**Question group 0: Demographics**

1. **What is your birthdate? MM/DD/YYYY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_;**

Don't Know [ask follow-up question];

Refused

**2. About how old are you?**

AGE \_\_\_\_\_\_\_;

Don't Know

Refused

**3. What is your current marital or cohabiting status?**

Married to a person

Not married but living together with a partner

Widowed  
Divorced or annulled  
Separated, because you and your spouse are not getting along  
Never been married

1. **Is your partner or spouse from the opposite or same sex?**

Same

**Opposite**

1. **Please give me your complete address.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apartment Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_City

\_\_\_\_\_\_\_\_\_\_\_\_\_\_State

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIPCODE

1. **What gender do you best identify as?**

MALE

FEMALE

female but I best identify myself as male

male but I best identify myself as female

other  
REFUSED

1. **Do you consider yourself to be Hispanic, Latino, or of Spanish origin?**

YES [GO TO RACE, automatically check “other”]

NO   
REFUSED   
DON'T KNOW

1. **What race or races do you consider yourself to be? Please select one or more.   
   CHECK ALL THAT APPLY.**

AMERICAN INDIAN OR ALASKA NATIVE  
ASIAN [GO TO Question 2]  
BLACK OR AFRICAN AMERICAN  
NATIVE HAWAIIAN OR PACIFIC ISLANDER [GO TO Question 3]

WHITE

OTHER, (which include Hispanic, Latino, or of Spanish origin )[GO TO QUESTION 4]  
DON’T KNOW

REFUSED

Note: If multi-race, probe combination of questions (e.g. question 2 and 4 if Asian-hispanic)…

1. **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  
MADAGASCAR/MALAGASY [ ] 32 MALAYSIAN  
MALDIVIAN  
MONG  
NEPALESE  
NIPPONESE  
OKINAWAN  
PAKISTANI  
SIAMESE  
SINGAPOREAN  
SRI LANKAN  
TAIWANESE  
THAI  
VIETNAMESE  
REFUSED

DON'T KNOW

1. **Where do your NATIVE HAWAIIAN OR PACIFIC ISLANDER ancestors come from?**

NATIVE HAWAIIAN  
GUAMANIAN OR CHAMORRO

SAMOAN  
OTHER PACIFIC ISLANDER

REFUSED  
DON’T KNOW

1. **Where do your OTHER (includes Hispanic, Latino, or of Spanish origin ) ancestors come from?**

MEXICAN  
PUERTO RICAN  
CUBAN  
DOMINICAN REPUBLIC

COSTA RICAN  
GUATEMALAN  
HONDURAN  
NICARAGUAN  
PANAMANIAN  
SALVADORAN  
ARGENTINEAN  
BOLIVIAN  
CHILEAN

COLOMBIAN  
ECUADORIAN  
PARAGUAYAN  
PERUVIAN  
URUGUAYAN  
VENEZUELAN  
OTHER SOUTH AMERICANFILIPINO  
SPANIARD  
SPANISH  
SPANISH AMERICAN  
HISPANO/HISPANA  
HISPANIC/LATINO  
OTHER HISPANIC/LATINO

CHICANA/CHICANO  
REFUSED  
DON'T KNOW

**Question group 1: chief complaint**

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

No

Yes 🡪

* 1. I have **completely lost** my sense of smell and I can’t smell anything

No

Yes

* 1. I’m **less sensitive** to odors than I used to be, but I still can perceive certain smells.

No

Yes

* 1. I’m **more sensitive** to odors than I used to be.

No

Yes

* 1. I can’t stand certain types of odors anymore.

No

Yes 🡪

1.4a) What are these odors that you can’t stand?

Free text

1.4b) Did you became more sensitive to these odors?

No

Yes

1.5c) Do you find them irritating?

No

Yes

* 1. Certain odors smell different than what they should.

No

Yes 🡪 1.5a) What type of odors smells now different ?

Free text

1.5b) These odors are now:

Pleasant

Unpleasant

1.5c) How do these odors smell like now?

Free text

* 1. I spontaneously perceive a unusual smell regardless weather I’m sniffing an odor or not.

No

Yes 🡪

1.6a) The unusual smell is (check only one):

pleasant

unpleasant

1.6b) How would you characterize this unusual smells?

Free text

1.6c) I’m experiencing these problem especially (check all that apply):

in the morning

At noon

During the afternoon

In the Evening

just before falling asleep

at night

I don’t know

1.6d) It happens every

second

Minute

Hour

Day

Week

Month

Year

I don’t know

* 1. I extremely fear that my my body smells unpleasant or fool.

Other:

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

No (next question)

Yes🡪

2.1) My ability to taste salt, sweet, sour, bitter and chicken broth is normal.

No

Yes

2.2) I have **completely** lost my ability to taste all aromas. Aromas are all the taste except salty, sweet, sour, bitter or chicken broth.

No

Yes

2.3) Some or all aromas taste **different** than what they should

No

Yes 🡪

2.3a) What type of food or beverage tastes now different ?

Free text

2.3b) These aromas are now?

Pleasant

Unpleasant

2.3c) How do these aromas taste like now?

Free text

2.4) I’m **less sensitive** to sour, bitter, salty, sweet or chicken broth taste, but I still can partially perceive it.

No

* Yes 🡪

2.4a) **the problem apply to the following (check all that apply) :**

Sweet

Sour

Salty

Bitter

Umami (chicken broth)

Other: free text

2.5 ) I have **completely lost** my ability to perceive sour, bitter, salty, sweet taste or chicken broth taste

No

Yes 🡪 2.5a) **the problem apply to the following (check all that apply):**

Sweet

Sour

Salty

Bitter

Umami (chicken broth)

Other: free text

.

2.6) I’m **more sensitive** to sour, bitter, salty or sweet taste.

No

Yes 🡪

2.6a) **the problem apply to the following (check all that apply):**

Sweet

Sour

Salty

Bitter

Umami (chicken broth)

Other: free text

2.7) My mouth is burning

No

Yes

2.8) There is an **unusual taste** in my mouth but it’s not triggered by anything

No

Yes 🡪

2.8a) The unusual taste is (check only one):

pleasant

unpleasant

2.8b) How would you characterize the unusual taste?

