smell_survey_final

SECTION: DEMOGRAPHICS

1. What is your birthdate?

My Birthdate is :

2. How old are you?

My age is:(1-150)

3. What is your current marital or cohabiting status?

Married
Not married but living together with a partner
Widowed
Divorced or annulled
Separated because you and your spouse are not getting along
Single

4. Where do you live?

Country (US,Taiwan,Saudi Arabia)
State (NY,CA,IL)
City
My zipcode is

5. What gender do you best identify as?

Male
Female
Transgender Female
Transgender male
Other
Prefer not to answer

6. Do you have American Indian or Alaska Native ancestrors?

Yes
No
Prefer not to answer

7. Do you have Black or African American ancestrors?

Yes
No
Prefer not to answer

8. Do you have White or Caucasian ancestrors?

Yes
No
Prefer not to answer

9. Do you have Asian ancestrors?

Yes
No
Prefer not to answer

10. Where do your Asian ancestors come from? Check all that apply.

Asian Indian
Bangladeshi
Bengalese
Bharat
Bhutanese
Burmese
Cambodian
Cantonese
Chinese
Dravidian
East Indian
Filipino
Goanese

Hmong
Indochinese
Indonesian
Iwo Jiman
Japanese
Korean
Laohmong
Laotian
Malaysian
Madagascar/Malagasy
Maldivian
Mong
Nepalese
Nipponese
Okinawan
Pakistani
Siamese
Singaporean
Sri Lankan
Taiwanese
Thai
Vietnamese
Do not know
Prefer not to answer

11. Do you have Native Hawaiian or Pacific Islander ancestrors?

Yes
No
Prefer not to answer

12. Where do your Native Hawaiian or Pacific Islander ancestors come from?

Native Hawaiian
Guamanian Or Chamorro
Samoan
Other Pacific Islander
Do Not Know
Prefer Not To Answer

13. Do you consider yourself to be Hispanic or Latino or of Spanish origin?

Yes
No
Do not know
Prefer not to answer

14. Where do your hispanic ancestors come from?

Mexican
Puerto Rican
Cuban
Dominican Republic
Costa Rican
Guatemalan
Honduran
Nicaraguan
Panamanian
Salvadoran
Argentinean
Bolivian
Chilean
Colombian
Ecuadorian
Paraguayan

Peruvian
Do not know
Prefer not to answer

15. Do you have any other ancestrors?

Yes
No
Prefer not to answer

15. What is(are) your other ancestror(s):

Please type here:

SECTION: CHIEF COMPLAINT

16. Are you experiencing any problems with your sense of smell?

Yes
No

17. Are you experiencing any problems with your ability to taste?

Yes
No

SECTION: DETAILS ABOUT YOUR SYMPTOMS

18. I have completely lost my sense of smell and I cannot smell anything.

Yes
No

19. When did this problem start?

It approximately started on:

20. How fast was the onset?

Progressively
Suddenly
I think I was born without a sense of smell because I have no memories of beeing able to smell.
Do not know

21. Have you ever noticed that your ability to smell may improve over a short or long period?

Do not know
Yes - my sense of smell fluctuates
No - I am constantly unable to smell

22. How frequently does it fluctuate?

Hourly
Daily
Weekly
Monthly
Yearly
Do not know
It is irregular

23. Is the loss of your sense of smell in one or both sides of your nose?

Do not know
Both sides
Left side
Right side

24. How has the situation changed since the beginning?

Do not know
No change
Better
Worse

25. What makes your ability to smell better?

Please describe it here:

26. What makes your ability to smell worse?

Please describe it here:

27. How does this problem affect your quality of life?

Please use a scale ranging from 1 (not at all) to 10 (very badly):(1-10)

28. I am less sensitive to odors than I used to be - but I still can perceive certain smells

Yes
No

29. When did this problem start?

This problem started on

30. How fast was the onset?

Progressively
Suddenly
Do not know
I have no memories of being able to smell

31. Have you ever noticed that your ability to smell may improve or get worse over a short or long period?

Do not know
Yes - my sense of smell fluctuates
No - my sense of smell is constantly impaired

32. How frequently does it fluctuate?

Hourly
Daily
Weekly
Monthly
Yearly
Do not know
It is irregular

33. Is the loss of your sense of smell in one or both sides of your nose?

Do not know
Both sides
Left side
Right side

34. How has the situation changed since the beginning?

Do not know
No change
Better
Worse

35. How does this problem affect your quality of life?

Please use a scale ranging from 1 (not at all) to 10 (very badly):(1-10)

36. What makes it worse?

Please describe it here:

37. What makes it better?

Please describe it here:

38. I am more sensitive to odors than I used to be.

Yes
No

39. When did this problem start?

It approximately started on:

40. How fast was the onset?

Progressively
Suddenly
Do not know
I have no memories of being able to smell

41. Have you ever noticed that your smell acuity return back to normal over a short or long period of time?

Do not know
Yes - my sense of smell fluctuates
No - my sense of smell is constantly impaired

42. How frequently does it fluctuate?

Hourly
Daily

Weekly
Monthly
Yearly
Do not know
It is irregular

43. Does the hypersensitivity to smell occur on one or both sides of your nose?

Do not know
Both sides
Left side
Right side

44. How has the situation changed since the beginning?

Do not know
No change
Better
Worse

45. How does this problem affect your quality of life?

Please use a scale ranging from 1 (not at all) to 10 (very badly):(1-10)

46. What makes this worse?

Please describe it here:

47. What makes this better?

Please describe it here:

48. I am very sensitive to chemical odors and cannot tolerate them. This happens most of the time or everytime I am exposed to them.

Yes
No

49. What happens when you smell them?

Nausea
Vomiting
Nasal irritation
Headache
Allergic reaction
Abdominal cramps
Oral cavity swelling
Redness of the eye
Cough
Diarrhea
Taste distortion
Shortness of breath
Excessive secretion of tears
Sensation of heat or warmth or facial redness
Headache
Loss of consciousness
Nausea
Itching
High-pitched breathing sound with sensation of respiratory obstruction
Throat clearing
Hives
Uterine cramps
Vomiting
Wheezing
Other
None

50. Please indicate other reactions that you might have experienced - if none please press next.

Type here:

51. How frequently do you experience this problem?

Please indicate a number and a time unit (e.g. 3 months or 15 minutes). I experience that every:
(second(s),minutes(s),hour(s),day(s),week(s),month(s),year(s))

52. When did this problem start?

It approximately started on:

53. How fast was the onset?

Progressively
Suddenly
Do not know
I have no memories of being able to smell

54. How has the situation changed since the beginning?

Do not know
No change
Better
Worse

55. How does this problem affect your quality of life?

Please use a scale ranging from 1 (not at all) to 10 (very badly):(1-10)

56. What makes this worse?

Type here:

57. What makes this better?

Type here:

58. What chemicals are you sensitive to?

Type here:

59. Certain odors smell different than what they should.

Yes
No

60. What type of odors smell different (e.g. coffee)?

Type here:

61. How pleasant are the distorted odors?

Please use a scale ranging from 1 (very unpleasant) to 10 (very pleasant):(1-10)

62. How intense are the distorted odors?

Please use a scale ranging from 1 (very weak) to 10 (very intense):(1-10)

63. How familiar are the distorted odors?

Please use a scale ranging from 1 (very unfamiliar) to 10 (very familiar):(1-10)

64. Please describe how the distorted odor smells like (e.g. burnt or smoke)

Type here:

65. I am experiencing these problems during the day especially between (check all that apply):

6 AM and 9 AM
9 AM and 12 PM
12 PM and 3 PM
3 PM and 6 PM
6 PM and 9 PM
9 PM and 12 AM
12 AM and 3 AM
3 AM and 6 AM
I do not know

66. How frequently do you experience distorted smell ?

Please indicate a number and a time unit (e.g. 3 months or 15 minutes). I experience that every:
(second(s),minutes(s),hour(s),day(s),week(s),month(s),year(s))

67. When did this problem start?

It approximately started on:

68. How fast was the onset?

Progressively
Suddenly
Do not know
I have no memories of being able to smell

69. Do you have distortion of smell in one or both sides of your nose?

Do not know
Both sides
Left side

Right side

70. How has the situation changed since the beginning?

Do not know
No change
Better
Worse

71. How does this problem affect your quality of life?

Please use a scale ranging from 1 (not at all) to 10 (very badly):(1-10)

72. What makes this worse?

Type here:

73. What makes this better?

Type here:

74. Sometimes I suddenly smell a strange odor despite the absence of a source of odor.

Yes
No

75. How pleasant are the strange or phantom smells?

Please use a scale ranging from 1 (very unpleasant) to 10 (very pleasant):(1-10)

76. How intense are the strange or phantom smells?

Please use a scale ranging from 1 (very weak) to 10 (very intense):(1-10)

77. How familiar do the strange or phantom odors smell?

Please use a scale ranging from 1 (very unfamiliar) to 10 (very familiar):(1-10)

78. Please describe how the phantom odor smells (e.g. burnt or sweet)?

Type here:

79. I experience phantom smells during the day especially between (check all that apply):

6 AM and 9 AM
9 AM and 12 PM
12 PM and 3 PM
3 PM and 6 PM
6 PM and 9 PM
9 PM and 12 AM
12 AM and 3 AM
3 AM and 6 AM
I do not know

80. How frequently do you experience phantom smells?

Please indicate a number and a time unit (e.g. 3 months or 15 minutes). I experience that every:
(second(s),minutes(s),hour(s),day(s),week(s),month(s),year(s))

81. When did this problem start?

It approximately started on:

82. How fast was the onset?

Progressively
Suddenly
Do not know
I have no memories of being able to smell

83. Do you experience phantom smells in one or both sides of your nose?

Do not know
Both sides
Left side
Right side

84. How has the situation changed since the beginning?

Do not know
No change
Better
Worse

85. How does this problem affect your quality of life?

Please use a scale ranging from 1 (not at all) to 10 (very badly):(1-10)

86. What makes this worse?

Type here:

87. What makes this better?

Type here:

88. I extremely fear that my my body smells unpleasant or foul.

Yes
No

89. When did this problem start?

It approximately started on:

90. I have another type of complaint about my sense of smell:

Yes
No

91. Please describe your problem:

Type here:

92. My ability to detect salty - sweet - sour - bitter tastes is normal.

Yes
No

93. I cannot taste anything except food or beverages that are salty - sweet - sour - bitter.

Yes
No

94. We use the word aromas for the tastes that are not salty - sweet - bitter or sour (e.g. chocolate - fish). Do some or all aromas taste different than what they should ?

Yes
No

95. What type of aromas taste different than what they should (e.g. fish)?

Type here:

96. How pleasant are the distorted aromas?

Please use a scale ranging from 1 (very unpleasant) to 10 (very pleasant):(1-10)

97. How intense are the distorted aromas?

Please use a scale ranging from 1 (very weak) to 10 (very intense):(1-10)

98. How familiar are the distorted aromas?

Please use a scale ranging from 1 (very unfamiliar) to 10 (very familiar):(1-10)

99. Please describe how the distorted aromas taste (e.g. burnt or smoke)

Type here:

100. I experience distorted aromas during the day especially between (check all that apply):

6 AM and 9 AM
9 AM and 12 PM
12 PM and 3 PM
3 PM and 6 PM
6 PM and 9 PM
9 PM and 12 AM
12 AM and 3 AM
3 AM and 6 AM
I do not know

101. How frequently do you experience distorted aromas?

Please indicate a number and a time unit (e.g. 3 months or 15 minutes). I experience that every:
(second(s),minutes(s),hour(s),day(s),week(s),month(s),year(s))

102. When did this problem start?

It approximately started on:

103. How fast was the onset?

Do not know
Progressively
Suddenly

104. How has the situation changed since the beginning?

Do not know
No change
Better
Worse

105. How does this problem affect your quality of life?

Please use a scale ranging from 1 (not at all) to 10 (very badly):(1-10)

106. What makes this condition worse?

Type here:

107. What makes this condition better?

Type here:

108. We use the word aromas for the tastes that are not salty - sweet - bitter or sour (e.g. chocolate - fish). Have you lost ALL ability to taste aromas and cannot perceive ANY aromas?

Yes
No

109. When did this problem start?

It approximately started on:

110. How fast was the onset?

Progressively
Suddenly
Do not know
I always had a bad sense of taste as long as I can remember.

111. Have you ever noticed that your ability to taste aromas may improve over a short or long period?

Do not know
Yes - It fluctuates
No - I am constantly unable to taste aromas

112. How frequently does it fluctuate?

Hourly
Daily
Weekly
Monthly
Yearly
Do not know
It is irregular

113. How has the situation changed since the beginning?

Do not know
No change
Better
Worse

114. What makes this worse?

Type here:

115. What makes this better?

Type here:

116. How does this problem affect your quality of life?

Please use a scale ranging from 1 (not at all) to 10 (very badly):(1-10)

117. We use the word aromas for the tastes that are not salty - sweet - bitter or sour (e.g. chocolate - fish). Have you lost SOME ability to taste aromas but still can sense some aromas?

Yes
No

118. When did this problem start?

It approximately started on:

119. How fast was the onset?

Progressively
Suddenly
Do not know
I always had a bad sense of taste as long as I can remember.

120. Have you ever noticed that your ability to taste aromas may improve or get worse over a short or long period?

Do not know
Yes - It fluctuates
No - It does not fluctuate

121. How frequently does it fluctuate?

Hourly
Daily
Weekly
Monthly
Yearly
Do not know
It is irregular

122. How has the situation changed since the beginning?

Do not know
No change
Better
Worse

123. What makes this worse?

Type here:

124. What makes this better?

Type here:

125. How does this problem affect your quality of life?

Please use a scale ranging from 1 (not at all) to 10 (very badly):(1-10)

126. I am less sensitive to sour - bitter - salty - sweet or chicken broth taste - But I still can partially perceive them.

