
The Hospital of the University of Pennsylvania
3400 Spruce Street, 5 Ravdin Building
Philadelphia, PA 19104.
Attention: Crystal Wylie.

1. We ask that you only get 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 doctor’s 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 booked 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 would like to bring your written reports with you, please let us know.

4. Make sure you fill out and return the entire packet at least 2 weeks prior 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 send back the documents via UPS or FedEx.**

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

6. If you bring family or friends with you, please note that only you and the tester will be permitted in testing areas. It is not a large waiting area and guests of patients may be required to go to another waiting area.

7. All payments must be made via credit card unless advance payment is made via check. Sorry but we do not accept cash at our office.

If you should have any questions about this packet, please feel free to call Crystal Wylie at 215-662-2797, Monday thru Friday, 9 am to 1 pm.
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>
</table>

**NAME OF PATIENT**

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

**SOCIAL SECURITY NUMBER**

**DATE OF BIRTH**

<table>
<thead>
<tr>
<th>SEX:</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
</table>

**EMERGENCY CONTACT**

<table>
<thead>
<tr>
<th>( )</th>
<th>AREA CODE</th>
<th>EMERGENCY CONTACT TELEPHONE</th>
</tr>
</thead>
</table>

**FATHER'S NAME:**

**MOTHER'S NAME:**

**MAIDEN NAME:**

**RACE:**

<table>
<thead>
<tr>
<th>Arab:</th>
<th>Asian:</th>
<th>Black:</th>
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<table>
<thead>
<tr>
<th>Caucasian:</th>
<th>Hispanic:</th>
<th>Indian:</th>
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<table>
<thead>
<tr>
<th>Other:</th>
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<tbody>
<tr>
<td>______</td>
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</tbody>
</table>

**MARITAL STATUS:**

<table>
<thead>
<tr>
<th>Married</th>
<th>Single</th>
<th>Divorced</th>
</tr>
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<tbody>
<tr>
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<table>
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<tr>
<th>Widowed</th>
<th>Separated</th>
<th>Other</th>
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</table>

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

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

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

**SOCIAL SECURITY NUMBER**

**DATE OF BIRTH**

<table>
<thead>
<tr>
<th>SEX:</th>
<th>M</th>
<th>F</th>
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</thead>
</table>

**FIRST LINE OF ADDRESS**

**SECOND LINE OF ADDRESS**

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
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</thead>
</table>

**AREA CODE**

**EMPLOYER NAME**

**FIRST LINE OF ADDRESS**

**SECOND LINE OF ADDRESS**

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
</tr>
</thead>
</table>

**AMA CODE**

**OCCUPATION**

**PRIMARY CARE/FAMILY PHYSICIAN**

<table>
<thead>
<tr>
<th>NAME</th>
<th>MD</th>
<th>DO</th>
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</thead>
</table>

**FIRST LINE OF ADDRESS**

**SECOND LINE OF ADDRESS**

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
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**AREA CODE**

**TELEPHONE**

**COMMENTS:**

<p>| |</p>
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</table>
**UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM**

**PATIENT REGISTRATION QUESTIONNAIRE**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Patient Identification Number/MRN</th>
</tr>
</thead>
</table>

**PRIMARY INSURANCE** (please "✓" the appropriate box below)

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

**NAME OF INSURANCE CO.**

**FIRST LINE OF ADDRESS**

**SECOND 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

---

**Health Insurance**

**SOCIAL SECURITY ACT**

**NAME OF BENEFICIARY**

**MEDICARE CLAIM NUMBER**

**SEX**

**IS ENTITLED TO**

**EFFECTIVE DATE**

**HOSPITAL** (PART A)

**MEDICAL** (PART B)

---

**Medicare Questions** *(Please Circle Y or N)*

- Are you or your spouse employed? Y or N
- Do you or your spouse have other insurance? Y or N
- Are you disabled or have end stage renal disease? Y or N
- Is this illness or injury the result of an auto accident? Y or N
- Did this illness or injury occur at work? Y or N
- Has treatment been authorized by the V.A.? Y or N
- Are you covered under the Black Lung Program? Y or N
- Is there Medigap coverage secondary to Medicare? Y or N
- Is there employer supplemental insurance secondary to Medicare? Y or N
- Is there insurance coverage primary to Medicare? Y or N
# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

