Appointment Reminder

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

Appointment Date: ___________ / ___________ / 2014 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 ___________ / ___________ / 2014, via Fedex or UPS 2 weeks before your appointment. Please do 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 only get a prescription from the doctor that recommended you to 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 booked several months in advance. We have no way of knowing 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 any films, please only send copies of WRITTEN reports. if you like to bring your written reports with you please let us know.

4. Make sure you return entire packet and send it 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 packet. We prefer you to send back 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 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.
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**
- LAST
- FIRST
- MIDDLE

**SOCIAL SECURITY NUMBER**

**DATE OF BIRTH**
- SEX: M F

**EMERGENCY CONTACT**
- ( )

**AREA CODE**
- EMERGENCY CONTACT TELEPHONE

**PARENT'S NAME**
- FATHER'S NAME:
- MOTHER'S NAME:

**RACE**
- Asian
- African
- Hispanic
- Indian
- Other

**MARRITAL 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)**
- LAST
- FIRST
- MIDDLE

**SOCIAL SECURITY NUMBER**

**DATE OF BIRTH**
- SEX: M F

**EMERGENCY CONTACT**
- ( )

**AREA CODE**
- HOME TELEPHONE

**FIRST LINE OF ADDRESS**

**SECOND LINE OF ADDRESS**

**CITY**
- STATE
- ZIP

**RELATIONSHIP TO GUARANTOR**
- ( )

**EMPLOYER NAME**

**FIRST LINE OF ADDRESS**

**SECOND LINE OF ADDRESS**

**CITY**
- STATE
- ZIP

**MD**
- DO

**NAME**

**FIRST LINE OF ADDRESS**

**SECOND LINE OF ADDRESS**

**CITY**
- STATE
- ZIP

**EMPLOYER NAME**

**FIRST LINE OF ADDRESS**

**SECOND LINE OF ADDRESS**

**CITY**
- STATE
- ZIP

**EMAIL ADDRESS**

**PATIENT EMPLOYMENT INFORMATION**

**FIRST LINE OF ADDRESS**

**SECOND LINE OF ADDRESS**

**CITY**
- STATE
- ZIP

**OCCUPATION**

**PRIMARY CARE/FAMILY PHYSICIAN**

**FIRST LINE OF ADDRESS**

**SECOND LINE OF ADDRESS**

**CITY**
- STATE
- ZIP

**EMAIL ADDRESS**

**COMMENTS**

---

**Signatures**

**Date:** 1.3.2001
**UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM**

**PATIENT REGISTRATION QUESTIONNAIRE**

<table>
<thead>
<tr>
<th><strong>PATIENT NAME</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRIMARY INSURANCE</strong> (please &quot;✓&quot; the appropriate box below)</td>
</tr>
<tr>
<td>□ BC/BS</td>
</tr>
<tr>
<td>NAME OF INSURANCE CO.</td>
</tr>
<tr>
<td>FIRST LINE OF ADDRESS</td>
</tr>
<tr>
<td>SECOND LINE OF ADDRESS</td>
</tr>
<tr>
<td>CITY</td>
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<tr>
<td>CERTIFICATE NUMBER</td>
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<tr>
<td>GROUP NUMBER</td>
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<tr>
<td>PLAN NUMBER</td>
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<tr>
<td>EFFECTIVE DATE</td>
</tr>
<tr>
<td>AREA CODE</td>
</tr>
<tr>
<td>SUBSCRIBER NAME (IF DIFFERENT)</td>
</tr>
<tr>
<td>RELATIONSHIP TO SUBSCRIBER</td>
</tr>
<tr>
<td>SUBSCRIBER'S BIRTHDAY</td>
</tr>
<tr>
<td>SUBSCRIBER'S SEX: M or F</td>
</tr>
</tbody>
</table>

**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) |

**SECONDARY 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 |

**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 Medicare coverage to Medicare? Y or N
- Is there Medicare coverage secondary to Medicare? Y or N
- Is there Medicare coverage primary to Medicare? Y or N

**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 Medicare coverage to Medicare? Y or N
- Is there Medicare coverage secondary to Medicare? Y or N
- Is there Medicare coverage primary to Medicare? Y or N
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 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

S. Ravdin | 3400 Spruce Street | Philadelphia, PA 19104-4283 | Phone: 215.662.6560 | Fax: 215.349.5266
**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:** (check all items to be released)

- Discharge Summary
- Discharge Instructions
- History and Physical
- Consultations
- 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):

**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.

PLEASEREADINSTRUCTIONSONREVERSE
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.