Free text

2.8c) I’m experiencing this problem especially (check all that apply):

in the morning

At noon

During the afternoon

In the Evening

just before falling asleep

at night

I don’t know

2.8d) It happens every

second

Minute

Hour

Day

Week

Month

Year

I don’t know

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

No

Yes 🡪

2.9a) What is triggering the unusual taste?

Free text

2.9b) the unusual taste is (check only one):

Pleasant

Unpleasant

2.9c) How does this unusual sensation taste like?

Free text

3.0) When I touch my tongue or some part of my oral cavity, it triggers an unusual taste

No

Yes

**Question group 2: History of illness**

1) **How long have you been experiencing smell or taste issues?**

I don’t know

As long as I can remember

Less than 1 week

1 – 4 weeks

1 -3 months

3 – 12 months

1-2 years

More than 2 years

2) **How did the problem start?**

I don’t remember

I was born with this issue

Progressively

Suddenly

1. **Does your ability to smell or taste remains constant or fluctuates?**

constant

fluctuates 🡪

3.1) How frequently does it fluctuates?

hourly

daily

weekly

monthly

yearly

It’s related to certain seasons

My symptoms are the same all-year long.

I don’t know

Other: free text

1. **Which side of the nostrils, tongue or mouth do you have an issue with?**

Both sides

Left

Right

I don’t know

1. **How has the situation changed?**

It’s getting better

No change

It’s getting worse

1. **How does your problem affect your quality of life?**

Very badly

Badly

Medium badly

Mildly

Hardly at all

Not at all

1. **Please select one or several situations that – in your opinion - may explain why you’re having issue with your sense of smell/taste:**

**7.1) I was born this way**

7.1.1) My puberty was delayed or never started

Yes

No

I don’t know

7.1.2) I have a micropenis, no menstrual period, or suffering from infertility

No

Yes

I don’t know

7.1.3) My heart is beating on the right side of my chest

No

Yes

I don’t know

**7.2) I suffered from head trauma 🡪**

* + 1. Have you ever been hospitalized or treated in an emergency room following an injury to your head or neck? Think about any childhood injuries you remember or were told about.

Yes

No

* + 1. Have you ever injured your head or neck in a car accident or from some other moving vehicle accident (e.g. motorcycle)?

Yes

No

* + 1. Have you ever injured your head or neck in a fall or from being hit by something (e.g. falling from a bike, horse, or rollerblades, falling on ice, being hit by a rock)? Have you ever injured your head or neck playing sports or on the playground?

Yes

No

* + 1. Have you ever injured your head or neck in a fight, from being hit by someone, or from being shaken violently? Have you ever been shot in the head?

Yes

No

* + 1. Have you ever been nearby when an explosion or a blast occurred? If you served in the military, think about any combat- or training-related incidents.

Yes

No

* + 1. If all above are "no" then proceed to question 7. If answered "yes" to *any* of the questions above, ask the following for each injury:

**Were you knocked out or did you lose consciousness (LOC)? If yes, how long? If no, were you dazed or did you have a gap in your memory from the injury? How old were you? (*age is only needed if there was LOC) ? point of impact?***

SEE TABLE OF PHENXTOOLKIT ABOUT **+ add column for point of impact**

* + 1. Have you ever lost consciousness from a drug overdose or being choked?

Yes \_\_\_\_# overdose

No

**7.3) I had a common cold - my sense of smell never returned back to normal**

🡪

* + 1. All the other symptoms resolved ( e.g. nasal blockage, runny nose, fever… ) except my sense of smell

No

Yes

* + 1. Along with my smell/taste problem, I have a runny nose and nasal blockage.

No

Yes

**7.4) Nose or Sinus infection**

* + 1. All the other symptoms resolved ( e.g. nasal blockage, runny nose, fever… ) except my sense of smell

No

Yes

* + 1. Along with my smell/taste problem, I have a runny nose and nasal blockage.

No

Yes

**7.5) Migraine/headache**

**7.5.1 Over the past year, have you suffered from severe headaches?**

Yes

No

If Yes, go to question 2.  
If No, questionnaire is complete.

**7.5.2 When you have a severe headache, do you experience any of the following? (X 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, circles, other shapes, or colors before the eyes, before the headache starts  
Numbness of lips, tongue, fingers, or legs before the headache starts

**7.5.3. About how often do your severe headaches occur? (Write In Number Of Headache Days You Have Per Week Or Month Or Year)**

\_\_\_\_\_\_\_# in a week, OR \_\_\_\_\_\_\_# in a month, OR \_\_\_\_\_\_\_# in a year

* + 1. **Which statement best describes the pain of your severe headaches? (X ONE)**

Extremely severe pain

Severe pain  
Moderately severe pain

Mild pain

* + 1. **Which best describes how you are usually affected by severe headaches? (X ONE)**

Able to work/function normally  
Working ability or activity impaired to some degree

Working ability or activity severely impaired  
Bed rest required

**7.5.6 Each time you have a severe headache, how long are you unable to work or undertake normal activities? (X ONE)**

0 days (no activity restriction)

Less than 1 day  
1-2 days  
3-5 days

6 or more days

**7.4.7. On how many days in the last 3 months did you have a headache (if headache lasted more than 1 day, count each day)?**

\_\_\_\_\_\_\_ (Write In # Days)  
**7.5.8. Because of your headaches on how many days in the last 3 months . . . ?**

**7.5.8.1. …did you miss work or school**

\_\_\_\_\_\_\_ (Write In # Days)

**7.5.8.2. ….was your productivity at work/school reduced by half or more (not including days missed in qu. 8 above)**

\_\_\_\_\_\_\_ (Write In # Days)

**7.5.8.3….did you not do household work**

\_\_\_\_\_\_\_ (Write In # Days)

**7.5.8.4. …..was your productivity in house-hold work reduced by half or more (not including days counted in qu. 9c above)**

\_\_\_\_\_\_\_ (Write In # Days)

**7.5.8.5. ….did you miss family, social, or leisure activities**

\_\_\_\_\_\_\_ (Write In # Days)

**7.5.9. At what age did you BEGIN having severe headaches?**

\_\_\_\_\_\_\_ (Write In Age)

**7.5.10. Have you ever gone to the hospital emergency room or to an urgent care clinic because of your severe headaches?**

Yes

No

* + 1. **Which best describes the way you usually treat severe headaches? (X ONE)**

Take non-prescription medications  
Take prescription medications  
Take both prescription and non-prescription medications

Take no medications

**7.5.12. Have you ever taken prescription medication for headache on a DAILY basis, whether or not you have a headache, to help prevent a severe headache from happening in the first place?**

Yes

No

**7.5.13. When did you last take prescription medication for headache on a DAILY basis to help prevent a severe headache from happening in the first place? (X ONE)**

Currently taking  
Last took within the past 3 months

Last took 3 to 12 months ago  
Last took more than 12 months ago

Never took

**7.5.14. Do you consider your severe headaches to be migraines?**

Yes

No

**7.5.15. Have you ever been diagnosed by a physician or other health professional as suffering from . . . ? (X ALL That Apply)**

Tension headaches

Sinus headaches  
Cluster headaches

Stress headaches

"Sick" headaches  
Migraine headaches🡪

7.5.15.1) At what age were you FIRST DIAGNOSED with migraines?

\_\_\_\_\_\_\_ (Write In Age)

**7.5.16) When do you experience issue with your sense of smell/taste regarding the episode of migraine ?**

before the episode

during the episode

after the episode

I don’t know

**7.5.17) How long does the migraine last?**

\_\_\_\_\_\_\_\_ Timing

**7.5.18) Which side is the headache located?**

Right Side

Left Side

Both side

**7.5.19) Where is it located?**

Image of a face and a cranium

**7.5.20) How long does the smell/taste problem last?**

\_\_\_\_\_\_\_\_\_Timing

**7.6) Seizure**

**7.7) Cancer**

7.7.1)

7.7.2) I received radio- or chemotherapy

No

Yes

**7.8) Smoking**

**7.9) I was exposed to some chemicals**

**7.10) I had nasal surgery**

**7.11) I had brain surgery**

**7.12) Ear infection**

**7.13) I started a new drug**

**7.14) Alzheimer’s Disease**

**7.15) Parkinson’s Disease**

7.16) Other:

free text

1. **What makes your symptoms better?**

Free text

1. **What triggers your symptoms or make them worse?**

Free text

1. **Did you receive any treatment based on alternative or eastern medicine?**

No

YES 🡪

10.1) What kind of intervention did you receive?

Ginko Biloba

Acupuncture

Other: free text

1. **Did you receive any medical treatment for your condition?**

No

Yes 🡪

11.a) What type of drug did you receive (check all that apply) ?

Alpha lipoic acid

Antibiotics

Antihistamine

Antileukotriene

Caroverine

Cocaine hydrochloride

Codeine

Corticosteroid by mouth

Corticosteroid nasal spray

Corticosteroid nasal drops in upwright position

Corticosteroid nasal drops with head tilted backward

Cromolyn eye drops

Gabapentine

Nasal lavage with hypertonic solution

Nasal lavage with normal saline

Nasal decongestant

Paracetamol

Pentoxyfillin

Sodium citrate

Theophylline

Vitamine A

Vitamin B12

Zinc gluconate

Other : Free text

1. **Have you been advised to modify your lifestyle ?**

No

Yes

**What type of lifestyle change?**

Avoid gas-related device

Check food expiration date to avoid spoiled food ingestion

Install a gas detector

Optimize my cooking recipes

Be self-conscious about smell loss and personal hygiene

Other.. FREE TEXT

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

No

Yes

1. **Did you undergo surgery for your current problem?**

No

Yes🡪

14a) **What kind of surgery?**

Brain surgery

Sinus surgery

Procedure that change the opening of my nostrils

Surgery to change the shape of your nose

Surgery to correct your nasal septum

Procedure to shrink enlarged turbinates

Other:

**Besides your smell or/and taste problem, have you noticed any other abnormalities, such as:**

1. **Issues with your ear or hearing (e.g. pressure or pain in the ear, etc….)?**

NO

YES🡪

**15.a) Do you feel any pressure or pain in the ear ?**

No

Yes 🡪 15.a.1) Which side?

Left

Right

both

15.a.2) Since when?

**15.b) … did you noticed any ear secretions ?**

No

Yes 🡪 15.b.1) Which side?

Left

Right

both

15.b.2) What’s the color like?

15.b.3) Since when?

**15.c) Are you experiencing vertigo or dizziness?**

No

Yes 🡪

15.c.1) **Does it feels like the world is spinning around you?**

No

Yes

15.c.2) **Do you feel unsteady when you walk?**

No

Yes

15.c.3) **How long does an episode of vertigo or dizziness last?**

Seconds

Minutes

Hours

Days

Weeks

Years

**15.d) did you experience hearing loss 🡪**

No

Yes 🡪 15.d.a) Which ear?

Left

Right

both

15.d.b) Since when?

**15.e) .. or Ringing in the ear?**

No

Yes 🡪 15.e.1) Which side?

Left

Right

both

15.e.2) Since when?

1. **Do you have issues with your nose or sinus (e.g. Nasal blockage or runny nose)?**

No

Yes 🡪

**16.a) Are you experiencing nasal blockage ?**

No

YES 🡪

16.a.1) How obstructed is your nose? (QUANTITATIVE SCALE)

16.a.2) Which side?

Left

Right

both

16.a.3) Is your nose always stuff or it fluctuates?

Always stuff

It fluctuates 🡪

hourly

daily

weekly

monthly

yearly

**16.b)…Nosebleeds ?**

No

YES🡪

16.b.1) Which side?

Left

Right

Both

16.b.2) I have nose bleed

hourly

daily

weekly

monthly

yearly

**16.c) ….Runny nose ?**

No

Yes🡪

16.c.1) Which side?

Left

Right

Both

16.c.2) What is the color of the secretion?

16.c.3) Since when?

**16.d)…Pressure or pain on the forehead?**

No

Yes 🡪

16.d.1) Since when ?

16.d.2) Please rate your pain or pressure:

Visual analogic scale 1= no pain or pressure 10= worst pain or pressure ever

**16.e) …Pressure or pain around or under the eyes ?**

No

Yes 🡪

16.e.1) Since when ?