<table>
<thead>
<tr>
<th>Patient Name (First, Middle, Last)</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City/State/Zip Code</td>
</tr>
</tbody>
</table>

## Disclosed Information:
- [ ] 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
- [ ] 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

Address

City/State/Zip Code | Telephone Number

## 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
Print Name
Date

Relationship of Personal Representative to Patient
Date

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

PLEASE READ INSTRUCTIONS ON REVERSE
HIPAA

Signature of Patient or Legally Authorized Representative

Date

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.
Welcome to the Hospital of the University of Pennsylvania. We appreciate your confidence in choosing our hospital for your health care needs.

Several local insurance carriers may not cover the total charges for outpatient diagnostic testing (procedure codes: 92512, 92700, 95900; diagnostic code: 781.1) at the Smell and Taste Center. In response to their policy, the Smell and Taste Center requires a non-refundable $450.00 payment to be made before any services are provided. If the insurance company does not pay our estimated charges, the payment will not be refunded. The $450.00 payment will be considered payment in full and charges will be adjusted to reflect $450.00 and not the full cost of testing. Therefore, you will not be charged more than $450.00 for this appointment, unless you are involved in a litigation case.

My signature indicates that I accept Payment Agreement.

All patients must sign below regardless of your health insurance coverage.

PATIENT SIGNATURE: ____________________________ __

DATE: ______________________________________________________
AOB – Assignment of Benefits

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 lawyer’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 ___________________________
Insurance Company Information

Below is a list of procedures that will be performed on the day of clinic, and that you may need when speaking with your insurance company to verify coverage and payments.