Yes
No

127. When did this problem start?

It approximately started on:

128. How fast was the onset?

Progressively
Suddenly
Do not know

I always had a bad or absent sense of taste as far as I can remember.

129. Have you ever noticed that your ability to taste may improve or get worse over a short or long period?

Do not know
Yes - my sense of taste fluctuates
No - my sense of taste is constantly impaired

130. How frequently does it fluctuate?

Hourly
Daily
Weekly
Monthly
Yearly
Do not know
It is irregular

131. Did you partially lose your sense of taste in one or both sides of the tongue?

Do not know
Both sides
Left side
Right side

132. How has the situation changed since the beginning?

Do not know
No change
Better
Worse

133. How does this problem affect your quality of life?

Please use a scale ranging from 1 (not at all) to 10 (very badly):(1-10)

134. What makes this worse?

Type here:

135. What makes this better?

Type here:

136. The problem affects the following (check all that apply) :

Sour
Salty
Sweet
Bitter
Chicken broth-like taste
All the 5 basic taste
I do not know

137. I have completely lost my ability to perceive sour - bitter - salty - sweet or chicken broth taste.

Yes
No

138. The problem affects the following (check all that apply) :

Sour
Salty
Sweet
Bitter
Chicken broth-like taste
All the 5 basic taste
I do not know

139. When did this problem start?

It approximately started on:

140. How fast was the onset?

Progressively
Suddenly
Do not know
I always had a bad or absent sense of taste as far as I can remember.

141. Does your ability to taste improve over a short or long period?

Do not know
Yes - my sense of taste fluctuates
No - my sense of taste is constantly impaired

142. How frequently does it fluctuate?

Hourly
Daily
Weekly
Monthly
Yearly
Do not know
It is irregular

143. Did you lose your sense of taste in one or both sides of the tongue?

Do not know
Both sides
Left side
Right side

144. How has the situation changed since the beginning?

Do not know
No change
Better
Worse

145. How does this problem affect your quality of life?

Please use a scale ranging from 1 (not at all) to 10 (very badly):(1-10)

146. What makes this worse?

Type here:

147. What makes this better?

Type here:

148. I am more sensitive to sour - bitter - salty or sweet tastes

Yes

No

149. The problem affects the following (check all that apply) :

Sour
Salty
Sweet
Bitter
Chicken broth-like taste
I do not know
All the 5 basic tastes

150. When did this problem start?

It approximately started on:

151. How fast was the onset?

Progressively
Suddenly
Do not know
I have always had a bad sense of taste as long as I can remember.

152. Does your ability to taste return back to normal over a short or long period?

Do not know
Yes - my sense of taste fluctuates
No - my sense of taste is constantly impaired

153. How frequently does it fluctuate?

Hourly
Daily
Weekly
Monthly
Yearly
Do not know
It is irregular

154. Does the problem affects one or both sides of the tongue?

Do not know
Both sides
Left side
Right side

155. How has the situation changed since the beginning?

Do not know
No change
Better
Worse

156. How does this problem affect your quality of life?

Please use a scale ranging from 1 (not at all) to 10 (very badly):(1-10)

157. What makes this worse?

Type here:

158. What makes this better?

Type here:

159. My mouth is burning

Yes
No

160. When did this problem start?

It approximately started on:

161. How fast was the onset?

Progressively
Suddenly
Do not know

162. Does the problem affects one or both sides of the mouth?

Do not know
Both sides
Left side

Right side

163. How has the situation changed since the beginning?

Do not know
No change
Better
Worse

164. How does this problem affect your quality of life?

Please use a scale ranging from 1 (not at all) to 10 (very badly):(1-10)

165. What makes this worse?

Type here:

166. What makes this better?

Type here:

167. Sometimes I suddenly perceive a strange or phantom taste despite the absence of food or beverages or other things in my mouth

Yes
No

168. How pleasant is the phantom taste?

Please use a scale ranging from 1 (very unpleasant) to 10 (very pleasant):(1-10)

169. How intense is the phantom taste?

Please use a scale ranging from 1 (very weak) to 10 (very intense):(1-10)

170. How familiar is the phantom taste?

Please use a scale ranging from 1 (very unfamiliar) to 10 (very familiar):(1-10)

171. Please describe the phantom taste (e.g. burnt or sweet)

Type here:

172. I am experiencing these problems during the day especially between (check all that apply):

6 AM and 9 AM
9 AM and 12 PM
12 PM and 3 PM
3 PM and 6 PM
6 PM and 9 PM
9 PM and 12 AM
12 AM and 3 AM
3 AM and 6 AM
I do not know

173. How frequently do you experience these phantom perception of taste?

Please indicate a number and a time unit (e.g. 3 months or 15 minutes). I experience that every:
(second(s),minutes(s),hour(s),day(s),week(s),month(s),year(s))

174. When did this problem start?

It approximately started on:

175. How fast was the onset?

Progressively
Suddenly
Do not know

176. Are you experiencing this problem on one or both sides of the tongue or mouth?

Do not know
Both sides
Left side
Right side

177. How has the situation changed since the beginning?

Do not know
No change
Better
Worse

178. How does this problem affect your quality of life?

Please use a scale ranging from 1 (not at all) to 10 (very badly):(1-10)

179. What makes this worse?

Type here:

180. What makes this better?

Type here:

181. There is an unusual taste in my mouth and it is triggered by something (e.g. saliva - food - beverage - other)

Yes
No

182. Please describe what triggers this unusual taste?

Type here:

183. How pleasant is the unusual taste?

Please use a scale ranging from 1 (very unpleasant) to 10 (very pleasant):(1-10)

184. How intense is the unusual taste?

Please use a scale ranging from 1 (very weak) to 10 (very intense):(1-10)

185. How familiar is the unusual taste?

Please use a scale ranging from 1 (very unfamiliar) to 10 (very familiar):(1-10)

186. Please describe the unusual taste?

Type here:

187. I am experiencing this during the day especially between (check all that apply):

6 AM and 9 AM
9 AM and 12 PM
12 PM and 3 PM
3 PM and 6 PM
6 PM and 9 PM
9 PM and 12 AM
12 AM and 3 AM
3 AM and 6 AM
I do not know

188. How frequently do you experience these triggered and unusual perceptions of taste ?

Please indicate a number and a time unit (e.g. 3 months or 15 minutes). I experience that every:
(second(s),minutes(s),hour(s),day(s),week(s),month(s),year(s))

189. When did this problem start?

It approximately started on:

190. How fast was the onset?

Progressively
Suddenly
Do not know

191. Are you experiencing this problem on one or both sides of the tongue or mouth?

Do not know
Both sides
Left side
Right side

192. How has the situation changed since the beginning?

Do not know
No change
Better
Worse

193. How does this problem affect your quality of life?

Please use a scale ranging from 1 (not at all) to 10 (very badly):(1-10)

194. What makes this worse?

Type here:

195. What makes this better?

Type here:

196. When I touch my tongue or some part of my oral cavity - it triggers an unusual taste

Yes
No

197. When did this problem start?

It approximately started on:

198. How fast was the onset?

Progressively
Suddenly
Do not know

199. Are you experiencing this problem on one or both sides of the tongue?

Do not know
Both sides
Left side
Right side

200. How has the situation changed since the beginning?

Do not know
No change
Better
Worse

201. How does this problem affect your quality of life?

Please use a scale ranging from 1 (not at all) to 10 (very badly):(1-10)

202. What makes this worse?

Type here:

203. What makes this better?

Type here:

SECTION: CHARACTERISTIC EVENT

204. We will now ask you several questions to understand why you have issues with your sense of smell or/and taste. Have you ever been hospitalized or treated in an emergency room following an injury to your head? Think about any childhood injuries you remember or were told about.