16.e.2) Please rate your pain or pressure:

Visual analogic scale 1= no pain or pressure 10= worst pain or pressure ever

**16.f) …Sneezing?**

No

Yes

**16.g) …Headache which get worse with walking, bending or head movement?**

No

Yes 🡪

16.g.1) **Where is it localized?**

**Picture cranium and patient’s can select**

**16.g.2) Which side?**

**Left**

**Right**

**Both**

1. **Have you noticed any abnormalities with your mouth, oral cavity, teeth, throat or swallowing?**

No

Yes 🡪

**17.a) Did you notice any changes in saliva consistency?**

No

Yes

**17.b)Do you constantly have a bad breath?**

No

Yes

**17.c) Do you constantly have a bad taste in your mouth?**

No

Yes

**17.d) …swollen gums?**

No

Yes

**17.e).… tender gums?**

No

Yes

**17.f) … loose tooth?**

No

Yes

**17.g) Are you experiencing throat pain while swallowing, eating or drinking ?**

No

Yes

**17.h) ..presence of throat secretions that are difficult to clear?**

No

Yes

**17.i) Cough ?**

No

Yes 🡪

**17.i.a) Does it get worse when lying down or during sleep?**

No

YES

**17.j) Sensation of foreign object in the mouth or throat**

No

Yes

**17.k) Mouth dryness**

No

Yes

**17.l) Mouth itchiness**

No

Yes

**17.m) Change in voice quality**

No

Yes

**17.n) Throat itchiness**

No

Yes

**17.o) Chocking while eating**

No

Yes

**17.p) Cough while eating**

No

Yes

**17.q) Swallowing problem**

No

Yes

**18.) Are you experiencing any tingling or numbness on your face / mouth / oral cavity?**

No

Yes 🡪

18.a) **Where is this located? (please check all that apply)**

Forehead

Cheek

Nose

Chin

Ear

Mouth

Oral cavity

Tongue

**18.b) Which side?**

Right

Left

Both sides

18.c.) **What trigger’s this?**

Touch

Eating

Talking

Other….

1. **Are you experiencing any pain on your face/mouth/oral cavity?**

No

Yes 🡪

**19.a) Where is this located? (please check all that apply)**

Forehead

Cheek

Nose

Chin

Region around the ear

Mouth

Oral cavity

Tongue

**19.b) Which side?**

Right

Left

Both sides

**19.c) What trigger’s this?**

Touch

Eating

Talking

Other: freetext….

1. **Are you experiencing any facial paralysis or weakness?**

No

Yes 🡪

20.a.) **Which part of the face? (please check all that apply)**

Forehead

Cheek

Nose

Chin

Region around the ear

Mouth

Oral cavity

Tongue

**20.b.) Which side?**

Right

Left

Both sides

**Group 3: Past history and comorbidities**

1. **Do you have or ever had any of the following (check all that apply):**

Alzheimer’s Disease

1.1) This condition is:

Resolved🡪

1.1a) When did you suffer from this condition

Quantify time

well-controlled🡪

uncontrolled🡪

in remission🡪

1.1b) Are you currently treated for this condition?

No

Yes

1.1c) Since when do you have this condition?

DATE

Asthma

Cancer

Chronic otitis media

Chronic rhinosinusitis without polyps (e.g. Allergic rhinitis)

Nasal polyps

Cystic fibrosis

Dermatitis

Diabetes

Infertility

Amenorrhea

Micropenis

Epilepsy

Food allergy

High blood pressure

High cholesterol

Osteoporosis

absence of puberty

Parkinson’s disease

Delayed puberty

Situs inversus (organ on the opposite side)

Sjorgren Syndrome

Intolerance to aspirin

Infection of the middle ear

Cryptorchidism

Inflammation of the tongue

Liver disease

Renal disease

Epilepsy

Inflammation of salivary gland

Obstruction of salivary gland’s canal

Subarachnoid hemorrhage

Thyroid diseases

1. **Is there any other conditions that you have or ever had that we should know?**

No

Yes 🡪 Table

Condition name - status (resolved, uncontrolled, well-controlled, in remission) – Treatment (Y/N) - Time

**Group 4: Past surgical history**

1. **Did you undergo any surgeries under general anesthesia in the past?**

No

Yes 🡪

* 1. **Was the surgery in the region of the head or neck?**

No (go to 1.2)

Yes 🡪

**Please select the type of surgery that you had:**

I had my adenoids removed

I had a ruptured brain aneurysm, which was treated surgically

Sinus surgery

Laryngectomy

Vocal cords surgery

Surgery of the middle ear

Oral surgery

Brain surgery for epilepsy (temporal lobe)

Nasal polyps removal

Procedure that changes the opening of my nostrils

Surgery to change the shape of my nose

Surgery to correct my nasal septum

Procedure to shrink enlarged turbinates

I had my tonsils removed

Surgery of the uvula for my snoring problems

other

* 1. **Please list all other surgeries under general anesthesia and year :**

**………………………… ………….**

**………………………… …………..**

1. **Did you have any dental procedures or installation of a dental prosthesis?**

No

Yes

1. **Did you undergo any procedures under local anesthesia?**

No

Yes 🡪

**3.1) Please list all procedures under local anesthesia and years**

**………………………… ………….**

**………………………… …………..**

**Group 5: Medication**

1. **Have you been recently treated for a medical condition or currently taking medication?**

No

Yes 🡪

* 1. **Did you receive medications to treat one of more of the following disorders (check all that apply):**

Bacterial infection (e.g. sinusitis, tonsillitis … )

Viral infection (e.g. herpes, flu, hepatitis C virus…)

Fungal infection (e.g. fingernail or toenail fungal infection…)

Inflammation

Epilepsy

Migraine

Parkinson’s Disease

Psychiatric condition such as schizophrenia, depression, bipolar disorder, or sleeping disorders

Thyroid disease

High blood pressure

Arrhythmias

High cholesterol

Cancer

Muscle spasticity

Nasal congestion

**What medication are you taking?**

FREE TEXT – medication ontology?

**Group 6: Allergy evaluation**

1. **Do you have any known allergies?**
   * + - * No
         * Yes🡪

**1.1) Please check any allergens below that you are allergic to**:

Insect 🡪 if checked go to 1.2

Pollen

Food

Animal

Mold

Medication

Other

**1.2) What are the reaction associated to your allergies to {response in 1.1 / e.g. insect}?**

Abdominal cramps

Swelling of the oral cavity

Redness of the eye

Cough

Diarrhea

Shortness of breath

Sensation of heat or warmth

Generalized itchiness

Unusual taste in your mouth

Headache

Loss of consciousness

Nausea

high-pitched, wheezing sound caused by shortness of breath from the throat.

Throat clearing

Skin rash, hives or urticarial

Uterine cramps

Vomiting

wheezing sound due to shortness of breath from the lung

**Group 7: Family History**

**Does anyone in your family have been diagnosed with smell / taste dysfunction?**

No

Yes 🡪 How many family members have issues with their sense of smell?

Select a number 1 to X

**What kind of dysfunction ?**

Insensitivity to odors or taste

Distorted perception of odor or taste

Odor or taste hallucination

I don’t know

**How is this person related to you?**

List

**Does anyone of your relatives suffer from (check all that apply):**

Allergic rhinitis

Alzheimer’s Disease

Asthma

Bardet-Biedl syndrome

Absence of smell since birth

Kallmann syndrome

Kartagener syndrome

Parkinson’s Disease

none

**Group 7: Review of systems**

**We are going to ask you questions about signs that might be linked to your smell and taste issue:**

1. **In general, do you have a lack of appetite?**

Yes

No

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

Yes

No

1. **Do you have fever ?**

Yes

No

1. **Did you recently gain weight?**

Yes

No

1. **Did you recently lose weight?**

Yes

No

1. **Do you sleep well?**

Yes

No

1. **Do you have Issues with your eyes or vision?**

No

Yes 🡪

7.1) **Since when?**

**7.2) Do you experience eye dryness?**

No

Yes

**7.3) …or eye itchiness?**

No

Yes

**7.4) …or eye secretion?**

No

Yes

**7.5) ..Excessive tearing?**

No

Yes

**7.6) …redness of the eyes?**

No

Yes

**7.7) …Diminished visual acuity?**

No

Yes

**7.8) …Double vision?**

No

Yes

**7.9) …Blind spot in the periphery of your visual field?**

No

Yes

**7.10) …Blurry at the center of your visual field?**

No

Yes

**7.11) ….Decreased ability to see in the dark?**

No

Yes

**7.12) …. Can only see clearly if the object is in the center of the field of view?**

No

Yes

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

**No**

**Yes 🡪**

**8.1) During the past month, have you often been bothered by feeling down, depressed, or hopeless?**

No

Yes

**8.2) During the past month, have you often been bothered by little interest or pleasure in doing things?**

No

Yes

**8.3) Do you feel that your emotions are fading away?**

No

Yes

**8.4) …or a lack of vitality?**

No

Yes

**8.5) …Misplacing object with increasing frequency?**

No

Yes

**8.6) … problem in handling financial tasks**

No

Yes

**8.7) … problems with concentration**

No

Yes

**8.8) … problems in recalling recent events and conversations?**

No

Yes

**8.9) …forgetting memories from your personal history**

No

Yes

**8.10) …disoriented in space?**

No

Yes

**8.11) ….difficulty in planning or organizing things?**

No

Yes

**8.12) …Problems producing people’s name or finding the right word for objects?**

No

Yes

1. **Do you have any problem with body movement (e.g. shaking) ?**

No

Yes 🡪

**9.1) Do you execute your movement slower than before?**

No

Yes

9.2) **Are you experiencing difficulty in relaxing your muscle?**

No

Yes

**9.3) Have you experienced involuntary shaking in body parts?**

No

Yes

9.4) **Do you feel stable when you’re walking?**

No

Yes

9.5) **Do you often fall?**

No

Yes

1. **Do you have any lung issue (e.g. shortness of breath, cough, sputum, chest pain) ?**

No

Yes 🡪

**Are you experiencing shortness of breath?**

No

Yes 🡪 Is it accompanied by a wheezing sound?

No

Yes

**…. or cough?**

No

Yes

**Do you produce sputum?**

No

Yes 🡪 **What color is it ?**

Yellow

White

clear

**Are you experiencing chest pain?**

No

Yes 🡪 **Is it exacerbated when you take a deep breath?**

No

Yes

**Do you have any problem with your stomach, passing urine or stool (e.g. heartburn)?**

No

Yes🡪 **Do you have difficulty passing stool?**

No

Yes

**…or urinating?**

No

Yes

**Do you suffer from heartburn?**

No

Yes

**Group 8: Social history and Environment**

1. **Air Contaminants in the Home Environment**
2. Prior the loss of your smell/taste, has there been a major renovation to this house or apartment, such as adding a room, putting up or taking down a wall, replacing windows, or refinishing floors? When was the last one?

READ CHOICES, ENTER ONE.

[ ] A. Yes, when was the last one?  
Type of renovation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] B. Yes, I don’t know when.  
Type of renovation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] C. Not renovated

[ ] D. Don’t know

1. Prior the dysfunction of your smell/taste were rugs, drapes or furniture professionally cleaned? Inside the house? When? What items?

[ ] A. Yes, they were cleaned on

* In the house
* Somewhere else  
  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Items: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] B. Yes, I don’t know when

* In the house
* Somewhere else  
  Items: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] C. Not professionally cleaned

* In the house
* Somewhere else

[ ] D. Don’t know

1. Prior the dysfunction of your smell/taste, was the inside of this house or apartment painted? When was the last time? On how many rooms?

READ CHOICES, ENTER ONE.

[ ] A. Yes, it was painted on  
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
No. of Rooms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] B. Yes it was painted, but I don’t know when

No. of Rooms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] C. Not painted

[ ] D. Don’t know

**4.** Prior the loss of your smell/taste **were new carpets or rugs installed? READ CHOICES, ENTER ONE.**

[ ] A. Yes, it was carpeted on  
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
No. of Rooms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] B. Yes it was installed but I don’t know when No. of Rooms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] C. No new carpet installed

[ ] D. Don’t know

**The next two questions ask about things that you may have done, or been in contact with, before your smell/taste impairment. Please check either No or Yes.**

1. **Were you involved in the production of chemicals such as acid compounds?**

[ ] No

[ ] Yes

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

[ ] No

[ ] Yes

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

[ ] No

[ ] Yes

1. **Did you work as a chemist, pharmacist or have you been exposed to chemicals ?**

[ ] No

[ ] Yes

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

[ ] No

[ ] Yes

1. **Were you producing/manufacturing fragrances, spice, tabacco, steel, metal, ship, rubber, plastic, thermometer, magnet or battery ?**

[ ] No

[ ] Yes

**The following questions are about things that you may have used or may have been used by someone near you prior your smell/taste impairment. Enter all that applies, if Yes, write for how long.**

