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 safe guarded according to Health Insurance Portability and Accountability Act (HIPAA) guidelines.

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

_____ ___/___/___

Signature of Patient (or Guardian) Date

_____ ___/___/___

Signature of University of Pennsylvania Smell and Taste Center Staff Date

SECTION I - GENERAL INFORMATION

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

1. Name: _____ _____ 2. Today's Date: _____/_____/_____
(Last) (First) (Middle) (Mo.) (Day) (Year)

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
(Mo.) (Day) (Year)

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

10. Height: _____ 11. Weight: _____

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

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

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

15. Is English your primary language? ☐ Yes ☐ No
If No: What is? _____

15 A. Have you ever served in the armed forces? ☐ Yes ☐ No
If yes, which one _____ and how long _____

16. Who referred you to this clinic?

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

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

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

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

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

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

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

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

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

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

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 man 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	Years
☐ Frequent or chronic sneezing or itchy nose	_____
☐ Prolonged abnormal nasal discharge	_____
☐ Frequent or chronic trouble breathing through the nose	_____
☐ Frequent or chronic post nasal drip	_____
☐ Sinus pain or headache	_____
☐ Sinus infection	_____
☐ Nasal polyps	_____
☐ Deviated septum of the nose	_____
☐ Frequent nosebleeds	_____
☐ Broken nose	_____
☐ Nasal allergy	_____
☐ Frequent colds	_____
☐ Other (specify) _____	_____

25. Do you have or have you ever had any serious respiratory problems? ☐ Yes ☐ No

Check all that apply	Years
☐ 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	Years
☐ Sensitive or sore tongue	_____

☐ 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	Years
☐ Partial dentures	_____
☐ Full dentures	_____
☐ Lower dentures	_____
☐ Upper dentures	_____

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

Check all that apply	How many times?	Date(s)	Specific nature of operation
☐ Deviated septum repair	_____	_____	_____
☐ Nasal polypectomy	_____	_____	_____
☐ Sinus surgery	_____	_____	_____
☐ Brain surgery	_____	_____	_____
☐ Mouth surgery	_____	_____	_____
29 B. Wisdom tooth removal	_____	_____	_____

If so, which teeth were removed?

- ☐ Right Upper
- ☐ Left Upper
- ☐ Right Lower
- ☐ Left Lower

If so, when were your wisdom teeth removed?

- ☐ One year ago
- ☐ Two to Five years ago
- ☐ Five to Ten years ago
- ☐ More than 10 years ago
- ☐ Don't Remember

☐ 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 **Years**

☐ 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

Years

How many times? _____ _____

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

Check all that apply	**Type of reaction**	**Years**
☐ Medication allergies		
Specify: _____	_____	_____
_____	_____	_____
_____	_____	_____
☐ Seasonal allergies		
(e.g., pollen, grass, ragweed)		
Specify: _____	_____	_____
_____	_____	_____

☐ 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	**Years**
☐ 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	**Amount of Exposure (hrs, days, months, or years)**
☐ 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	Years
☐ 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	
☐ Sjorgen's syndrome	
☐ Stroke	
☐ Thyroid problem	
☐ Other (specify) _____	

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

Name	Milligrams	How often	Start	Ended	Reason for use	Onset

Past Medications

Name	Milligrams	How often	Start	Ended	Reason for use	Onset

Please list any over the counter Antacids you have taken

What brand	How often	How many	How long
_____	_____	_____	_____
_____	_____	_____	_____

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

If Yes: Explain: _____

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	**Explain**
☐ 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):

Odor	Normal	Diminished	Absent	Distorted	Heightened
Ammonia/Vinegar	____	____	____	____	____
Body odors	____	____	____	____	____
Cigarette smoke	____	____	____	____	____
Flowers	____	____	____	____	____
Food flavors	____	____	____	____	____
Household gas	____	____	____	____	____
Perfumes	____	____	____	____	____
Smoke	____	____	____	____	____
Spoiled food	____	____	____	____	____
Vicks/Menthol	____	____	____	____	____

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 had you 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) _____

☐ Pleasant, food-like (specify)_____
☐ Other (specify) _____
☐ Unknown

95. Has the phantom odor changed in quality since you first noticed it?

☐ Yes ☐ No

If Yes: Explain: _____

96. Does anything cause a variation in the phantom odor? ☐ Yes ☐ No

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

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

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

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

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

☐ Weak
☐ Moderate
☐ Strong

SECTION IV - TASTE AND ORAL INFORMATION

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

☐ My sense of taste is distorted, that is, things taste peculiar.
☐ I experience a taste when nothing is there (phantom taste).

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

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

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

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

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

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

Does it decrease:
☐ Before meals (specify which meals) _____
☐ After meals (specify which meals) _____
☐ Before going to sleep
☐ After waking up
☐ Certain time of the day (specify time) _____
☐ Other (specify exactly what and when) _____

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

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

☐ 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
☐ Gums
☐ Roof of mouth
☐ Tongue (specify area) _____
☐ Other (specify) _____
☐ Not sure
☐ Throat
☐ Dentures or caps

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) _____

☐ Other (specify) _____
☐ Present since birth
☐ Unknown

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:

Taste	Better	Same	Worse
Sweet	☐	☐	☐
Salty	☐	☐	☐
Sour	☐	☐	☐
Bitter	☐	☐	☐
Metallic	☐	☐	☐
Other (specify) _____	☐	☐	☐

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

☐ At all times
☐ Other; Explain: _____

115. Describe and rate your ability to taste in relation to what it used to be:

Taste	Stronger	Same	Weaker
Sweet	☐	☐	☐
Salty	☐	☐	☐
Sour	☐	☐	☐
Bitter	☐	☐	☐
Metallic	☐	☐	☐
Other (specify) _____	☐	☐	☐

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