



Anosmia / Loss of Smell Questionnaire

Name: _____ Date of Onset: _____ Today's Date: _____

Tick all that apply

Loss of smell

- Complete
- Partial
- Sudden
- Gradual

Loss of taste

- Cannot taste sweet
- Cannot taste bitter
- Cannot taste sour
- Distorted sense of taste

My Symptoms began

- After a cold or flu
- After a head injury
- After change in medication
- After environmental exposure
- Other _____

Other symptoms

- Runny nose
- Post nasal drip
- Difficulty breathing through nose
- Mouth breathing

- Burning tongue
- Burning mouth
- Dry mouth
- Dry eyes

- Frequent yeast infections
- Migraine headaches

Your Medical History

- Environmental allergies
- Nasal polyps
- Previous nose or sinus surgery
- Previous ear surgery
- Previous brain surgery
- Liver disease
- Glandular problems

- Thyroid problems
- Diabetes
- Sjogren's Syndrome
- Dental problems
- Dentures
- Recent mouth, throat or oral surgery
- Psychiatric problems

- Depression
- Previous chemotherapy
- Tobacco use
- Vitamin or mineral deficiency
- Hysterectomy/ovarian removal
- Post menopause

Please describe any tumour or cancers you have had or currently have:

Please describe any neurologic problems you have had or currently have:

Mouthwash you use and how long you have been using it: _____

Toothpaste you use and how long you have been using it: _____

Any other information about your condition:
