Modified Monell-Jefferson Taste & Smell Questionnaire

Date: _____Patient Name: _____DOB: _____ Office: _____

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:

	Unchanged	Improved	Worsened
SMELL LOSS	☐	☐	☐
HYPERSENSITIVITY	☐	☐	☐
SMELL DISTORTIONS	☐	☐	☐
PHANTOM SMELL(S)	☐	☐	☐

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:

	Normal	Diminished	Absent	Distorted	Heightened	Unknown
HOUSEHOLD GAS	☐	☐	☐	☐	☐	☐
SMOKE	☐	☐	☐	☐	☐	☐
GASOLINE	☐	☐	☐	☐	☐	☐
SPOILED FOOD	☐	☐	☐	☐	☐	☐
FLOWERS	☐	☐	☐	☐	☐	☐
FOOD FLAVORS	☐	☐	☐	☐	☐	☐
AMMONIA/VINEGAR	☐	☐	☐	☐	☐	☐
VICKS/MENTHOL	☐	☐	☐	☐	☐	☐
CIGARETTE SMOKE	☐	☐	☐	☐	☐	☐
PERFUMES	☐	☐	☐	☐	☐	☐
BODY ODORS	☐	☐	☐	☐	☐	☐

5. Your smell problem began when you had (check <u>all</u> 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 <u>LOSS OR DISTORTION OF SMELL</u>, 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:

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

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 <u>NOT</u> EXPERIENCE <u>SMELL DISTORTIONS</u>, PLEASE SKIP TO QUESTION #12

8. The kinds of odors that smell <u>DISTORTED</u> (peculiar) to you are (check <u>all</u> 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):

	Not at All	Weakly	Moderately	Strongly
INFECTED TISSUE	☐	☐	☐	☐
SMOKY/BURNT	☐	☐	☐	☐
FECAL	☐	☐	☐	☐
ROTTEN	☐	☐	☐	☐
MUSTY/MOLDY	☐	☐	☐	☐
SWEET	☐	☐	☐	☐
METALLIC	☐	☐	☐	☐
CHEMICAL	☐	☐	☐	☐
OTHER	☐	☐	☐	☐

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:

	Better	Worse
AT UNPREDICTABLE TIMES	☐	☐
WHEN I TAKE MEDICATION (Specify what): _____	☐	☐
WHEN MY NOSE IS CONGESTED	☐	☐
WHEN I AM EXPOSED TO STRONG ODORS (Specify what): _____	☐	☐
WHEN I PUT MY HEAD DOWN	☐	☐
AT CERTAIN TIMES OF THE DAY (Specify when): _____	☐	☐
AFTER I SLEEP OR REST (Specify when): _____	☐	☐
OTHER (Specify): _____ _____	☐	☐

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)**

	Date Problem Began (month/year)
☐ 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)	____/____

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:

	Unchanged	Improved	Worsened
TASTE LOSS	☐	☐	☐
HYPERSENSITIVITY	☐	☐	☐
TASTE DISTORTIONS	☐	☐	☐
PHANTOM TASTE(S)	☐	☐	☐

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:

	Normal	Diminished	Absent	Distorted	Heightened
SWEET	☐	☐	☐	☐	☐
SALTY	☐	☐	☐	☐	☐
SOUR(e.g., lemon, vinegar)	☐	☐	☐	☐	☐
BITTER(e.g., tonic water, medicine)	☐	☐	☐	☐	☐

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:

	Better	Worse
AT UNPREDICTABLE TIMES	☐	☐
WHEN I EXERCISE	☐	☐
WHEN I TAKE MEDICATION (Specify what): _____	☐	☐
WHEN I EAT OR DRINK (Specify foods/beverages): _____	☐	☐
WHEN I ENGAGE IN SOME OTHER ACTIVITY (Specify what): _____	☐	☐
AT CERTAIN TIMES OF THE DAY (Specify when): _____	☐	☐
AT CERTAIN TIMES OF THE YEAR (Specify when): _____	☐	☐
WHEN MY NOSE IS CONGESTED	☐	☐
OTHER (Specify): _____	☐	☐

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):

	Not at All	Weakly	Moderately	Strongly
SWEET	☐	☐	☐	☐
SALTY	☐	☐	☐	☐
SOUR	☐	☐	☐	☐
BITTER	☐	☐	☐	☐
ROTTEN	☐	☐	☐	☐
METALLIC	☐	☐	☐	☐
BURNING	☐	☐	☐	☐
TINGLING	☐	☐	☐	☐
OTHER	☐	☐	☐	☐

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).

Yes	Year(s)
☐ SENSITIVE OR SORE TONGUE	_____
☐ GUM DISEASE	_____
☐ JAW PROBLEMS	_____
☐ TOOTHACHE	_____
☐ GUM ABSCESS OR BOIL	_____
☐ BROKEN TOOTH	_____
☐ ULCERS OR SORES	_____
☐ TROUBLE SWALLOWING	_____
☐ TROUBLE CHEWING	_____
☐ PARTIAL DENTURES	_____
☐ COMPLETE DENTURES	_____
☐ MISSING TEETH	_____
☐ ROOT CANAL(S)	_____
☐ JAW SURGERY	_____