1. **Paints or solvents (paint thinners and removers, typewriter corrective fluids)?**

[ ] A. No (GO TO THE NEXT QUESTION)

[ ] B. Did you handle them yourself? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

[ ] C. Were you near somebody else who handled them? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

1. **Glues and adhesives, such as contact cement, super glues, and aerosol adhesives that contain chemical solvents?)**

[ ] A. No (GO TO THE NEXT QUESTION)

[ ] B. Did you handle them yourself? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

[ ] C. Were you near somebody else who handled them? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

1. **Gasoline lawn mower?**  
   [ ] A. No (GO TO THE NEXT QUESTION)

[ ] B. Did you handle them yourself? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

[ ] C. Were you near somebody else who handled them? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

1. **Chain saw or other gasoline equipment?**  
   [ ] A. No (GO TO THE NEXT QUESTION)

[ ] B. Did you handle them yourself? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

[ ] C. Were you near somebody else who handled them? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

1. **Sander and/or saw?**  
   [ ] A. No (GO TO THE NEXT QUESTION)

[ ] B. Did you handle them yourself? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

[ ] C. Were you near somebody else who handled them? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

1. **Pesticides sprayed?**  
   [ ] A. No (GO TO THE NEXT QUESTION)

[ ] B. Did you handle them yourself? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

[ ] C. Were you near somebody else who handled them? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

1. **Vacuuming?**

[ ] A.No (GO TO THE NEXT QUESTION)

[ ] B. Did you handle them yourself? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

[ ] C. Were you near somebody else who handled them? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

1. **Sweeping indoors?**  
   [ ] A. No (GO TO THE NEXT QUESTION)

[ ] B. Did you handle them yourself? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

[ ] C. Were you near somebody else who handled them? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

1. **Dusting?**

[ ]A.No (GO TO THE NEXT QUESTION)

[ ] B. Did you handle them yourself? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

[ ] C. Were you near somebody else who handled them? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

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

[ ] A. No (GO TO THE NEXT QUESTION)

[ ] B. Did you handle them yourself? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

[ ] C. Were you near somebody else who handled them? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

1. **Gardening?**

[]A.No (GO TO THE NEXT QUESTION)

[ ] B. Did you handle them yourself? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

[ ] C. Were you near somebody else who handled them? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

1. **Broiling, smoking, grilling or frying inside the house?**

[ ] A. No (GO TO THE NEXT QUESTION)

[ ] B. Did you handle them yourself? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

[ ] C. Were you near somebody else who handled them? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

[ ] D. Did you turn on the kitchen or stove exhaust fan?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

1. Broiling, smoking, grilling or frying outside the house?

[ ] A. No (GO TO THE NEXT QUESTION)

[ ] B. Did you handle them yourself? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_

[ ] C. Were you near somebody else who handled them? If Yes, for how long?

[ ] No

[ ] Yes Hrs \_\_\_\_\_\_\_\_\_\_ Min \_\_\_\_\_\_\_\_\_\_  
[ ] D. What is the distance from the grill to the house?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ft

1. **Characteristics of Current Residence**
2. What is the type of dwelling?

[To distinguish between the types of buildings, you may ask: How many other families live in the building? and/or  
How many other families live on this floor?]

1 [ ] Detached house  
2 [ ] Duplex/Triplex  
3 [ ] Row house  
4 [ ] Low rise apartment (1-3 floors)

5 [ ] High rise apartment (>3 floors)

6 [ ] Mobile home / Trailer

7 [ ] Other Specify: a.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is this property actively used as a farm or ranch?

1 [ ] YES

2 [ ] NO

1. What is the approximate age of your building?  
   Age of building \_\_\_\_\_\_\_\_ or Year built \_\_\_\_\_\_\_\_\_\_\_

Years at Address

1. When did you start living there?  
   MO and YR \_\_\_\_\_\_\_\_\_\_ or AGE\_\_\_\_\_\_\_\_\_\_
2. When did you move from there?  
   MO and YR \_\_\_\_\_\_\_\_\_\_ or AGE\_\_\_\_\_\_\_\_\_\_
3. IF R DOES NOT KNOW 4 OR 5, ASK For how many years (have/did) you live(d) there?

Years |\_\_\_|\_\_\_|

Attached Garage

1. Is there an enclosed garage attached to this (house/apartment)?

1 [ ] YES CONTINUE

2 [ ] NO → SKIP NEXT QUESTION  
7a. Are automobiles, vans, trucks or other motor vehicles parked in this attached

garage?  
1 [ ] YES

2 [ ] NO

1. Are any gas powered devices stored in any room, basement, or attached garage in this (house/apartment)?  
   DO NOT INCLUDE CARS, VANS, OR TRUCKS. DO INCLUDE MOTORCYCLES, GAS-POWERED LAWNMOWERS, TRIMMERS OR BLOWERS, BOAT ENGINES, ETC.

1 [ ] YES  
2 [ ] NO  
9 [ ] DON’T KNOW

Water Damage

9. During the past 12 months, has there been water or dampness in your home from broken pipes, leaks, heavy rain, or floods?

1 [ ] YES  
2 [ ] NO  
8 [ ] DON’T KNOW

1. Does your home frequently have a mildew odor or musty smell?

1 [ ] YES

2 [ ] NO  
8 [ ] DON’T KNOW

Heating Source / Air Conditioning / HVAC

1. Is air conditioning (refrigeration) used to cool this (house/apartment)?

1 [ ] YES → CONTINUE

[ ] NO → SKIP REMAINING AIR CONDITIONING QUESTIONS

1. Which types of air conditioning units do you use? CHECK ALLTHAT APPLY

1 [ ] Central unit/units  
2 [ ] Window or wall unit/units 3 [ ] Portable unit/units

1. During which month (do you usually/would you) start using air conditioning to cool this (house/apartment)? During which month (do you usually/would you) stop using air conditioning?
2. CIRCLE THE START AND STOP MONTHS.  
   Start Month: Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec

Stop Month: Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec

1. Which fuels are used for heating this (house/apartment)? CHECK ALL THAT APPLY

1 [ ] Gas: from underground pipes serving the neighborhood 2 [ ] Gas: bottled, tank, or LP  
3 [ ] Electricity  
4 [ ] Fuel oil, kerosene, etc

