ENT SURGICAL CONSULTANTS

SMELL AND TASTE QUESTIONNAIRE (3/04)

Name____Date________________

The following checklist will assist in determining the cause of your loss of taste or smell sensation. Please read each item carefully and check *only* those factors that apply to you.

- ☐ Date of onset ______________________________
- ☐ Loss of smell (Complete or partial?)
- ☐ Increased sensitivity to odors
- ☐ Distortion or perversion in the sense of smell
- ☐ Loss of taste (Complete or partial?)
- ☐ Increased sensitivity to tastes
- ☐ Distortion or perversion in the sense of flavor
- ☐ Can't taste sweet, sour, or bitter flavors
- ☐ Runny nose
- ☐ Postnasal drip
- ☐ Difficulty breathing through your nose
- ☐ Mouth breathing
- ☐ Burning tongue or mouth
- ☐ Dry mouth
- ☐ Dry eyes
- ☐ Recent or preceding "flu", "cold" or upper respiratory infection
- ☐ Recent or preceding head injury
- ☐ Recent or preceding change in medication (Please list below)
- ☐ Recent or preceding antibiotic use (Please list below)
- ☐ Recent or preceding exposure to air pollutants (Which?)
- ☐ Recent or preceding chemical exposure
- ☐ Mouthwash use (What kind?)
- ☐ Recent change in oral hygiene agents (toothpaste, etc)
- ☐ Frequent yeast infections (Where?)
- ☐ Tobacco use (chewing, smoking, etc)
- ☐ Vitamin or mineral deficiency
- ☐ Environmental allergies (Please list)
- ☐ Nasal allergies or hayfever
- ☐ Previous nasal polyps
- ☐ Previous nose or sinus surgery
- ☐ Previous ear surgery
- ☐ Previous brain surgery
- ☐ Epilepsy, convulsion or seizure disorder
- ☐ Neurological problems (Please list)
- ☐ Liver problems (Hepatitis, cirrhosis, etc)
- ☐ Kidney problems (Kidney failure, dialysis treatment)
- ☐ Migraine headaches
- ☐ Congenital birth defects (Please list)
- ☐ Glandular problems (Please list)
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Sjogren's syndrome
- ☐ Dental problems
- ☐ Denture use
- ☐ Recent mouth, throat, or oral surgery
- ☐ Psychiatric problems (Please list)
- ☐ Depression
- ☐ Tumors or cancers (Please list)
- ☐ Previous radiation therapy
- ☐ Previous chemotherapy

Women only

- ☐ Post-menopause
- ☐ Previous hysterectomy or ovary removal

Please describe in your own words any other information about your problem. You may use this space to expand your answers above.