<table>
<thead>
<tr>
<th>Signature of Patient or Legally Authorized Representative</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Printed Name of Legally Authorized Representative</th>
<th>Legal Relationship to Patient (e.g., parent or guardian)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

GENERAL CONSENT TO
USE AND DISCLOSE PROTECTED HEALTH INFORMATION
### 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).

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I am not discouraged about my future.</td>
<td>0</td>
<td>I do not feel like a failure.</td>
</tr>
<tr>
<td>1</td>
<td>I feel more discouraged about my future than I used to be.</td>
<td>1</td>
<td>I have failed more than I should have.</td>
</tr>
<tr>
<td>2</td>
<td>I do not expect things to work out for me.</td>
<td>2</td>
<td>As I look back, I see a lot of failures.</td>
</tr>
<tr>
<td>3</td>
<td>I feel my future is hopeless and will only get worse.</td>
<td>3</td>
<td>I feel I am a total failure as a person.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>5. Guilty Feelings</strong></th>
<th><strong>6. Punishment Feelings</strong></th>
<th><strong>7. Self-Dislike</strong></th>
<th><strong>8. Self-Criticalness</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I don't feel particularly guilty.</td>
<td>0</td>
<td>I don't feel I am being punished.</td>
</tr>
<tr>
<td>1</td>
<td>I feel guilty over many things I have done or should have done.</td>
<td>1</td>
<td>I feel I may be punished.</td>
</tr>
<tr>
<td>2</td>
<td>I feel quite guilty most of the time.</td>
<td>2</td>
<td>I expect to be punished.</td>
</tr>
<tr>
<td>3</td>
<td>I feel guilty all of the time.</td>
<td>3</td>
<td>I feel I am being punished.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>9. Suicidal Thoughts or Wishes</strong></th>
<th><strong>10. Crying</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I don't have any thoughts of killing myself.</td>
</tr>
<tr>
<td>1</td>
<td>I have thoughts of killing myself, but I would not carry them out.</td>
</tr>
<tr>
<td>2</td>
<td>I would like to kill myself.</td>
</tr>
<tr>
<td>3</td>
<td>I would kill myself if I had the chance.</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 that 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.

1. Numbness or tingling.
2. Feeling hot.
3. Wobbliness in legs.
4. Unable to relax.
5. Fear of the worst happening.
6. Dizzy or lightheaded.
7. Heart pounding or racing.
8. Unsteady.
11. Feelings of choking.
14. Fear of losing control.
15. Difficulty breathing.
17. Scared.
18. Indigestion or discomfort in abdomen.
19. Faint.
20. Face flushed.
21. Sweating (not due to heat).

<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>
<td></td>
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<tr>
<td>2. Feeling hot.</td>
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</tr>
<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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<td>7. Heart pounding or racing.</td>
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<tr>
<td>20. Face flushed.</td>
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<tr>
<td>21. Sweating (not due to heat).</td>
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<tr>
<td>indicate hand preference</td>
<td>Always Left</td>
<td>Usually Left</td>
<td>No preference</td>
<td>Usually Right</td>
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</tr>
<tr>
<td>1. To write a letter legibly</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 any of your (natural) parents left-handed?  
How many siblings of each sex did you have?  
Which eye do you use when using one (e.g. telescope, keyhole)?  
Have you ever suffered any severe head trauma?  

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: ___________________________ ext.