Yes
No

205. Have you -in your opinion- lost your sense of smell or taste after a head injury?

Yes
No

206. When did the head injury occur?

It approximately occured on the:

207. How did you injure your head?

I do not know
Fall
Car or other moving vehicule accident (e.g. motorcycle)
Being hit by something
Playing sports or on the playground
Fight or from being hit by someone
Gun shot
Explosion or a blast
Military combat- or training-related incidents
Other

208. Please tell us with your own words about how you injured your head.

Type here:

209. Have you been hospitalized after your head injury that led to smell or taste loss?

Yes
No

210. Were you knocked out or did you lose consciousness?

Yes
No

211. Where was the head impact located?

Do not know
Back
Front
Right side
Left side
Top

212. My smell or taste issues started with a common cold or a flu (fever - runny nose - blocked nose). Since then - my sense of smell never returned back to normal.

Yes
No

213. When did the common cold or flu or sinus or nose problem start?

It approximately started on the:

214. All the flu symptoms like fever or nasal blockage or runny nose are now resolved - except my sense of smell and or taste.

Yes
No

215. With my smell or taste problems - I currently experience a runny nose or nasal blockage or sinus pressure or nosebleed.

Yes

215. With my smell or taste problems - I currently have a runny nose or nasal blockage or sinus pressure or nosebleed.

No

216. With my smell or taste problems - I currently have a runny nose or nasal blockage or sinus pressure or nosebleed.

Yes
No

217. When did the sinus or/and nasal problems start?

It approximately started on the:

218. I was born without a sense of smell or taste because I have no memories of beeing able to smell or taste.

Yes
No

219. Do you suffer from any of these issues?

Delayed puberty
Absence of puberty
Absence of menstruation
Micropenis
Infertility
My heart is beating on the right side of my chest
None

220. For the past year - Have you been suffering from headache?

Yes
No

221. When you have a headache - do you experience any of the following? (Check all that apply)

Nausea
Vomiting
One side of head only
Pulsating / throbbing headaches
Pain-free intervals of days or weeks between severe headache attacks
Sensitivity to light
Sensitivity to noise
Blurring of vision
Seeing shimmering lights or circles or Other shapes or colors before the headache starts
Numbness of Lips or Tongue or fingers or legs before the headache starts
None

222. Have you ever been diagnosed by a physician or other health professional as suffering from the following (check all that apply):

None
Tension headaches
Sinus headaches
Cluster headaches
Stress headaches
Migraine headaches

223. Have you noticed a relationship between headaches and your smell and / or taste symptoms? If yes - when does the smell/taste symtoms occur in reference to the headache?

Before
During
After
I am not sure
No relationship

224. How long does an episode of migraine last?

Do Not Know
Minutes
Hours
Days
Weeks

225. Is the migraine located on the face (e.g. forehead or on the cheek)?

Yes
No

226. Please select one or several situations that -in your opinion- may explain why you are having issues with your sense of smell or taste.

Other
I was born this way because I have no memories of beeing able to smell.
I suffered from head trauma
I had a common cold - my sense of smell never returned back to normal
Nose or Sinus issues
Migraine / headache
Epilepsy and seizure
Cancer
Smoking
Radiotherapy
Chemotherapy
I was exposed to chemicals
Nasal surgery
Brain surgery
Drug side effect
Ear surgery
Alzheimers Disease
Parkinsons Disease
Acid reflux
Aging
Brain issues
Pregnancy
I do not know

SECTION: RECEIVED MEDICAL INTERVENTION(S) FOR SMELL AND TASTE DISORDERS

227. For your smell or/and taste issue have you ever tried any treatment based on alternative or eastern medicine such as Gingko Biloba or Acupuncture?

Yes
No

228. Please rate the effectivness of this treatment?

The effectiveness is (1= not effective at all - 10 = very effective):(1-10)

229. For your smell or / and taste issue have you ever tried any drugs listed below (Check all that apply)? If yes was it effective (1= not effective at all - 10 = very effective)?

Alpha lipoic acid(1-10)
Antibiotics(1-10)
Antihistamine(1-10)
Antileukotriene(1-10)
Caroverine(1-10)
Cocaine hydrochloride(1-10)

Codeine(1-10)
Corticosteroid by Mouth(1-10)
Corticosteroid nasal spray(1-10)
Corticosteroid nasal drops in upright position(1-10)
Corticosteroid nasal drops with head tilted backward(1-10)
Cromolyn eye drops(1-10)
Gabapentine(1-10)
Nasal lavage with hypertonic solution(1-10)
Nasal lavage with normal saline(1-10)
Nasal decongestant(1-10)
Minocycline(1-10)
Paracetamol(1-10)
Pentoxyfillin(1-10)
Sodium citrate(1-10)
Theophylline(1-10)
Vitamine A(1-10)
Vitamin B12(1-10)
Zinc gluconate(1-10)
None
Other

230. Please indicate other drugs that you might have taken for your smell and/or taste issues - if none please press next.

The drugs I have been taking are:

231. Have you been advised to modify your lifestyle with the following recommendation? (Check all that apply)

Avoid natural gas-related device at home
Check food expiration date to avoid spoiled food ingestion
Install a natural gas detector
Optimize cooking recipes
Be self-conscious about smell loss and personal hygiene
None of the above

232. Have you been advised to train your sense of smell by smelling 4 odors several times a day for several months?

Yes
No

233. Was smell training effective in improving your sense of smell?

The effectiveness is (1= not effective at all - 10 = very effective):(1-10)

234. Did you undergo any of the listed surgery for your current problem? If yes was it effective (1= not effective at all - 10 = very effective)?

Brain surgery(1-10)
Sinus surgery(1-10)
Procedure that change the opening of the nostrils(1-10)
Surgery to change the shape of the nose(1-10)
Surgery to correct nasal septum(1-10)
Procedure to shrink enlarged turbinates(1-10)
Other (,Abdominal cramps,Mouth swelling, Red eyes,Cough,Diarrhea,Taste disturbance,Shortness of breath,Watery eye,Facial skin redness or sensation of heat,Headache,Loss of consciousness,nausea,Itchiness,Chocking,throat clearing,Hives,uterine cramps,wheezing while breathing,nasal congestion,Runny nose,Skin rash,None)
None

235. Please indicate other surgeries that you might have undergone to treat your smell and/or taste issues - if none please press next.

