Section 1: Smell Identification

1. Check all of the following statements that apply to you now and provide dates:

- ☐ I have a NORMAL sense of smell (If checked, please skip to question #23) Date Problem Began (month/year)
- ☐ 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) _____/____

2. The change in your sense of smell happened:

- ☐ SUDDENLY
- ☐ OVER A PERIOD OF DAYS
- ☐ OVER A PERIOD OF WEEKS
- ☐ OVER A PERIOD OF MONTHS
- ☐ OVER A PERIOD OF YEARS
- ☐ UNKNOWN

3. For each type of smell problem you experience, indicate by a check how your symptoms have changed in the past 6 months:

<table>
<thead>
<tr>
<th></th>
<th>Unchanged</th>
<th>Improved</th>
<th>Worsened</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMELL LOSS</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>HYPERSENSITIVITY</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>SMELL DISTORTIONS</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>PHANTOM SMELL(S)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

4. For each of the following odors, indicate with a check whether your perception of it is currently normal, diminished, absent, distorted, heightened or unknown:

<table>
<thead>
<tr>
<th>Odor</th>
<th>Normal</th>
<th>Diminished</th>
<th>Absent</th>
<th>Distorted</th>
<th>Heightened</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOUSEHOLD GAS</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>SMOKE</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>GASOLINE</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>SPOILED FOOD</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>FLOWERS</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>FOOD FLAVORS</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>AMMONIA/VINEGAR</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>VICKS/MENTHOL</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>CIGARETTE SMOKE</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>PERFUMES</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>BODY ODORS</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
5. Your smell problem began when you had (check all that apply):

- NASAL DISEASE – e.g., sinusitis, polyps (specify):
- ALLERGIES (to what?):
- DENTAL PROBLEMS (specify):
- UPPER RESPIRATORY INFECTION - e.g., cold or flu (specify):
- CHEMICAL EXPOSURE - e.g., herbicides, pesticides, chemicals, smoke (describe):
- RADIATION, MEDICATION, CHEMOTHERAPY (specify):
- HEAD INJURY (describe):
- OTHER ILLNESS, SURGERY, STROKE (specify):
- OTHER (specify):
- UNKNOWN

6. If you have experienced a LOSS OR DISTORTION OF SMELL, please indicate whether there are ever times when your ability to smell seems to get BETTER or WORSE. Provide specific examples if applicable.

- I DO NOT HAVE SMELL LOSS OR DISTORTIONS.
- MY ABILITY TO SMELL NEVER CHANGES.
- MY ABILITY TO SMELL FLUCTUATES:

<table>
<thead>
<tr>
<th>Better</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT UNPREDICTABLE TIMES</td>
<td></td>
</tr>
<tr>
<td>WHEN I EXERCISE</td>
<td></td>
</tr>
<tr>
<td>WHEN I TAKE MEDICATION (Specify what):</td>
<td></td>
</tr>
<tr>
<td>WHEN I EAT OR DRINK (Specify foods/beverages):</td>
<td></td>
</tr>
<tr>
<td>WHEN I ENGAGE IN SOME OTHER ACTIVITY (Specify what):</td>
<td></td>
</tr>
<tr>
<td>AT CERTAIN TIMES OF THE DAY (Specify when):</td>
<td></td>
</tr>
<tr>
<td>AT CERTAIN TIMES OF THE YEAR (Specify when):</td>
<td></td>
</tr>
<tr>
<td>WHEN MY NOSE IS CONGESTED</td>
<td></td>
</tr>
<tr>
<td>OTHER (Specify):</td>
<td></td>
</tr>
</tbody>
</table>

7. Do you sometimes perceive a smell or food flavor when you first encounter it, but find that the sensation disappears rapidly?

- NO
- YES

IF YOU DO NOT EXPERIENCE SMELL DISTORTIONS, PLEASE SKIP TO QUESTION #12

8. 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):
- EVERYTHING SMELLS DISTORTED
9. Are there any odors that smell normal to you?

☐ NO
☐ YES (specify):

10. Do all of the odors you perceive to be distorted now smell the same to you?

☐ NO, DIFFERENT ODORS STILL SMELL DIFFERENTLY, BUT THEY DO NOT HAVE THE SAME QUALITY THEY USED TO.
☐ YES, THEY ALL SMELL THE SAME.

