Please read carefully through the instructions below.

Please mail packet back by _____ / _____ / 2013

Appointment Reminder

You have been scheduled for an appointment at the Smell and Taste Center for an evaluation and treatment recommendation if there are any available for your smell and/or taste disorder.

Appointment Date: _____ / _____ / 2013 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.

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

1. All payments if any are to be paid by Check or Cash.
2. We require you to get only a prescription from a doctor that recommended you visit us, if your insurance requires a referral please make sure you obtain one. If you would like to see an ENT here at UPenn after your visit with the Smell and Taste Center, please call 215-662-2778 to set up an appointment.
3. We don’t not need any films, please only send copies of WRITTEN reports.
4. Please DO NOT staple any pages, nor separate and/or remove pages, we will do that for you.
5. Make sure you return all filled out and signed paper work back 2 weeks prior to your appointment. We suggest you do not send by regular mail (all regular mail take 7 to 10 business days for receipt), if you do please make a copy and bring the copies with you. We prefer you to send packet back via UPS or Fed ex.
6. Please bring a lunch!!! There is no refrigeration available and you will not be permitted to leave our waiting are to go get something, if you do it will prolong your testing.
7. If you bring family or friends with you, please note that only you and the tester will be permitted in testing areas. All visitors will be escorted to another waiting area.

If you should have any questions about this packet please feel free to call Gerry Brennan at the center 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 __________

FATHER'S NAME: __________ MOTHER'S NAME: __________

MAIDEN NAME: __________

RACE: * Arab: __________ Asian: __________ Black: __________

Caucasian: __________ Hispanic: __________ Indian: __________

Other: __________

MARITAL STATUS: * Married __________ Single __________ Divorced __________

Widowed __________ Separated __________ Other __________

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

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

LAST __________ FIRST __________ MIDDLE __________

SOCIAL SECURITY NUMBER

DATE OF BIRTH __________ SEX: M/F

FIRST LINE OF ADDRESS __________

SECOND LINE OF ADDRESS __________

CITY __________ STATE __________ ZIP __________

RELATIONSHIP TO GUARANTOR __________

AREA CODE __________

EMPLOYER NAME __________

FIRST LINE OF ADDRESS __________

SECOND LINE OF ADDRESS __________

CITY __________ STATE __________ ZIP __________

EMAIL ADDRESS __________

**PATIENT ADDRESS**

FIRST LINE OF ADDRESS __________

SECOND LINE OF ADDRESS __________

CITY __________ STATE __________ ZIP __________

AREA CODE HOME TELEPHONE __________

AREA CODE DAY TELEPHONE __________

**PATIENT EMPLOYMENT INFORMATION**

EMPLOYER NAME __________

FIRST LINE OF ADDRESS __________

SECOND LINE OF ADDRESS __________

CITY __________ STATE __________ ZIP __________

AREA CODE TELEPHONE __________

OCCUPATION __________

**PRIMARY CARE/FAMILY PHYSICIAN**

MD __________ DO __________

NAME __________

FIRST LINE OF ADDRESS __________

SECOND LINE OF ADDRESS __________

CITY __________ STATE __________ ZIP __________

AREA CODE TELEPHONE __________

COMMENTS: __________

____________________________________________________

____________________________________________________

____________________________________________________

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____________________________________________________

____________________________________________________
### UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM

### PATIENT REGISTRATION QUESTIONNAIRE

<table>
<thead>
<tr>
<th><strong>PATIENT NAME</strong></th>
<th><strong>PATIENT IDENTIFICATION NUMBER/MRN</strong></th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>BC/BS</th>
<th>Commercial</th>
<th>HMO/PPO</th>
<th>POS</th>
</tr>
</thead>
</table>

**NAME OF INSURANCE CO.**

**FIRST LINE OF ADDRESS**

**SECOND LINE OF ADDRESS**

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

**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**

<table>
<thead>
<tr>
<th>MEDICARE CLAIM NUMBER</th>
<th>SEX</th>
</tr>
</thead>
</table>

**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

---

#### SECONDARY INSURANCE (please "✓" the appropriate box below)

<table>
<thead>
<tr>
<th>BC/BS</th>
<th>Commercial</th>
<th>HMO/PPO</th>
<th>POS</th>
</tr>
</thead>
</table>

**NAME OF INSURANCE CO.**

**FIRST LINE OF ADDRESS**

**SECOND LINE OF ADDRESS**

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

**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

#### WORKER’S COMPENSATION/AUTO ACCIDENT INFO

*Please Circle Either Worker’s Compensation or Auto Accident*

**INSURANCE CARRIER’S NAME**

**FIRST LINE OF ADDRESS**

**SECOND LINE OF ADDRESS**

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

**AREA CODE**

**TELEPHONE**

**DATE OF INJURY/ACCIDENT**

**CLAIM NUMBER/POLICY NUMBER**

**MULTIPLE CLAIMS?** 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 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
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 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