Type here:

SECTION: EAR NOSE AND THROAT SYMPTOMS

236. We will now ask you several questions about other symptoms that might be associated with smell or taste problems. Are you also experiencing any issues with your ear(s) or hearing?

Yes
No

237. Are you experiencing one or more of the following symptoms? If yes - please indicate approximately the starting date and the affected side.

Ear pain (Both sides,Left side,Right side,Do not know)
Ear pressure (Both sides,Left side,Right side,Do not know)
Ear discharge (Both sides,Left side,Right side,Do not know)
Hearing loss (Both sides,Left side,Right side,Do not know)
I hear a ringing or clicking or roaring noise when no sounds is present (tinnitus) (Both sides,Left side,Right side,Do not know)
Other (Both sides,Left side,Right side,Do not know,)

238. Please indicate other problems you may experience with your ear(s) or hearing? If none - please press next.

My other ear or hearing problem(s) is(are):

239. Do you sometimes experience vertigo -that is- a sensation that the world is spinning around you?

Yes
No

240. How long does an episode of vertigo last?

Do not know
seconds
Minutes
Hours
Days
Weeks

241. Do you feel unsteady when you walk?

Yes
No

242. Do you have issues with your nose or sinus (e.g. nasal blockage/runny nose/nosebleeds/facial pressure/sinus infection)

Yes
No

243. Are you experiencing one or more of the following symptoms? If yes - please indicate approximately the starting date and the affected side.

Other (Both sides,Left side,Right side,Do not know,)
Nasal congestion (Both sides,Left side,Right side,Do not know)
Nosebleeds (Both sides,Left side,Right side,Do not know)
Runny nose (Both sides,Left side,Right side,Do not know)
Pressure or pain on the forehead or above the eyes (Both sides,Left side,Right side,Do not know)
Pressure or pain on the cheek or below the eyes? (Both sides,Left side,Right side,Do not know)

244. Please indicate other problems you may experience with your nose or sinus(es)? If none - press next.

My other nose or sinus(es) problem(s) is(are):

245. Do you experience any problems with your mouth / oral cavity / teeth / throat / cough / swallowing / voice?

Yes
No

246. Are you experiencing one or more of the following symptoms? If yes - please indicate approximately the starting date.

Changes in the amount or constistency of your saliva
I constantly have bad breath
Bad taste in my mouth
Swollen or bleeding or tender gums
Sore throat
Presence of throat secretions that are difficult to clear
Sensation of a foreign object in the mouth or throat
Mouth itchiness

Chocking while eating
Cough while eating
Cough that gets worse when lying down or during sleep
Change in voice quality
Throat itchiness
Other

247. Please indicate other problems you may experience with your mouth / oral cavity / teeth / throat / cough / swallowing / voice? If none - press next.

My other mouth / oral cavity / teeth / throat / cough / swallowing / voice problems is (are):

248. Are you experiencing any tingling sensation anywhere above your shoulders?

Yes
No

249. In which region is this sensation located? Which side?

Forehead (both sides,left side,right side)
Cheek (both sides,left side,right side)
Nose (both sides,left side,right side)
Chin (both sides,left side,right side)
Ear (both sides,left side,right side)
Lips (both sides,left side,right side)
Mouth (both sides,left side,right side)
Tongue (both sides,left side,right side)
Neck (both sides,left side,right side)

250. Are you experiencing any sensation of numbness anywhere above your shoulders?

Yes
No

251. In which region is this sensation located? Which side?

Forehead (both sides,left side,right side)
Cheek (both sides,left side,right side)
Nose (both sides,left side,right side)
Chin (both sides,left side,right side)
Ear (both sides,left side,right side)
Lips (both sides,left side,right side)
Mouth (both sides,left side,right side)
Tongue (both sides,left side,right side)
Neck (both sides,left side,right side)

252. Are you experiencing any pain above your shoulders?

Yes
No

253. In which region is this sensation located? Which side?

Forehead (both sides,left side,right side)
Cheek (both sides,left side,right side)
Nose (both sides,left side,right side)
Chin (both sides,left side,right side)
Ear (both sides,left side,right side)
Lips (both sides,left side,right side)
Mouth (both sides,left side,right side)
Tongue (both sides,left side,right side)
Neck (both sides,left side,right side)

254. What triggers this pain?

Type here:

255. Are you experiencing any paralysis or muscle weakness above your shoulders?

Yes
No

256. In which region is this located? Which side?

Forehead (both sides,left side,right side)
Cheek (both sides,left side,right side)
Nose (both sides,left side,right side)

Chin (both sides,left side,right side)
Ear (both sides,left side,right side)
Lips (both sides,left side,right side)
Mouth (both sides,left side,right side)
Tongue (both sides,left side,right side)
Neck (both sides,left side,right side)

SECTION: MEDICAL HISTORY AND OTHER HEALTH ISSUES

257. Do you have or ever had any of the following conditions (Check all that apply) ? If yes - please describe the evolution / onset date:

Alzheimer-s Disease (resolved,better,no change,worse)
Amyotrophic lateral sclerosis (resolved,better,no change,worse)
Asthma (resolved,better,no change,worse)
Bardet-Biedl syndrome (resolved,better,no change,worse)
Bell-s palsy (resolved,better,no change,worse)
Borreliosis (resolved,better,no change,worse)

258. Do you have or ever had any of the following conditions (Check all that apply) ? If yes - please describe the evolution / onset date:

Burning Mouth syndrome (resolved,better,no change,worse)
Carotid gustatory syndrome (resolved,better,no change,worse)
Cervical artery dissection (resolved,better,no change,worse)
Chemotherapy induced smell loss (resolved,better,no change,worse)
Chronic otitis media (resolved,better,no change,worse)
Nasal polyps (resolved,better,no change,worse)

259. Do you have or ever had any of the following conditions (Check all that apply) ? If yes - please describe the evolution / onset date:

Allergic rhinitis or Other cause of chronic rhinosinusitis (resolved,better,no change,worse)
Cluster headache (resolved,better,no change,worse)
Creutzfeld-jakob disease (resolved,better,no change,worse)
Cystic fibrosis (resolved,better,no change,worse)
Dermatitis (resolved,better,no change,worse)
Diabetes (resolved,better,no change,worse)

260. Do you have or ever had any of the following conditions (Check all that apply) ? If yes - please describe the evolution / onset date:

Drug-induced smell loss (resolved,better,no change,worse)
Drug-induced taste loss (resolved,better,no change,worse)
Epilepsy (resolved,better,no change,worse)
Familial dysautonomia (resolved,better,no change,worse)
Food allergy (resolved,better,no change,worse)
Acid reflux (resolved,better,no change,worse)

261. Do you have or ever had any of the following conditions (Check all that apply) ? If yes - please describe the evolution / onset date:

Inflammation of the gum (resolved,better,no change,worse)
Inflammation of the Tongue (resolved,better,no change,worse)
Stroke (resolved,better,no change,worse)
Hepatitis C (resolved,better,no change,worse)
Herpes Zoster infection (resolved,better,no change,worse)
HIV AIDS (resolved,better,no change,worse)

262. Do you have or ever had any of the following conditions (Check all that apply) ? If yes - please describe the evolution / onset date:

High cholesterol (resolved,better,no change,worse)
Hyperemesis gravidarum (resolved,better,no change,worse)
High blood pressure (resolved,better,no change,worse)
Thyroid disease (resolved,better,no change,worse)
Intolerance to aspirin (resolved,better,no change,worse)
Congenital anosmia (resolved,better,no change,worse)

263. Do you have or ever had any of the following conditions (Check all that apply) ? If yes - please describe the evolution / onset date:

Kallmann syndrome (resolved,better,no change,worse)
Kartagener syndrome (resolved,better,no change,worse)
Kidney diseases (resolved,better,no change,worse)
Liver diseases (resolved,better,no change,worse)
Lung cancer (resolved,better,no change,worse)
Machado-Joseph disease (resolved,better,no change,worse)

264. Do you have or ever had any of the following conditions (Check all that apply) ? If yes - please describe the evolution / onset date:

Migraine (resolved,better,no change,worse)
Mild cognitive impairment (resolved,better,no change,worse)
Multiple chemical sensitivity (resolved,better,no change,worse)
Multiple sclerosis (resolved,better,no change,worse)
Myasthenia gravis (resolved,better,no change,worse)
Nasal cancer (resolved,better,no change,worse)

265. Do you have or ever had any of the following conditions (Check all that apply) ? If yes - please describe the evolution / onset date:

Olfactory groove meningioma (resolved,better,no change,worse)
Olfactory reference syndrome (resolved,better,no change,worse)
Osteoporosis (resolved,better,no change,worse)
Traumatic brain injury and olfactory loss (resolved,better,no change,worse)
Traumatic brain injury and taste loss (resolved,better,no change,worse)
Postviral olfactory loss (resolved,better,no change,worse)

266. Do you have or ever had any of the following conditions (Check all that apply) ? If yes - please describe the evolution / onset date:

Age-related taste loss (resolved,better,no change,worse)
Age-related smell loss (resolved,better,no change,worse)
Rabies (resolved,better,no change,worse)
Radiotherapy induced smell or taste loss (resolved,better,no change,worse)
Kidney diseases (resolved,better,no change,worse)
Inflammation of the salivary gland (resolved,better,no change,worse)

267. Do you have or ever had any of the following conditions (Check all that apply) ? If yes - please describe the evolution / onset date:

Obstruction of the salivary gland (resolved,better,no change,worse)
Sjorgren Syndrome or Sicca syndrome (resolved,better,no change,worse)
Subarachnoid hemorrhage (resolved,better,no change,worse)
Smoking related smell or taste loss (resolved,better,no change,worse)
Tension headache (resolved,better,no change,worse)
Smell loss due to toxic substance exposure (resolved,better,no change,worse)

268. Do you have or ever had any of the following conditions (Check all that apply) ? If yes - please describe the evolution / onset date:

Trigeminal neuralgia (resolved,better,no change,worse)
Vitamin deficiency (resolved,better,no change,worse)
Wegener granulomatosis (resolved,better,no change,worse)

269. Is there any other conditions that you have or ever had that we should know? If yes - please also describe the evolution / onset date:

Type here:

SECTION: PAST SURGICAL HISTORY

270. Have you undergone any medical procedures under general anesthesia in the past?

Yes
No

271. Have you had any dental procedures or installation of a dental prosthesis?

Yes
No

272. Have you undergone any of the following surgical procedures (Check all that apply) ? If yes please tell us how it has helped the situation and when the procedure was performed.

I had my adenoids removed (resolved,better,no change,worse)
I had a ruptured brain aneurysm which was treated surgically (resolved,better,no change,worse)
Sinus surgery (resolved,better,no change,worse)
Laryngectomy (resolved,better,no change,worse)
Vocal cords surgery (resolved,better,no change,worse)
Surgery of the middle ear (resolved,better,no change,worse)
Oral surgery (resolved,better,no change,worse)
Brain surgery for epilepsy (resolved,better,no change,worse)
Nasal polyps removal (resolved,better,no change,worse)
Procedure that changes the opening of my nostrils (resolved,better,no change,worse)
Surgery to change the shape of my nose (resolved,better,no change,worse)
Surgery to correct my nasal septum (resolved,better,no change,worse)
Procedure to shrink enlarged turbinates (resolved,better,no change,worse)
Surgery of the uvula for my snoring problems (resolved,better,no change,worse)

273. Is there any other surgical procedure that you underwent that we should know?

Type here:

SECTION: MEDICATION

274. Are you currently taking any medications ?

Yes
No

275. Do you take any medications to treat the following conditions? (check all that apply)

Bacterial infection (e.g. sinusitis or tonsillitis)
Viral infection (e.g. herpes or flu or hepatitis C virus)
Fungal infection (e.g. fingernail or toenail fungal infection)
Inflammation
Epilepsy
Migraine
Parkinsons Disease
Psychiatric condition such as schizophrenia / depression / bipolar disorder/ or sleeping disorders
Thyroid disease
High blood pressure
Abnormal rhythms of the heart
High cholesterol
Cancer
Muscle spasticity
Nasal congestion
None
Do not know

SECTION: ALLERGIES

276. Do you have any known allergies?

Yes
No

277. What are you allergic to? For each allergy what is the most severe and characteristic symptom? (check all the apply)

Other (,Abdominal cramps,Mouth swelling, Red eyes,Cough,Diarrhea,Taste disturbance,Shortness of breath,Watery eye,Facial skin redness or sensation of heat,Headache,Loss of consciousness,nausea,Itchiness,Chocking,throat clearing,Hives,uterine cramps,wheezing while breathing,nasal congestion,Runny nose,Skin rash,None)
Insect (Abdominal cramps,Mouth swelling, Red eyes,Cough,Diarrhea,Taste disturbance,Shortness of breath,Watery eye,Facial skin redness or sensation of heat,Headache,Loss of consciousness,nausea,Itchiness,Chocking,throat clearing,Hives,uterine cramps,wheezing while breathing,nasal congestion,Runny nose,Skin rash,None,)