11. If you block one side of your nose and sniff with the other, can you smell the distortions in:

☐ THE RIGHT NOSTRIL ONLY
☐ THE LEFT NOSTRIL ONLY
☐ BOTH NOSTRILS

IF YOU DO NOT EXPERIENCE A PHANTOM SMELL, PLEASE SKIP TO QUESTION #23

12. Do you currently experience more than one type of phantom smell sensation?

☐ NO
☐ YES

13. The phantom odor(s) smell(s) like (check all that apply):

<table>
<thead>
<tr>
<th></th>
<th>Not at All</th>
<th>Weakly</th>
<th>Moderately</th>
<th>Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>INFECTED TISSUE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMOKY/BURNT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FECAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ROTTEN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUSTY/MOLDY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SWEET</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>METALLIC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHEMICAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Specify quality:

14. Has the phantom odor(s) changed in quality since you first noticed it?

☐ NO
☐ YES, specify how:

15. If you block one side of your nose and sniff with the other, can you smell the phantom odor(s) in:

☐ THE RIGHT NOSTRIL ONLY
☐ THE LEFT NOSTRIL ONLY
☐ BOTH NOSTRILS

16. Does the phantom odor(s) occur when:

☐ BREATHING IN ONLY
☐ BREATHING OUT ONLY
☐ BREATHING IN OR OUT
☐ NOT BREATHING AT ALL
☐ IT IS NOT RELATED TO BREATHING
17. Can other people smell the phantom odor(s) you smell?
   - NO, I DO NOT BELIEVE SO.
   - YES, I THINK SO BUT NO ONE HAS COMMENTED ON IT.
   - YES, I HAVE BEEN TOLD SO BY OTHERS.

18. The last time you had the phantom odor(s) was:
   - MORE THAN 6 MONTHS AGO
   - 1 TO 6 MONTHS AGO
   - 1 TO 4 WEEKS AGO
   - WITHIN THE LAST FEW DAYS
   - PRESENTLY

19. How often do you experience the phantom odor(s):
   - CONSTANTLY (ALWAYS PRESENT)
   - DAILY
   - WEEKLY
   - MONTHLY

20. How long does your phantom usually last:
   - THE PHANTOM ODOR IS ALWAYS THERE.
   - 24 HOURS OR MORE
   - SEVERAL HOURS
   - MINUTES
   - FLEETING

21. How strong is your phantom odor(s) usually:
   - VERY WEAK
   - WEAK
   - MODERATE
   - STRONG

22. Please indicate with a check AND specific examples whether there are ever times when your phantom smell seems to get BETTER or WORSE.
   - MY PHANTOM ODOR NEVER CHANGES.
   - MY PHANTOM ODOR FLUCTUATES:

<table>
<thead>
<tr>
<th>Better</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT UNPREDICTABLE TIMES</td>
<td>☐</td>
</tr>
<tr>
<td>WHEN I TAKE MEDICATION</td>
<td>☐</td>
</tr>
<tr>
<td>(Specify what):</td>
<td></td>
</tr>
<tr>
<td>WHEN MY NOSE IS CONGESTED</td>
<td>☐</td>
</tr>
<tr>
<td>WHEN I AM EXPOSED TO STRONG ODORS</td>
<td>☐</td>
</tr>
<tr>
<td>(Specify what):</td>
<td></td>
</tr>
<tr>
<td>WHEN I PUT MY HEAD DOWN</td>
<td>☐</td>
</tr>
<tr>
<td>AT CERTAIN TIMES OF THE DAY</td>
<td>☐</td>
</tr>
<tr>
<td>(Specify when):</td>
<td></td>
</tr>
<tr>
<td>AFTER I SLEEP OR REST</td>
<td>☐</td>
</tr>
<tr>
<td>(Specify when):</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td>☐</td>
</tr>
<tr>
<td>(Specify):</td>
<td></td>
</tr>
</tbody>
</table>
Section 2: Taste Information

23. Check all of the following statements that apply to you now and provide dates:

- I have a NORMAL sense of taste (If checked, please skip to question 43)
- 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)

Date Problem Began (month/year)

24. The change in your sense of taste happened:
- SUDDENLY
- OVER A PERIOD OF DAYS
- OVER A PERIOD OF WEEKS
- OVER A PERIOD OF MONTHS
- OVER A PERIOD OF YEARS
- UNKNOWN

25. For each type of taste problem you experience, indicate by a check how your symptoms have changed in the past 6 months:

<table>
<thead>
<tr>
<th></th>
<th>Unchanged</th>
<th>Improved</th>
<th>Worsened</th>
</tr>
</thead>
<tbody>
<tr>
<td>TASTE LOSS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HYPERSENSITIVITY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TASTE DISTORTIONS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHANTOM TASTE(S)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

26. For each of the following taste qualities, indicate with a check whether your perception of it is currently normal, diminished, absent, distorted or heightened:

<table>
<thead>
<tr>
<th>Taste Quality</th>
<th>Normal</th>
<th>Diminished</th>
<th>Absent</th>
<th>Distorted</th>
<th>Heightened</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWEET</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>SALTY</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>SOUR(e.g., lemon, vinegar)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>BITTER(e.g., tonic water, medicine)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