Phone: 215.662.6580 | Fax: 215.349.5266
<p><strong>HIPPA</strong></p>

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.
Payment Agreement

For Independence Blue Cross and Blue Shield Insurance Subscribers

University of Pennsylvania Health System: The Smell and Taste Center

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

Unlike most insurance carriers, Independence Blue Cross and Blue Shield (e.g. Personal Choice, Keystone East, Keystone Mercy, Health Partners, AmeriChoice) will not cover the total charges for outpatient diagnostic testing (procedure codes: 92512, 92700, 95900 and 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 patient must sign below regardless of you health insurance coverage.

PATIENT SIGNATURE: ___________________ DATE: ____________
For a Referral

Below is a list of procedures that will be performed on the day of clinic, and that you may need when speaking with your PRIMRAY CARE PHYSICIAN.

This ONLY applies to Aetna, Cigna, and Blue Cross/Blue Shield patients. Medicare patients do not need Referrals.

<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 chords 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>

Total Cost: $2,931.00
**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).

### 1. Sadness
- **0** I do not feel sad.
- **1** I feel sad much of the time.
- **2** I am sad all the time.
- **3** I am so sad or unhappy that I can't stand it.

### 2. Pessimism
- **0** I am not discouraged about my future.
- **1** I feel more discouraged about my future than I used to be.
- **2** I do not expect things to work out for me.
- **3** I feel my future is hopeless and will only get worse.

### 3. Past Failure
- **0** I do not feel like a failure.
- **1** I have failed more than I should have.
- **2** As I look back, I see a lot of failures.
- **3** I feel I am a total failure as a person.

### 4. Loss of Pleasure
- **0** I get as much pleasure as I ever did from the things I enjoy.
- **1** I don't enjoy things as much as I used to.
- **2** I get very little pleasure from the things I used to enjoy.
- **3** I can't get any pleasure from the things I used to enjoy.

### 5. Guilty Feelings
- **0** I don't feel particularly guilty.
- **1** I feel guilty over many things I have done or should have done.
- **2** I feel quite guilty most of the time.
- **3** I feel guilty all of the time.

### 6. Punishment Feelings
- **0** I don't feel I am being punished.
- **1** I feel I may be punished.
- **2** I expect to be punished.
- **3** I feel I am being punished.

### 7. Self-Dislike
- **0** I feel the same about myself as ever.
- **1** I have lost confidence in myself.
- **2** I am disappointed in myself.
- **3** I dislike myself.

### 8. Self-Criticalness
- **0** I don't criticize or blame myself more than usual.
- **1** I am more critical of myself than I used to be.
- **2** I criticize myself for all of my faults.
- **3** I blame myself for everything bad that happens.

### 9. Suicidal Thoughts or Wishes
- **0** I don't have any thoughts of killing myself.
- **1** I have thoughts of killing myself, but I would not carry them out.
- **2** I would like to kill myself.
- **3** I would kill myself if I had the chance.

### 10. Crying
- **0** I don't cry anymore than I used to.
- **1** I cry more than I used to.
- **2** I cry over every little thing.
- **3** I feel like crying, but I can't.
### 11. Agitation
- 0: No more restless or wound up than usual.
- 1: Feel more restless or wound up than usual.
- 2: So restless or agitated that it's hard to stay still.
- 3: So restless or agitated that I have to keep moving or doing something.

### 12. Loss of Interest
- 0: Not lost interest in other people or activities.
- 1: Less interested in other people or things than before.
- 2: Lost most of interest in other people or things.
- 3: Hard to get interested in anything.

### 13. Indecisiveness
- 0: Make decisions about as well as ever.
- 1: Find it more difficult to make decisions than usual.
- 2: Have much greater difficulty in making decisions than I used to.
- 3: Have trouble making any decisions.

### 14. Worthlessness
- 0: Don't feel I am worthless.
- 1: Don't consider myself as worthwhile and useful as I used to.
- 2: Feel more worthless as compared to other people.
- 3: Feel utterly worthless.

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

### 16. Changes in Sleeping Pattern
- 0: No change in my sleeping pattern.
- 1a: Sleep somewhat more than usual.
- 1b: Sleep somewhat less than usual.
- 2a: Sleep a lot more than usual.
- 2b: Sleep a lot less than usual.
- 3a: Sleep most of the day.
- 3b: Wake up 1-2 hours early and can't get back to sleep.