5 [ ] Coal or coke  
6 [ ] Wood  
7 [ ] Solar energy  
8 [ ] Other fuel (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

9 [ ] No fuel used

99 [ ] DON’T KNOW

1. Does this (house/apartment) have a central heating system with ducts that blow air into most rooms?

1 [ ] YES

2 [ ] NO

**17. During which month (do you usually/would you) start using heating devices? During which month (do you usually/would you) stop using heating devices?**

CIRCLE THE START AND STOP MONTH  
Start Month: Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec Stop Month: Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec

Current Pets

**18. In the last 12 months, did any dogs, cats or other small furry animals, such as a rabbit, guinea pig or hamster, live or spend time inside your home?**

1 [ ] YES  
2 [ ] NO (END OF SECTION)  
7 [ ] REFUSED (END OF SECTION)  
9 [ ] DON’T KNOW (END OF SECTION)

**19. What kind of pet was it? CHECK ALL THAT APPLY**

1 [ ] DOG  
2 [ ] CAT  
3 [ ] SMALL FURRY ANIMAL

77 [ ] REFUSED  
99 [ ] DON’T KNOW

1. **Exposure at Work and in Daily Life**

In your work or daily life, are (were) you regularly exposed to any of the following? If "yes", indicate the number of years exposed.

Exposure to:

Yes / No Number of years

**Asbestos**

**Chemicals/Acids/Solvents**

**Coal or Stone Dusts**

**Coal Tar/Pitch/Asphalt**

**Diesel Engine Exhaust**

**Dyes**

**Formaldehyde**

**Gasoline Exhaust**

**Pesticides/Herbicides**

**Textile Fibers/Dusts**

**Wood Dust**

**X-rays/Radioactive Materials**

**Acetaldehyde**

**Acetic acid**

**Acetophenone**

**Alum**

**Ammonia**

**Arsenic**

**Arsenite**

**Benzene**

**Butyl acetate**

**Cadmium**

**Carbon disulfide**

**Carbon monoxide**

**Cement**

**Chlorine**

**Chloroform**

**Chlorometanes**

**Chromium**

**Copper**

**Cyanide**

**Dichromates**

**Dioxide**

**Ethyl acetate**

**Fluorides**

**Formaldehyde**

**Hardwoods**

**Hydrogen**

**Lead**

**Manganese**

**Nickel**

**Nitrate**

**Nitric acid**

**Potash**

**Selenium dioxide**

**Silicon**

**Silver**

**Tin**

**Trichloroethane**

**Trichloroethylene**

**Wax**

**Zinx**

1. **Occupational History**
2. How many hours did you work **last week** at **all** jobs or businesses? ENTER NUMBER OF HOURS: |\_\_\_|\_\_\_|\_\_\_|  
   7-77 [ ] REFUSED

9-99 [ ] DON’T KNOW

1. **Do you usually** work 35 hours or more per week in total at all jobs or businesses? 1 [ ] YES

2 [ ] NO  
7 [ ] REFUSED  
9 [ ] DON’T KNOW

1. For whom did you work at your main job or business? (What is the name of the company, business, organization or employer?)

ENTER NAME OF EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7-77 [ ] REFUSED  
9-99 [ ] DON’T KNOW

1. What kind of business or industry is this? (For example: a TV or radio station, retail shoe store, state labor department, farm.)

ENTER NAME OF BUSINESS OR INDUSTRY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7-77 [ ] REFUSED  
9-99 [ ] DON’T KNOW

1. What kind of work {were you/was SP} doing? (For example: farming, mail clerk, computer specialist, machine operator, welder, mechanic.)

ENTER NAME OF OCCUPATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7-77 [ ] REFUSED

9-99 [ ] DON’T KNOW

6. What were your most important activities on this job? (For example: sells cars, keeps account books, operates printing press.)

ENTER NAME OF DUTIES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7-77 [ ] REFUSED  
9-99 [ ] DON’T KNOW

7. Which of the following best describes the hours you **usually** work at your main job or business?

1 [ ] A regular daytime schedule

2 [ ] A regular evening shif**t  
3 [ ]** A regular night shift  
4 [ ] A rotating shift

5 [ ] Another schedule

[ ] REFUSED  
9 [ ] DON’T KNOW

HELP AVAILABLE  
Standard Shift Definitions are:

* •  A regular daytime schedule: between 6am and 6pm.
* •  A regular evening shift: between 2pm and midnight.
* •  A regular night shift: between 9pm and 8am.
* •  A rotating shift: a work shift that changes periodically from days to evenings or nights.
* •  Another schedule includes: a split shift (consisting of two distinct work periods each

day), an irregular schedule arranged by the employer, or any other schedule.

8. About how long have you worked for {EMPLOYER} as a(n) {OCCUPATION}? ENTER NUMBER (OF DAYS, WEEKS, MONTHS OR YEARS)|\_\_\_|\_\_\_|\_\_\_|  
7 [ ] REFUSED

9 [ ] DON’T KNOW

ENTER UNIT

1 [ ] DAYS  
2 [ ] WEEKS

3 [ ] MONTHS

4 [ ] YEARS

7 [ ] REFUSED  
9 [ ] DON’T KNOW

**(Longest Held Job)**

1. Thinking of all the paid jobs you ever had, what kind of work were you doing the longest? (For example, electrical engineer, stock clerk, typist, farmer.)

ENTER OCCUPATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or

3 [ ] ARMED FORCES (Go to 11)  
4 [ ] NEVER WORKED (END OF SECTION)

7 [ ] REFUSED (Go to 11)  
9 [ ] DON’T KNOW (Go to 11)

1. What kind of business or industry did you work in for the longest period of time as a (DISPLAY LONGEST OCCUPATION)? (For example, a TV or radio station, retail shoe store, state labor department, farm, plastics manufacturer.)

ENTER DESCRIPTION FOR KIND OF BUSINESS/INDUSTRY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7 [ ] REFUSED  
9 [ ] DON’T KNOW

1. What were your most important activities on this job or business? (For example: sells cars, keeps account books, operates printing press.)