27. Your taste problem began when you had (check all that apply):

- NASAL DISEASE – e.g., sinusitis, polyps (specify):
- ALLERGIES (to what?):
- DENTAL PROBLEMS (specify):
- UPPER RESPIRATORY INFECTION – e.g., cold or flu (specify):
- CHEMICAL EXPOSURE – e.g., herbicides, pesticides, chemicals, smoke (describe):
- RADIATION, MEDICATION, CHEMOTHERAPY (specify):
- HEAD INJURY (describe):
- OTHER ILLNESS, SURGERY, STROKE (specify):
- OTHER (specify):
- UNKNOWN
28. If you have experienced a **LOSS OR DISTORTION OF TASTE**, please indicate whether there are ever times when your ability to taste seems to get BETTER or WORSE. Provide specific examples if applicable.

- I DO NOT HAVE TASTE LOSS OR DISTORTIONS.  
- MY ABILITY TO TASTE NEVER CHANGES.  
- MY ABILITY TO TASTE FLUCTUATES:

<table>
<thead>
<tr>
<th></th>
<th>Better</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT UNPREDICTABLE TIMES</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>WHEN I EXERCISE</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>WHEN I TAKE MEDICATION (Specify what):</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>WHEN I EAT OR DRINK (Specify foods/beverages):</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>WHEN I ENGAGE IN SOME OTHER ACTIVITY (Specify what):</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>AT CERTAIN TIMES OF THE DAY (Specify when):</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>AT CERTAIN TIMES OF THE YEAR (Specify when):</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>WHEN MY NOSE IS CONGESTED</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>OTHER (Specify):</td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>

**IF YOU DO NOT EXPERIENCE TASTE DISTORTIONS, PLEASE SKIP TO QUESTION #32**

29. The kinds of things that taste **DISTORTED** (peculiar) to you are (check all that apply):

- FOODS/BEVERAGES (specify):
- TOBACCO PRODUCTS (specify):
- OTHER (specify):
- EVERYTHING TASTES DISTORTED

30. Is there anything that tastes normal to you?

- NO
- YES (specify):

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

- NO, DIFFERENT THINGS STILL **TASTE DIFFERENTLY**, BUT THEY DO NOT HAVE THE SAME QUALITY THEY USED TO.  
- YES, THEY ALL **TASTE THE SAME**.

**IF YOU DO NOT EXPERIENCE AN ORAL PHANTOM, PLEASE SKIP TO QUESTION #40**

32. Do you currently experience more than one type of oral phantom sensation?

- NO
- YES
33. The oral phantom(s) is/are (check all that apply):

<table>
<thead>
<tr>
<th></th>
<th>Not at All</th>
<th>Weakly</th>
<th>Moderately</th>
<th>Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWEET</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SALTY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOUR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BITTER</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ROTTEN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>METALLIC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BURNING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TINGLING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Specify quality:

34. Has the oral phantom changed in quality since you first noticed it?

☐ NO
☐ YES
(If yes, specify how):

35. Does the oral phantom come from your (check all that apply):

☐ TONGUE (specify where): _____________________________________________________
☐ THROAT
☐ GUMS
☐ DENTURES OR CAPS
☐ ROOF OF MOUTH
☐ SALIVA
☐ WHOLE MOUTH
☐ OTHER (specify): __________________________________________________________

36. The most recent occurrence of the oral phantom was:

☐ MORE THAN 6 MONTHS AGO
☐ 1 TO 6 MONTHS AGO
☐ 1 TO 4 WEEKS AGO
☐ WITHIN THE LAST FEW DAYS
☐ PRESENTLY

37. The frequency with which you experience the oral phantom(s) is:

☐ CONSTANTLY (ALWAYS PRESENT)
☐ DAILY
☐ WEEKLY
☐ MONTHLY

38. The duration of your phantom episodes is typically:

☐ THE ORAL PHANTOM IS ALWAYS THERE.
☐ 24 HOURS OR MORE
☐ SEVERAL HOURS
☐ MINUTES
☐ FLEETING

39. The strength of the oral phantom you experience is usually:

☐ VERY WEAK
☐ WEAK
☐ MODERATE
☐ STRONG
40. Since your smell or taste problem began, have you received any treatment(s) that you or your physician thought might help your smell/taste problem but which were not at all effective? (Check all that apply):

- [ ] NO
- [ ] YES, MEDICATION(S) (specify):
  1. Type: ______________________
     Dosage: ______________________
     Taken from ___/___/___ to ___/___/___
  2. Type: ______________________
     Dosage: ______________________
     Taken from ___/___/___ to ___/___/___
  3. Type: ______________________
     Dosage: ______________________
     Taken from ___/___/___ to ___/___/___
  4. Type: ______________________
     Dosage: ______________________
     Taken from ___/___/___ to ___/___/___
- [ ] YES, SURGERY (please describe):
- [ ] YES, DENTAL TREATMENT (please describe):
- [ ] OTHER (including vitamins) (specify):