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
<th>COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>92700D</td>
<td>Intake/Exit Interview and History Questionnaire: The review of Olfactory and Taste History and 350 item intake Questionnaire</td>
<td>$309.00</td>
</tr>
<tr>
<td>92700F</td>
<td>Bilateral Smell Threshold Test: Bilateral testing of smell acuity using phenyl ethyl alcohol.</td>
<td>$309.00</td>
</tr>
<tr>
<td>92700E</td>
<td>Smell ID Test (UPSIT): The University of Pennsylvania Smell Identification test. This bilateral test is a microencapsulated olfactory test that is routinely administered by many physicians throughout the world.</td>
<td>$180.00</td>
</tr>
<tr>
<td>92700H</td>
<td>Smell Threshold Unilateral Testing: A detection threshold measurement of the smell acuity within each naris using the odorant phenyl ethyl alcohol.</td>
<td>$290.00</td>
</tr>
<tr>
<td>92700I</td>
<td>Taste-Suprathreshold Test: A test of the patient's whole mouth taste ability that uses various concentrations of sweet, sour, bitter and salty stimuli to establish suprathreshold determinates of taste dysfunction.</td>
<td>$335.00</td>
</tr>
<tr>
<td>92700J</td>
<td>Taste Quadrant Test: A test to ascertain whether localized deficits are present on regions of the tongue subserved by the left and right chord tympani and the left and right glossopharyngeal nerves.</td>
<td>$412.00</td>
</tr>
<tr>
<td>92512A</td>
<td>Acoustic Rhinometry: A sonar-like procedure for determining the volume of the nasal chamber.</td>
<td>$258.00</td>
</tr>
<tr>
<td>92700K</td>
<td>Nasal Air Flow: An anterior rhinomanometric procedure for determining the resistance of the airflow within each side of the nose.</td>
<td>$290.00</td>
</tr>
<tr>
<td>95900A</td>
<td>Electrogustometry: A threshold measurement of the lowest electric current (in microamperes) detectable on each side of the tongue. This test provides a means of assessing basal nerve sensitivity.</td>
<td>$290.00</td>
</tr>
<tr>
<td>92700L</td>
<td>Smell Suprathreshold Odor Memory Test: A test designed to assess central components of smell dysfunction.</td>
<td>$258.00</td>
</tr>
</tbody>
</table>
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>1. Sadness</th>
<th>6. Punishment Feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  I do not feel sad.</td>
<td>0  I don't feel I am being punished.</td>
</tr>
<tr>
<td>1  I feel sad much of the time.</td>
<td>1  I feel I may be punished.</td>
</tr>
<tr>
<td>2  I am sad all the time.</td>
<td>2  I expect to be punished.</td>
</tr>
<tr>
<td>3  I am so sad or unhappy that I can't stand it.</td>
<td>3  I feel I am being punished.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Pessimism</th>
<th>7. Self-Dislike</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  I am not discouraged about my future.</td>
<td>0  I feel the same about myself as ever.</td>
</tr>
<tr>
<td>1  I feel more discouraged about my future than I used to be.</td>
<td>1  I have lost confidence in myself.</td>
</tr>
<tr>
<td>2  I do not expect things to work out for me.</td>
<td>2  I am disappointed in myself.</td>
</tr>
<tr>
<td>3  I feel my future is hopeless and will only get worse.</td>
<td>3  I dislike myself.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Past Failure</th>
<th>8. Self-Criticalness</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  I do not feel like a failure.</td>
<td>0  I don’t criticize or blame myself more than usual.</td>
</tr>
<tr>
<td>1  I have failed more than I should have.</td>
<td>1  I am more critical of myself than I used to be.</td>
</tr>
<tr>
<td>2  As I look back, I see a lot of failures.</td>
<td>2  I criticize myself for all of my faults.</td>
</tr>
<tr>
<td>3  I feel I am a total failure as a person.</td>
<td>3  I blame myself for everything bad that happens.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Loss of Pleasure</th>
<th>9. Suicidal Thoughts or Wishes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  I get as much pleasure as I ever did from the things I enjoy.</td>
<td>0  I don’t have any thoughts of killing myself.</td>
</tr>
<tr>
<td>1  I don’t enjoy things as much as I used to.</td>
<td>1  I have thoughts of killing myself, but I would not carry them out.</td>
</tr>
<tr>
<td>2  I get very little pleasure from the things I used to enjoy.</td>
<td>2  I would like to kill myself.</td>
</tr>
<tr>
<td>3  I can’t get any pleasure from the things I used to enjoy.</td>
<td>3  I would kill myself if I had the chance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Guilty Feelings</th>
<th>10. Crying</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  I don’t feel particularly guilty.</td>
<td>0  I don’t cry anymore than I used to.</td>
</tr>
<tr>
<td>1  I feel guilty over many things I have done or should have done.</td>
<td>1  I cry more than I used to.</td>
</tr>
<tr>
<td>2  I feel quite guilty most of the time.</td>
<td>2  I cry over every little thing.</td>
</tr>
<tr>
<td>3  I feel guilty all of the time.</td>
<td>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 usual.
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.

---

**NOTICE:** This form is printed with both blue and black ink. If your copy does not appear this way, it has been photocopied in violation of copyright laws.
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></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>
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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>
<td></td>
<td></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>
<td>21. Sweating (not due to heat).</td>
<td></td>
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</tr>
</tbody>
</table>
Today's Date: ____________________________

Name: ____________________________
Age: ______ Sex: __Male __Female

Ethnicity: __ American Indian __Asian/Pacific __Black __Hispanic __White __Other

<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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<td>4. At the top of a broom to sweep dust from the floor</td>
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<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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<td>8. To hold tread 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 do/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: Briggs, 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, 5 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: ____________________________
   (Last) (First) (Middle)

2. Today’s Date: ______/______/____

3. Home Telephone: (___) ______-______

4. Work Telephone: (___) ______-______ ext.____

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

6. Date of Birth: ______/______/____

7. Age: ______

8. Sex:  □ Male  □ Female

9. MRN# (OFFICE USE ONLY): __________________

9A. SS# __________________

10. Height: ______

11. Weight: ______

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)
   □ Engineer □ Student (High School)
   □ Home Economist □ Teacher
   □ Professional (specify) ______
   □ Other (specify) ______
   □ Unemployed

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

15 A. Have you ever served in the armed forces? □ Yes  □ No
   If yes, which one ______ and how long ______
Smell and Taste Center Questionnaire

