Center for Smell and Taste
Patient Assessment Questionnaire

NAME **DOB.** **DATE**

I. History of Olfactory Dysfunction

How would you describe your current sense of smell?

- **Normosmia:** Normal sense of smell
- **Hyposmia:** Decreased or dulled sense of smell
- **Anosmia:** Complete loss of smell
- **Parosmia:** Distorted smell (things smell "off" or "foul")
- **Phantosmia:** Smelling things that aren't there (e.g., burning)

Onset and Progression:

- When did you first notice this problem? _____
- Was the onset: [ ] Sudden (over hours/days) or [ ] Gradual (over weeks/months)?
- Does your sense of smell ever return or fluctuate? [ ] Yes [ ] No

Potential Triggers:

- Did the problem begin after any of the following? (Check all that apply)
  - Head injury or concussion
  - Viral infection (e.g., Flu, COVID-19, Common Cold)
  - Sinus infection or chronic allergies
  - Exposure to chemicals, solvents, or pesticides

II. Associated Symptoms

Taste Perception:

- Can you still perceive basic tastes? (Check all that apply)
    - Sweet [ ] Sour [ ] Salty [ ] Bitter
- Do you feel the *flavor* of your food has changed? [ ] Yes [ ] No

Nasal & Dental Health:

- Do you have a history of nasal polyps or sinus surgery? [ ] Yes [ ] No
- Do you have any current dental or gum problems? [ ] Yes [ ] No

III. Lifestyle and Impact

Safety & Quality of Life:

- Are you able to smell smoke or household gas? []Yes [] No
- Are you able to smell if food has spoiled? [ ] Yes [ ] No
- On a scale of 1–10, how much does this affect your quality of life? (1 = None, 10 = Severe) ____

Tobacco Use:

- Do you currently smoke or use tobacco products? [ ] Yes [ ] No
- If yes, how many years/how much per day? _____