SECTION 3: Nutritional Information

41. Since your taste or smell problem began, your appetite has been:
- [ ] I DO NOT HAVE A TASTE OR SMELL PROBLEM
- [ ] BETTER
- [ ] UNCHANGED
- [ ] WORSE

42. Since your taste or smell problem began, you have enjoyed food:
- [ ] I DO NOT HAVE A TASTE OR SMELL PROBLEM
- [ ] MORE
- [ ] THE SAME
- [ ] LESS

43. Does your taste or smell problem affect the way you eat (e.g., types of foods, meal and snacking frequency)?
- [ ] I DO NOT HAVE A TASTE OR SMELL PROBLEM
- [ ] NO
- [ ] YES (describe change):
44. Since your taste or smell problem began, have you altered the amount of salt, sugar or spices you add to your food?
   - I DO NOT HAVE A TASTE OR SMELL PROBLEM
   - NO
   - YES (describe change):

45. Since your taste or smell problem began, have you started to strongly dislike or avoid certain foods?
   - I DO NOT HAVE A TASTE OR SMELL PROBLEM
   - NO
   - YES (specify foods):

46. Are there any foods you don’t eat for other reasons (e.g., religious, cultural, vegetarian)?
   - NO
   - YES (specify foods avoided):

47. Since your taste or smell problem began, have you had a strong desire or craving for certain foods?
   - I DO NOT HAVE A TASTE OR SMELL PROBLEM
   - NO
   - YES (specify foods craved):

48. Do you have any cravings for non-food items such as cornstarch, plaster, dirt, clay or ice?
   - NO
   - YES (specify):

49. Are you now on a special diet (e.g., weight loss, low salt, diabetic, gallbladder, etc.)?
   - NO
   - YES (specify):

50. Are you taking any vitamins or nutrient supplements? (e.g., vitamin C, iron, protein)?
   - NO
   - YES (specify nutrients and amounts):
     - How often?
     - When were they started?
     - Were they prescribed by a physician?

51. Do you feel nauseated or sick to your stomach often?
   - NO
   - YES
     - How severely?
       - MILDLY
       - EXTREMELY
     - When?

52. Since your taste or smell problem began, your weight has:
   - I DO NOT HAVE A TASTE OR SMELL PROBLEM
   - INCREASED BY __________ POUNDS
   - REMAINED UNCHANGED
   - DECREASED BY __________ POUNDS

53. If your weight has changed, was the change due to your taste or smell problem?
   - I HAVE NOT EXPERIENCED A WEIGHT CHANGE
   - NO (specify cause) __________________________________________
   - YES (specify cause) __________________________________________

54. Your current weight is: ________ lbs
    Your current height is: ________ feet ________ inches.

55. How many glasses, bottles or cans do you drink per week of:
    - BEER: ___________ 12 oz BOTTLES OR CANS
    - WINE: ___________ 6 oz GLASSES
    - LIQUOR: ___________ SHOTS OR DRINKS
56. Do you experience a dry mouth?
- NEVER
- OCCASIONALLY
- OFTEN
- ALL THE TIME

57. Does your saliva feel thick or ropy?
- NEVER
- OCCASIONALLY
- OFTEN
- ALL THE TIME

58. Do you currently have any problems with your mouth or teeth?
- NO
- YES (Check all that apply and indicate the year(s) the problem(s) occurred).

<table>
<thead>
<tr>
<th>Yes</th>
<th>Year(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SENSITIVE OR SORE TONGUE</td>
<td></td>
</tr>
<tr>
<td>GUM DISEASE</td>
<td></td>
</tr>
<tr>
<td>JAW PROBLEMS</td>
<td></td>
</tr>
<tr>
<td>TOOTHACHE</td>
<td></td>
</tr>
<tr>
<td>GUM ABSCESS OR BOIL</td>
<td></td>
</tr>
<tr>
<td>BROKEN TOOTH</td>
<td></td>
</tr>
<tr>
<td>ULCERS OR SORES</td>
<td></td>
</tr>
<tr>
<td>TROUBLE SWALLOWING</td>
<td></td>
</tr>
<tr>
<td>TROUBLE CHEWING</td>
<td></td>
</tr>
<tr>
<td>PARTIAL DENTURES</td>
<td></td>
</tr>
<tr>
<td>COMPLETE DENTURES</td>
<td></td>
</tr>
<tr>
<td>MISSING TEETH</td>
<td></td>
</tr>
<tr>
<td>ROOT CANAL(S)</td>
<td></td>
</tr>
<tr>
<td>JAW SURGERY</td>
<td></td>
</tr>
</tbody>
</table>