5. Mailing Address: ___________________________ ___________________________ ___________________________ ___________________________

6. Date of Birth: __/__/____

7. Age: ______

8. Sex: □ Male □ Female

9. MRN# (OFFICE USE ONLY): ___________________________

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 □ Legal Worker
□ Biomedical Worker □ Business/Financial □ Manager
□ Chemical Industry Worker □ Military □ Clerical Worker □ Retired
□ Construction □ Sales/Service Industry
□ Craftsperson □ Student (Full time college) □ Engineering
□ Home Economist □ Student (High School) □ Professional (specify)
□ Other (specify) ___________________________
□ Unemployed

15. Is English your primary language? □ Yes □ No
If No: What is? ___________________________
16. Who referred you to this clinic?
- [ ] General Practitioner
- [ ] Neurologist
- [ ] Dentist
- [ ] 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:
   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
   □ Sinus 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

Check all that apply

□ Partial dentures
□ Full dentures
□ Lower dentures
□ Upper dentures

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

Check all that apply

□ Deviated septum repair
□ Nasal polypectomy
□ Sinus surgery
□ Brain surgery
□ Mouth surgery
□ Wisdom teeth 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
Other tooth extractions
Gum surgery
Tonsillectomy
Laryngectomy
Ear surgery:
Other surgeries (specify)

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

☐ 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

☐ Medication allergies
Specify:

☐ Seasonal allergies
(e.g., pollen, grass, ragweed)
Specify:

☐ Type of reaction
□ Yes □ No
Smell and Taste Center Questionnaire

1. Personal allergies (e.g., dust, molds, animals)
   Specify: __________________________

2. Food allergies
   Specify: __________________________

3. 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) __________________________
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.)

Problem
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

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<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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<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

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<th>What brand</th>
<th>How often</th>
<th>How many</th>
<th>How long</th>
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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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Symptoms</th>
<th>Effectiveness</th>
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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 brand 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")?  

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<th>Yes</th>
<th>No</th>
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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?  

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<th>Yes</th>
<th>No</th>
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If Yes: Was your ability increased during:  

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<tr>
<th></th>
<th>Menses</th>
<th>Mid-cycle</th>
<th>Pre-menstrual</th>
<th>None of these</th>
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Was your ability decreased during:  

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<thead>
<tr>
<th></th>
<th>Menses</th>
<th>Mid-cycle</th>
<th>Premenstrually</th>
<th>None of these</th>
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SECTION III - SMELL AND NASAL INFORMATION

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

<table>
<thead>
<tr>
<th></th>
<th>My sense of smell is distorted, that is things smell peculiar.</th>
<th>I experience a smell when nothing is there (phantom smell).</th>
<th>My sense of smell is heightened (hypersensitive).</th>
<th>My sense of smell is diminished (partial loss).</th>
<th>My sense of smell is absent (complete loss).</th>
<th>My main complaint is an abnormal body odor.</th>
<th>My sense of smell is normal.</th>
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<- 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?  

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<th>Yes</th>
<th>No</th>
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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?  

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<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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</table>

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:
   - [ ] 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:

   - [ ] 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>
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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.
  If Yes: Explain:

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

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.

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? 
     
     | Month | 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 when and what)

   - 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 when and what)

104. Has the amount of your saliva changed?  
   - Yes  
   - No  
   - If Yes: What month and year did this begin? 
     
     | Month | Year |
     |-------|------|
     |       |      |

   How has it changed?  
   - More  
   - Less  
   - Different (specify)

105. Is your taste problem increased by:  
   - Rinsing with
   - Chewing
   - Eating
   - Heat or cold

---

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Smell and Taste Center Questionnaire

106. Is your taste problem reduced by:
- □ Rinsing with
- □ Chewing
- □ Eating
- □ Heat or cold
- □ 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)
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>
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<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Sour</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<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.</td>
<td>Marriott Residence Inn</td>
<td>Near Phila.</td>
</tr>
<tr>
<td>100 N. Christopher Columbus Drive (215) 627-7900 or (800) 228-1150 Fax: (215) 627-0109.</td>
<td>Located at Penn's Landing.</td>
<td>International</td>
<td></td>
</tr>
<tr>
<td>Clarion Suites 10th and Arch Sts. (215) 922-6236</td>
<td>Approx. 2.5 miles from HUP in Center City.</td>
<td>Embassy Suites Hotel 9000 Bartram Ave. (215) 365-4500 or 1-800 EMBASSY Fax: (215) 365-3165</td>
<td>Near Phila. International Airport. 5 miles from HUP.</td>
</tr>
<tr>
<td>Divine Tracey Hotel 201 S. 36th St. (215) 387-0157 Fax: (215) 387-1157</td>
<td>4.6 Blocks from HUP.</td>
<td>Sheraton University City 30th and Chestnut Streets (215) 387-8000 or (877) 458-1146 Fax: (215) 387-5339</td>
<td>In University City, 5 blocks from HUP.</td>
</tr>
<tr>
<td>Double Tree Hotel Broadway and Locust Streets (215) 993-1954 Fax: (215) 993-1954</td>
<td>In Center City, 2 miles from HUP</td>
<td>Radisson Plaza Warwick Hotel 1701 Locust St. (215) 790-7818 or (800) 523-4210 Fax: (215) 790-6106</td>
<td>In Center City, 2 miles from HUP.</td>
</tr>
<tr>
<td>Four Seasons Hotel One Logan Square (215) 563-1500 Fax: (215) 563-9517</td>
<td>Approx. 2 miles from HUP in Center City.</td>
<td>Westin 591 N 22nd Street Philadelphia, Pa. 19130 (215) 568-4300 Fax: (215) 557-7646</td>
<td>4.5 miles from HUP.</td>
</tr>
<tr>
<td>Holiday Inn Excess Miotics 1305 Walnut Street Philadelphia, Pa. 19102 (215) 739-9300 or (800) 504-3689 Fax: (215) 732-3296</td>
<td>In Center City, 2 miles from HUP</td>
<td>The Windsor 700 Ben Franklin Parkway (215) 981-5673 Fax:(215) 981-7664</td>
<td>Valet parking $22.00/day with in and out privileges</td>
</tr>
<tr>
<td>The Inn at Penn 3500 Sansom St. (215) 222-2200 Fax: (215) 222-2200</td>
<td>On Penn campus, 4 blocks from HUP</td>
<td>Hawthorn Suites 1100 Vine Street (215) 689-4900 or (800) 627-1152 Fax: (215) 282-1856</td>
<td>Self-Parking $17/day. Valet parking $21.00/day</td>
</tr>
<tr>
<td>Latrobe Hotel 1700 Walnut St. (215) 562-7474 Fax: (215) 568-0110</td>
<td>In Center City, 2 miles from HUP.</td>
<td>The Ritz Carlton 10 Avenue of the Arts (215) 735-7700 Fax: (215) 739-7710</td>
<td>4 miles from HUP.</td>
</tr>
</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 10:00 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 6 p.m.

**Self Parking is available in the Penn Tower Parking Garage**
Please park in the Penn Towers parking garage. All patients must pay for parking, however when you go to pay on your way out, inform the attendant that you are a patient and you will receive a discounted rate for parking.

**Direction from the Walt Whitman Bridge**

Take the ramp onto I-76 W
Partial toll road
Entering Pennsylvania
Take exit 346A on the left for South Street
Turn left onto South St
South St turns slightly left and becomes Spruce St
Turn left onto S 34th St
Hospital of the University of Pennsylvania is on right

**From I-95**

Take I-95
Take ramp to I-676/Central Phila/I-76
Follow signs for I-76 E/International Airport and merge onto I-76 E
Take exit 346A on the left for South Street
Turn left onto South St
South St turns slightly left and becomes Spruce St
Turn left onto S 34th St
Hospital of the University of Pennsylvania is on right