Pollen (Abdominal cramps,Mouth swelling, Red eyes,Cough,Diarrhea,Taste disturbance,Shortness of breath,Watery eye,Facial skin redness or sensation of heat,Headache,Loss of consciousness,nausea,Itchiness,Chocking,throat clearing,Hives,uterine cramps,wheezing while breathing,nasal congestion,Runny nose,Skin rash,None,)
Food (Abdominal cramps,Mouth swelling, Red eyes,Cough,Diarrhea,Taste disturbance,Shortness of breath,Watery eye,Facial skin redness or sensation of heat,Headache,Loss of consciousness,nausea,Itchiness,Chocking,throat clearing,Hives,uterine cramps,wheezing while breathing,nasal congestion,Runny nose,Skin rash,None,)
Animal (Abdominal cramps,Mouth swelling, Red eyes,Cough,Diarrhea,Taste disturbance,Shortness of breath,Watery eye,Facial skin redness or sensation of heat,Headache,Loss of consciousness,nausea,Itchiness,Chocking,throat clearing,Hives,uterine cramps,wheezing while breathing,nasal congestion,Runny nose,Skin rash,None,)
Mold (Abdominal cramps,Mouth swelling, Red eyes,Cough,Diarrhea,Taste disturbance,Shortness of breath,Watery eye,Facial skin redness or sensation of heat,Headache,Loss of consciousness,nausea,Itchiness,Chocking,throat clearing,Hives,uterine cramps,wheezing while breathing,nasal congestion,Runny nose,Skin rash,None,)
Medication (Abdominal cramps,Mouth swelling, Red eyes,Cough,Diarrhea,Taste disturbance,Shortness of breath,Watery eye,Facial skin redness or sensation of heat,Headache,Loss of consciousness,nausea,Itchiness,Chocking,throat clearing,Hives,uterine cramps,wheezing while breathing,nasal congestion,Runny nose,Skin rash,None,)

SECTION: FAMILY HISTORY

278. Does anyone in your family have been diagnosed with smell or / and taste dysfunction?

Yes
No

279. How are you related to this / these family member(s) with smell or / and taste dysfunction ? How many of them are affected?

Aunt(1-150)
Brother(1-150)
Daughter(1-150)
Father(1-150)
Maternal grandfather(1-150)
Maternal grandmother(1-150)
Mother(1-150)
Nephew(1-150)
Niece(1-150)
Oncle(1-150)
Paternal grandfather(1-150)
Paternal grandmother(1-150)
Sister(1-150)
Son(1-150)

280. Does anyone of your relatives suffer from any of the following (check all that apply)? If yes - how many relatives?

Alzheimers Disease(1-150)
Bardet-Biedl syndrome(1-150)
Congenital anosmia(1-150)
Kallmann syndrome(1-150)
Kartagener syndrome(1-150)
Parkinsons Disease(1-150)
None

281. Is there any other condition that may have caused smell or taste loss among relatives? Please describe what is the condition?

Type here:

SECTION: OTHER SYMPTOMS

282. We would like to ask you questions about signs that might be linked to your smell and taste issues. Do you have a lack of appetite?

Yes
No

283. Do you feel tired or have a lack of energy despite resting well?

Yes
No

284. Do you currently have fever?

Yes
No

285. Did you gain weight since the onset of your smell or / and taste issues?

Yes
No

286. Did you lose weight since the onset of your smell or / and taste issues?

Yes
No

287. Do you have any trouble falling or staying asleep?

Yes
No

288. Do you have issues with your eyes or vision ?

Yes
No

289. Do you experience eye dryness?

Yes
No

290. or eye itchiness?

Yes
No

291. or eye discharge?

Yes
No

292. Excessive tearing?

Yes
No

293. Redness of the eyes?

Yes
No

294. Diminished visual acuity?

Yes
No

295. Double vision?

Yes
No

296. Blind spot in the periphery of your visual field?

Yes
No

297. Blurry spot at the center of your visual field?

Yes
No

298. Decreased ability to see in the dark?

Yes
No

299. Can you only see clearly if the object is in the center of your field of view?

Yes
No

300. Do you have issues with your mood or memory or concentration or planning things or taking care of your finance or talking or finding your way home?

Yes
No

301. During the past month - have you often been bothered by feeling down depressed or hopeless?

Yes
No

302. During the past month - have you often been bothered by little interest or pleasure in doing things?

Yes
No

303. Do you feel that your emotions are fading away?

Yes
No

304. or lack of vitality?

Yes
No

305. or misplacing object with increasing frequency?

Yes
No

306. or problems in handling financial tasks?

Yes
No

307. or problems with concentration?

Yes
No

308. or problems in recalling recent events and conversations?

Yes
No

309. or forgetting memories from your personal history?

Yes
No

310. or feel disoriented in various places?

Yes
No

311. or difficulty in planning or organizing things?

Yes
No

312. or problems remembering peoples name or finding the right word for objects?

Yes
No

313. Do you have any problem with body movement (e.g. shaking or execution or walking) ?

Yes
No

314. Do you execute your movement slower than in the past or experience difficulty in relaxing your muscles (rigidity)?

Yes
No

315. Do you execute your movement slower than in the past or experience reduction of spontaneous movement or facial expressivity?

Yes
No

316. Have you experienced involuntary shaking (e.g. hand / arm / leg) that gets better upon movement of that body part?

Yes
No

317. Do you feel unstable when standing upright?

Yes
No

318. Do you often fall?

Yes
No

319. Do you have any lung issue (e.g. shortness of breath or cough or sputum or chest pain) ?

Yes
No

320. Are you experiencing shortness of breath?

Yes
No

321. Is it accompanied by a wheezing sound?

Yes
No

322. or cough?

Yes
No

323. Do you produce mucus or coughed-up material from the lungs or throat?

Yes
No

324. What color is the material?

Do Not Know
Other (Both sides,Left side,Right side,Do not know,)
bloody (red)
watery (clear)
purulent (yellowish)
Foul smelling

325. Are you experiencing chest pain?

Yes
No

326. Is it worse when you take a deep breath?

Yes
No

327. Are you experiencing loss of consciousness when you stand up quickly?

Yes
No

328. Do you experience heartburn?

Yes
No

329. Do you experience nausea or regurgitation or stomach discomfort?

Yes
No

330. Do you suffer from constipation - that is - difficulty passing stool?

Yes
No

331. Have you any trouble delaying urination which results in urine leakage?

Yes
No

332. Do you experience the need to urinate extremely frequently?

Yes
No

333. Do you experience sexual dysfunction (e.g. erection dysfunction - ejaculation problems - difficulties achieving orgasm)

Yes
No

SECTION: EXPOSURE TO CHEMICALS

334. Were you involved in the production of or exposed to acid compounds or other chemicals?

Yes
No

335. Did you work with asphalt or have you been near any site involving asphalt manufacturing?

Yes
No

336. Did you work with wood (e.g. tanning or carpenting) or have you been near any site involving woodworking?

Yes
No

337. Were you involved in machining or metal working or have you been exposed to coolant or lubricant designed for machining processes?

Yes
No

338. Were you producing/manufacturing any of the following: fragrances - spice - tabacco - steel - metal - ship - rubber - plastic - thermometer - magnet or battery ?

Yes
No

339. Prior to your smell/taste issues were you exposed to paints or solvents (e.g. paint thinners) ?

Yes
No

340. Glues and adhesives such as contact cement or super glues or aerosol adhesives that contain chemical solvents?

Yes
No

341. Gasoline lawn mower?

Yes
No

342. Chain saw or other gasoline equipment?

Yes
No

343. Sander and/or saw?

Yes
No

344. Pesticides sprayed?

Yes
No

345. Did you use or were you near somebody else who used cleaning solutions (including household cleaners and chemicals)?