### 17. Irritability
- 0: No more irritable than usual.
- 1: More irritable than usual.
- 2: Much more irritable than usual.
- 3: Irritable all the time.

### 18. Changes in Appetite
- 0: No change in appetite.
- 1a: Appetite is somewhat less than usual.
- 1b: Appetite is somewhat greater than usual.
- 2a: Appetite is much less than before.
- 2b: Appetite is much greater than usual.
- 3a: No appetite at all.
- 3b: Crave food all the time.

### 19. Concentration Difficulty
- 0: Can concentrate as well as ever.
- 1: Can't concentrate as well as usual.
- 2: Hard to keep mind on anything for very long.
- 3: Find I can't concentrate on anything.

### 20. Tiredness or Fatigue
- 0: No more tired or fatigued than usual.
- 1: Get more tired or fatigued more easily than usual.
- 2: Too tired to do a lot of the things I used to do.
- 3: Too tired to do most of the things I used to do.

### 21. Loss of Interest in Sex
- 0: Not noticed any recent change in my interest in sex.
- 1: Less interested in sex than I used to be.
- 2: Much less interested in sex now.
- 3: 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.

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).
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>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. To throw a ball to hit a target</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. To play a game requiring the use of a racquet</td>
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<td></td>
<td></td>
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</tr>
<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 tread to guide through the eye of a needle</td>
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<td></td>
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</tr>
<tr>
<td>9. To deal playing cards</td>
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<td></td>
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</tr>
<tr>
<td>10. To hammer a nail into wood</td>
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<td></td>
</tr>
<tr>
<td>11. To hold a toothbrush while cleaning teeth</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. To unscrew the lid of a Jar</td>
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<td></td>
</tr>
</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: ____________________________ 2. Today's Date: ______ / ______ / ______
   (Last) (First) (Middle)

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): ______________

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)
   ☐ Engineering ☐ Student (High School)
   ☐ Home Economist ☐ Teacher
   ☐ 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   ☐ Dentist
☐ Neurologist           ☐ Ear, Nose & Throat Specialist
☐ Lawyer                ☐ Other (specify) __________

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

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

Name: ________________________________________________

**If doctor:** Degree (e.g., MD, DO, Ph.D., DDS, etc.): ______________________________
Specialty or Practice Name: ______________________________________________________
Phone Number: (____) ____-____
Mailing Address: ________________________________________________________________

(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: ________________________________________________________________
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 be 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) _____________________________
   Years

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) _____________________________
   Years

26. Do you have or have you ever had any dental or mouth problems? □ Yes □ No

   Check all that apply
   □ Sensitive or sore tongue
   Years
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

Check all that apply
☐ Partial dentures
☐ Full dentures
☐ Lower dentures
☐ Upper dentures

☐ Yes □ No

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 tooth removal

How many times? Date(s) Specific nature of operation

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):
  **Years**
  - [ ] Less than 12 hours
  - [ ] Between 12 hours and 24 hours
  - [ ] More than 24 hours

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

  **Years**
  How many times? __

32. Do you suffer from any allergies?  [ ] Yes  [ ] No

**Check all that apply**

- Medication allergies
  **Specify:**

- Seasonal allergies
  **Specify:**
    - (e.g., pollen, grass, ragweed)
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>Check all that apply</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol abuse</td>
<td></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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<tr>
<td>Cancer or tumor (specify)</td>
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<tr>
<td>Cerebral Palsy</td>
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<tr>
<td>Cystic fibrosis</td>
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<td>Depression</td>
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<td>Diabetes mellitus</td>
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<td>Drug abuse</td>
<td></td>
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<tr>
<td>Frequent ear aches</td>
<td></td>
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<tr>
<td>Gastroesophageal reflux disorder</td>
<td></td>
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<tr>
<td>Frequent heartburn or vomiting</td>
<td></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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<td>Lupus</td>
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<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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<tr>
<td>Parkinson’s disease</td>
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<tr>
<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>Sjörgen’s syndrome</td>
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<td>Stroke</td>
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<td>Thyroid problem</td>
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<tr>
<td>Other (specify)</td>
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</table>

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

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

Please list any over the counter Antacids you have taken

<table>
<thead>
<tr>
<th>What brand</th>
<th>How often</th>
<th>How many</th>
<th>How long</th>
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</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) _______________________
   □ 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>
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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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<tr>
<td>Food flavors</td>
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<tr>
<td>Household gas</td>
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<tr>
<td>Perfumes</td>
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<td>Smoke</td>
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<tr>
<td>Spoiled food</td>
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<tr>
<td>Vicks/Menthol</td>
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</tbody>
</table>

74. Do you experience any strange or distorted odors?  □ Yes  □ No
   **If No:** Go to question 84. **If Yes:** Got 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) _______________________

18
05. 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?  (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>
<td></td>
</tr>
<tr>
<td>Bitter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metallic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

If Yes: Specify: __________________________________________

117. Does everything you perceive to be distorted now taste the same to you?

□ No, different things taste differently; they just do not have the same quality they used to have.
□ Yes, they all taste the same.