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 ALL 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: ______________________________________________________
(Street) (city) (state) (Zip)

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: ______________________________________________________
(Street) (city) (state) (Zip)

Name: ____________________________________________
If doctor: Degree (e.g., MD, DO, Ph.D., DDS, etc.): __________________________
Specialty or Practice Name: ____________________________________________
Phone Number: (____) ____ - ____
Mailing Address: ______________________________________________________
(Street) (city) (state) (Zip)

Name: ____________________________________________
If doctor: Degree (e.g., MD, DO, Ph.D., DDS, etc.): __________________________
Specialty or Practice Name: ____________________________________________
Phone Number: (____) ____ - ____
Mailing Address: ______________________________________________________
(Street) (city) (state) (Zip)

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: _______________________________________________________


Smell and Taste Center Questionnaire

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 ___
Smell and Taste Center Questionnaire

- Dry mouth
- Trouble with wisdom teeth
- Ulcer or sores
- Trouble swallowing
- Caps or crowns
- Gum disease
- Other (specify) ________________

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>
<td></td>
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<tr>
<td>Lower dentures</td>
<td></td>
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<tr>
<td>Upper dentures</td>
<td></td>
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</tbody>
</table>

29 A. 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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<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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</tbody>
</table>

29 B. Wisdom tooth removal

- 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
Smell and Taste Center Questionnaire

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Check all that apply</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol abuse</td>
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<tr>
<td>Alzheimer’s disease</td>
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<tr>
<td>Bell’s palsy (facial nerve weakness or paralysis)</td>
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<td>Cancer or tumor (specify)</td>
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<tr>
<td>Cerebral Palsy</td>
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<td>Cystic fibrosis</td>
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<td>Depression</td>
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<tr>
<td>Diabetes mellitus</td>
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<tr>
<td>Drug abuse</td>
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<tr>
<td>Frequent ear aches</td>
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<tr>
<td>Gastroesophageal reflux disorder</td>
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<tr>
<td>Frequent heartburn or vomiting</td>
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<tr>
<td>Headaches</td>
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<td>High blood pressure</td>
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<td>Liver condition</td>
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<tr>
<td>Lupus</td>
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<tr>
<td>Multiple sclerosis</td>
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<td>Neurosis</td>
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<tr>
<td>Vitamin or mineral deficiency</td>
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<td>Parkinson’s disease</td>
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<td>Psychosis</td>
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<tr>
<td>Rheumatoid arthritis</td>
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<td>Sarcoidosis</td>
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<td>Schizophrenia</td>
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<td>Seizures or epilepsy</td>
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<td>Sjorgren’s syndrome</td>
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<tr>
<td>Stroke</td>
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<td>Thyroid problem</td>
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<tr>
<td>Other (specify)</td>
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</tbody>
</table>

36. Has anyone in your family had a smell and/or taste problem?  □ Yes  □ No

If Yes:  Relationship (e.g., sibling, grandparent, etc.)  □ Yes  □ No

Problem

□ Yes  □ No

□ Yes  □ No

□ Yes  □ No

□ 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 ‘on going’ 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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### Past Medications

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<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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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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</tbody>
</table>
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 1 = 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
- □ Pre-menstrual
- □ None of these

Was your ability decreased during:
- □ Menses
- □ Midcycle
- □ 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) Explain:
☐ 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)______________________________________

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 No: 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>
</tr>
</thead>
<tbody>
<tr>
<td>Ammonia/Vinegar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body odors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cigarette smoke</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flowers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food flavors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household gas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perfumes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoke</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spoiled food</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vicks/Menthol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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) ___________________
Smell and Taste Center Questionnaire

□ Pleasant, food-like (specify)
□ Other (specify)
□ Unknown

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

☐ My sense of taste is heightened (hypersensitive).
☐ My sense of taste is diminished (partial loss).
☐ My sense of taste is absent (complete loss).
☐ My sense of taste is normal. <- If you checked this box please go to BDI – If it is separate from this 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? ___ / ___
            (Mo.) (Year)
   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? ___ / ___
            (Mo.) (Year)
    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