Yes
No

346. Gardening?

Yes
No

SECTION: RISK AT WORK AND IN DAILY LIFE

347. In your work or daily life - are (were) you regularly exposed to any of the following? If yes indicate the number of years exposed (from 0 to 100).

Asbestos
Chemicals/Acids/Solvents
Coal or Stone Dusts
Asphalt
Engine Exhaust
Dyes
Formaldehyde

348. In your work or daily life - are (were) you regularly exposed to any of the following? If yes indicate the number of years exposed (from 0 to 100).

Pesticides/Herbicides
Textile process dusts
Wood Dust

X-rays/Radioactive Materials
Acetaldehyde
Acetic acid
AcetopheNone

349. In your work or daily life - are (were) you regularly exposed to any of the following? If yes indicate the number of years exposed (from 0 to 100).

Alum
Ammonia
Arsenic
Arsenite
Benzene
Butyl acetate
Cadmium

350. In your work or daily life - are (were) you regularly exposed to any of the following? If yes indicate the number of years exposed (from 0 to 100).

Carbon disulfide
Carbon monoxide
Cement
Chlorine
Chloroform
Chlorometanes
Chromium

351. In your work or daily life - are (were) you regularly exposed to any of the following? If yes indicate the number of years exposed (from 0 to 100).

Copper
Cyanide
Dichromates
Dioxide
Ethyl acetate
Fluorides
Hardwoods
Hydrogen

352. In your work or daily life - are (were) you regularly exposed to any of the following? If yes indicate the number of years exposed (from 0 to 100).

Lead
Manganese
Nickel
Nitrate
Nitric acid
Potash

353. In your work or daily life - are (were) you regularly exposed to any of the following? If yes indicate the number of years exposed (from 0 to 100).

Selenium dioxide
Silicon
Silver
Tin
Trichloroethane
Trichloroethylene
Wax
Zinc
Do not know
None

354. What is your profesisonal occupation?

Type here:

SECTION: TABACCO

355. Have you smoked at least 100 cigarettes in your entire life? (100 Cigarettes = approximately 5 packs)

Yes
No

356. I do not smoke cigarette.

Yes
No

357. Have you EVER smoked cigarettes EVERY DAY for at least 6 months?

Yes
No

358. When you last smoked every day - on average how many cigarettes did you smoke each day?

Type here:

359. and for how many years?

I have been smoking for this number of years:

360. Do you smoke cigarettes on SOME DAY?

Yes
No

361. On how many of the past 30 days did you smoke cigarettes?

Type here:

362. On the average - on those days - how many cigarettes did you usually smoke each day?

Type here:

363. Do you smoke cigarettes EVERYDAY?

Yes
No

364. On the average about how many cigarettes do you now smoke each day?

Everyday - I smoke this number of cigarette:

365. and for how many years?

I have been smoking for this number of years:

SECTION: ALCOHOL

366. Have you ever drank alcohol?

Yes
No

367. About how old were you when you first started drinking - not counting small tastes or sips of alcohol?

Type here:

368. Have you ever drunk alcohol regularly - that is - drinking at least once a month for 6 months or more?

Yes
No

369. At what age did you begin to drink regularly?

Type here:

370. Have you ever been drunk - that is - your speech was slurred or you were unsteady on your feet?

Yes
No

371. How old were you the first time you got drunk?

Type here:

372. In your lifetime - what is the largest number of drinks you have ever had in a 24-hour period (including all types of alcohol)?

3 drinks or fewer
more than 3 drinks

373. Did you ever find you could drink a lot more before you got drunk?

Yes
No

374. Have you ever tried to stop or cut down on drinking? COUNT ANY REASON.

Yes

No

375. How many times were you unable to stop or cut down?

Less than 3 times
More than 3 times

376. Have you ever started drinking at times you promised yourself that you would not - or have you ever drunk more than you intended? (e.g. when you decided to drink 2 drinks and ended up drinking 4 or more?)

Yes
No

377. Did this happen 3 or more times?

Yes
No

378. Have you ever started drinking and become drunk when you did not want to?

Yes
No

379. Did this happen 3 or more times?

Yes
No

380. Have you ever given up or greatly reduced important activities while drinking like sports work or associating with friends or relatives?

Yes
No

381. Did this happen 3 or more times or for a month or more?

Yes
No

382. Has there ever been a period of several days or more when you spent so much time drinking or recovering from the effects of alcohol that you had little time for anything else?

Yes
No

383. Did this period last for a month or more or have you experienced 3 or more such periods?

Yes
No

384. There are several health problems that can result from long stretches of drinking. Did drinking ever cause you to have: (Check all that apply)

None
Liver disease or yellow jaundice
Stomach inflammation or make you vomit blood
Pancreatitis
Damage to your heart - cardiomyopathy
Memory problems even when you were not drinking (not counting blackouts)
Other physical health problems

385. What other physical health problems have you experienced because of alcohol? If none please press next.

Type here:

386. Have you ever continued to drink when you knew you had any serious physical illness or condition that might be made worse by drinking?

Yes
No

387. Has drinking ever caused you emotional or psychological problems like:

Feeling depressed or uninterested in things for more than 24 hours to the point that it interfered with your functioning
Feeling jumpy or easily startled or nervous for more than 24 hours to the point that it interfered with your functioning?
Having such trouble thinking clearly for more than 24 hours that it interfered with your functioning?
Feeling paranoid or suspicious of people for more than 24 hours to the point that it interfered with your relationships?
Hearing or seeing things that werent really there?

Smelling things that are not really there?
None of the above

388. Have you ever continued to drink when you knew you had any psychological illness that might be made worse by drinking?

Yes
No

389. Have you ever tried to cut down or stop or go without drinking after drinking steadily for some time?

Yes
No

390. People who cut down or stop or go without drinking after drinking steadily for some time may not feel well. These feelings are more intense and can last longer than the usual hangover. When you stopped - cut down or went without drinking - did you ever experience any of the following problems for most of the day for 2 days or longer?

The shakes (hands trembling)
Unable to sleep
Feeling anxious
Feeling depressed or irritable
Irritable
Fast heartbeat
Sweating
Nausea or vomiting
Feeling physically weak
Headaches
Seeing or hearing things that were not there
Fidgety or restless
None of the above

391. When you stopped cut down or went without drinking did you ever have fits seizures or convulsions where you lost consciousness fell to the floor and had difficulty remembering what happened?

Yes
No

392. On 3 or more different occasions have you taken a drink to keep from having fits or seizures or convulsions or to make them go away?

Yes
No

393. When you stopped / cut down/ or went without drinking - did you ever have the DTs - that is - where you were very confused / extremely shaky / felt very frightened / or nervous / or saw things that werent really there?

Yes
No

394. On 3 or more different occasions have you taken a drink to keep from having the DTs or to make them go away?

Yes
No