118. What specific things taste distorted to you? (Check all that apply)

□ Everything tastes distorted
□ Foods/beverages (Specify): _____________________________
□ Tobacco products (Specify): ___________________________
□ Other (Specify): ________________________________

119. Do you believe your taste distortion arises from your: (Check all that apply)

□ Throat
□ Gums
□ Dentures or caps
□ Roof of mouth
□ Saliva
□ Post-nasal drip
□ Reflux (secretion of the stomach)
□ Whole mouth
□ Tongue (Specify area) ________________________________
□ Other (Specify) ________________________________
□ Not sure

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

121. Have you experienced more than one type of oral phantom sensation?  □ Yes  □ No

If Yes: Explain: __________________________________________
122. Can you determine about when your taste phantom began?  □ Yes  □ No

If Yes:  When?  ___/___/____
(Mo.)  (Day)  (Year)

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

If Yes:  Explain: ________________________________

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

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

If Yes:  Explain: ________________________________

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

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

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

If Yes:  Explain: ________________________________

129. On average, what is the strength of the oral phantom?
□ Weak
□ Moderate
□ Strong
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>Near Phila. International Airport; 5 miles from HUP</td>
</tr>
<tr>
<td>100 N. Christopher Columbus Drive (215) 627-7900 or (800) 228-5150 Fax: (215) 627-0809</td>
<td></td>
<td>Studio Suites 4630 Island Ave. (215) 492-1611 Fax: (215) 492-1665</td>
<td></td>
</tr>
<tr>
<td>Clarion Suites</td>
<td>Approx. 2.5 miles from HUP in Center City.</td>
<td>Embassy Suites Hotel</td>
<td>Near Phila. International Airport; 5 miles from HUP</td>
</tr>
<tr>
<td>10th and Arch Sts.</td>
<td></td>
<td>9000 Bartram Ave. (215) 365-4500 or 1-(800) EMBASSY Fax: (215) 365-3195</td>
<td></td>
</tr>
<tr>
<td>(215) 922-1730 Fax: (215) 922-6258</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divine Tracy Hotel</td>
<td>4.5 Blocks from HUP.</td>
<td>Sheraton University City</td>
<td>In University City, 5 blocks from HUP</td>
</tr>
<tr>
<td>20 S. 36th St. (215) 382-4310 Fax: (215) 387-0157</td>
<td></td>
<td>36th and Chestnut Streets (215) 387-8000 or (877) 459-1146 Fax: (215) 387-5339</td>
<td></td>
</tr>
<tr>
<td>Double Tree Hotel</td>
<td>In Center City, 2 miles from HUP</td>
<td></td>
<td>In Center City, 2 miles from HUP</td>
</tr>
<tr>
<td>Broad and Locust Streets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(215) 893-1600 Fax: (215) 993-1664</td>
<td></td>
<td></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 Philadelphia, Pa. 19130</td>
<td></td>
</tr>
<tr>
<td>(215) 963-1500 Fax: (215) 963-9507</td>
<td></td>
<td>(215) 568-8300 Fax: (215) 557-9448</td>
<td></td>
</tr>
<tr>
<td>Holiday Inn Express</td>
<td>In Center City, 2 miles from HUP</td>
<td>The Windsor</td>
<td>Valet parking $22.00/day with in and out privileges</td>
</tr>
<tr>
<td>Midtown 1305 Walnut Street Phila., Pa. 19102</td>
<td></td>
<td>700 Ben Franklin Parkway (215) 981-5978 Fax: (215) 981-5684</td>
<td></td>
</tr>
<tr>
<td>(215) 735-9300 or (800) 564-3689 Fax: (215)732-2598</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Inn at Penn</td>
<td>On Penn campus, 4 blocks from HUP</td>
<td>Hawthorn Suites</td>
<td>Self-Parking $17/day; Valet parking $21.00/day</td>
</tr>
<tr>
<td>3600 Sansom St. (215) 222-0200 Fax: (215) 222-4600</td>
<td></td>
<td>1100 Vine Street (215) 829-8300 or (800) 527-1133 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 (215) 735-7700 Fax: (215) 735-7710</td>
<td></td>
</tr>
<tr>
<td>(215) 563-7474 Fax: (215) 568-0110</td>
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</table>

PARKING

VALET PARKING

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

Ravin 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 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