□ Certain foods (specify) ____________
□ Other (specify) ____________
□ Never increases

106. Is your taste problem reduced by:  
□ Rinsing with ______________
□ Chewing
□ Eating
□ Heat or cold
□ Certain foods (specify) ____________
□ Other (specify) ____________
□ Never decreases

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
□ Dentures or caps
□ 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) ____________
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>
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</tr>
<tr>
<td>Bitter</td>
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</tr>
<tr>
<td>Metallic</td>
<td>[ ]</td>
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<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: ______________________

23
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
# Hotel Accommodations

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></td>
</tr>
<tr>
<td>100 N. Christopher</td>
<td></td>
<td>Studio Suites 4630 Island Ave.</td>
<td></td>
</tr>
<tr>
<td>Columbus Drive</td>
<td></td>
<td>(215) 492-1811</td>
<td></td>
</tr>
<tr>
<td>(215) 529-7900 or (800)</td>
<td></td>
<td>Fax (215) 492-1655</td>
<td></td>
</tr>
<tr>
<td>228-5150</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax (215) 627-0809</td>
<td></td>
<td></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></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>Fax (215) 922-0258</td>
<td></td>
<td>Fax: (215) 365-3195</td>
<td></td>
</tr>
<tr>
<td>Divina 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. 38th 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>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) 893-1600</td>
<td></td>
<td>(215) 790-7781 or (800) 523-4210</td>
<td></td>
</tr>
<tr>
<td>Fax: (215) 893-1644</td>
<td></td>
<td>Fax: (215) 700-8106</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>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></td>
</tr>
<tr>
<td>Midtown 1305 Walnut Street Phila., Pa.</td>
<td></td>
<td>700 Ben Franklin Parkway</td>
<td>Valet parking $22.00 day with in and out</td>
</tr>
<tr>
<td>19102</td>
<td></td>
<td>(215) 981-5678 Fax: (215) 981-5684</td>
<td>privileges</td>
</tr>
<tr>
<td>(215) 736-5300 or (800)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>564-3869</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax: (215) 732-2598</td>
<td></td>
<td></td>
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<tr>
<td>The Inn at Penn</td>
<td>On Penn campus, 4 blocks from HUP</td>
<td>Hawthorn Suites</td>
<td>$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 Phila., 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>
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</tbody>
</table>

## PARKING

### VALET PARKING

Valet parking is available outside the Hospital of the University of Pennsylvania at the following locations:

- **Ravdin Entrance**
  - 34th Street, south of Spruce Street
  - Monday-Friday, 6:00 a.m. to 10 p.m.
  - Saturday, 12 p.m. to 5 p.m.

- **Penn Tower Motor Lobby**
  - Lower Motor Lobby
  - Convention Boulevard
  - Monday-Friday, 7 a.m. to 8 p.m.

*Self Parking is available in the Penn Tower Parking Garage*
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 326, Valley Forge. Take 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 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 light 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 is available at the front entrances of the Hospital of the University of Pennsylvania and the Perelman Center for Advanced Medicine (left turn from Civic Center Boulevard). Valet parking is also available in the garage on Delancey Street.

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>3 hrs.</td>
</tr>
<tr>
<td>Rates Vary</td>
<td>Rates Vary</td>
</tr>
<tr>
<td>7-24 hrs.</td>
<td>3-7 hrs.</td>
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</tbody>
</table>

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 36th Street. Turn right on 36th Street to enter the Penn Presbyterian campus.

DIRECTIONS TO PENNSYLVANIA HOSPITAL
Take I-76 West to 676 East. Follow I-76 (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.
Free Shuttle Service

A FREE shuttle service will be available to the Hospital of the University of Pennsylvania and the Perelman Center for Advanced Medicine on a continuous loop from the new 3600 Civic Center Boulevard garage Level 2 transportation center.

Valet Parking

Hospital of the University of Pennsylvania, Main Entrance:
Monday through Friday 5:30 am to 10 pm
Saturday and Sunday closed

Perelman Center for Advanced Medicine:
Monday through Friday 5:30 am to 9 pm
Saturday and Sunday closed