ENTER NAME OF DUTIES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7 [ ] REFUSED  
9 [ ] DON’T KNOW

12. About how long did you work at that job or business?  
ENTER NUMBER (OF DAYS, WEEKS, MONTHS OR YEARS)|\_\_\_|\_\_\_|\_\_\_|

7 [ ] REFUSED

9 [ ] DON’T KNOW

ENTER UNIT

1 [ ] DAYS  
2 [ ] WEEKS

3 [ ] MONTHS

4 [ ] YEARS

7 [ ] REFUSED  
9 [ ] DON’T KNOW

**COMPLETE OCCUPATIONAL WORKSHEET (SEE PDF)**

**+**

**Exposures from Hobbies** (SEE PDF)

**Home and Workplace Exposures to Floor and Wall Materials**

1. Has there been renovation or repairs in your workspace because of moisture damage? 1 [ ] no

2 [ ] yes, during the past 12 months

3 [ ] yes, 1-3 years ago  
4 [ ] yes, more than 3 years ago  
5 [ ] I don’t know

1. What is the floor material in your workspace?

1 [ ] concrete

2 [ ] wood  
3 [ ] cork  
4 [ ] vinyl  
5 [ ] wall-to-wall carpet  
6 [ ] other, what? \_\_\_\_\_\_\_\_\_\_\_\_\_

7 [ ] I don’t know

1. Is the wall material of your work space textile (cloth, jute, etc.)

1 [ ] no

2 [ ] yes, less than half of the wall surfaces 3 [ ] yes, at least half of the wall surfaces

1. Is the wall material of your work space plastic?

1 [ ] no

2 [ ] yes, less than half of the wall surfaces 3 [ ] yes, at least half of the wall surfaces

HOME ENVIRONMENT

1. Has there been renovation or repairs in your home due to moisture damage? 1 [ ] no

2 [ ] yes, during the past 12 months 3 [ ] yes, 1-3 years ago  
4 [ ] yes, more than 3 years ago

1. Has there been renovation in your home during the past 12 months? 1 [ ] yes

2 [ ] no

If you answered yes, answer also 6B, otherwise go straight to 7.

6B. Which of the following repairs was done in your home during the past 12 months? (You may circle more than one alternative):

1 [ ] Painting, less than half of the wall area  
2 [ ] Painting, at least half of the wall area  
3 [ ] Wall-papering, less than half of the wall area

4 [ ] Wall-papering, at least half of the wall area

5 [ ] Lacquering of the floor  
6 [ ] Use of floor putty  
7 [ ] Other, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have wall-to-wall carpeting in your home? 1 [ ] no

2 [ ] yes, less than half of the floor area 3 [ ] yes, at least half of the floor area

1. Is the floor material in your home plastic/vinyl? (excluding the bathroom) 1 [ ] no

2 [ ] yes, less than half of the floor area 3 [ ] yes, at least half of the floor area

1. Is the wall material in your home textile (cloth, jute, etc.)?

1 [ ] no  
2 [ ] yes, less than half of the wall surface area 3 [ ] yes, at least half of the wall surface area

1. Is the wall material in your home plastic? (excluding the bathroom)

1 [ ] no

2 [ ] yes, less than half of the wall surface area 3 [ ] yes, at least half of the wall surface area

**Tobacco - Smoking Status**

1. Have you smoked at least 100 cigarettes in your entire life?

*(Note to interviewer: 100 CIGARETTES = APPROXIMATELY 5 PACKS)*

[ ] Yes  
[ ] No  
[ ] Don’t Know / Refused

*If Question 1 is "Yes" then respondent is asked:*

2. Do you now smoke cigarettes every day, some days, or not at all?

[ ] Every day

[ ] Some days  
[ ] Not at all  
[ ] Don’t Know / Refused

*If Question 1 is "Yes" and Question 2 is "Some days" (Current some day smoker) or if Question 1 is "Yes" and Question 2 is "Not at all" (Former smoker), then respondent is asked:*

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

[ ] Yes

[ ] No  
[ ] Don’t Know / Refused

*Interpreting responses to assess smoking status of adults:*

If answer to Question 1 is *"No"*, then respondent is a "Never Smoker".  
If answer to Question 1 is *"Yes"* and answer to Question 2 is *"Every day"*, then

respondent is a "Current Every-Day Smoker".  
If answer to Question 1 is *"Yes"* and answer to Question 2 is *"Some days"*, then

respondent is a "Current Some-Day Smoker".  
If answer to Question 1 is *"Yes"* and answer to Question 2 is *"Not at all"*, then

respondent is a "Former Smoker".

Question 3 allows further classification of Current Some-Day and Former Smokers into those who smoked every day in the past from those who have not done so. The former would be indicating heavier past exposure.

AFTER CLASSIFICATION 🡪 ASSESSMENT OF 30 DAYS QUANTITY AND FREQUENCY ACCORDING TO CLASSIFICATION

**Tobacco - 30-Day Quantity and Frequency (Adult Protocol)**

***A. Every-Day Smokers***

*Note to interviewer: Every-Day Smokers (that is, Tobacco - Smoking Status adult protocol, if Question 1 is "Yes" and Question 3 is "Every day" ) are asked:*

1. On the average, about how many cigarettes do you now smoke each day? Response:

Enter number of cigarettes per day \_\_\_\_ [RANGE: 1 - 99] [ ] Don’t Know / Refused

*(Note to interviewer: One pack usually equals 20 cigarettes, If converting packs to cigarettes, always verify calculation with respondent.)*

***B. Some-Day Smokers***

*Note to interviewer: Some-Say Smokers (that is, Tobacco - Smoking Status adult protocol, If Question 1 is "Yes" and Question 3 is "Some days") are asked:*

1. On how many of the past 30 days did you smoke cigarettes? Response:

\_\_\_\_ [Range: 1-30, Enter (X) for none] [ ] Don’t Know / Refused

1. On the average, on those [NUMFILL] days, how many cigarettes did you usually smoke each day?

Response:

\_\_\_\_ [Range: 1-99]  
[ ] Don’t Know / Refused

\* NUMFILL is the number of days provided in Question 1.

***C. Former Smokers***

*Note to interviewer: Former Smokers (that is, Tobacco - Smoking Status adult protocol, If Question 1 is "Yes", Question 3 is "Not at all") are asked the following questions:*

1. Have you EVER smoked cigarettes EVERY DAY for at least 6 months? [ ] Yes

[ ] No  
[ ] Don’t Know / Refused

*If Question 1 is "Yes" then respondent is asked Question 2a\*\*:*

2a. When you last smoked every day, on average how many cigarettes did you smoke each day?

Response:

Enter number of cigarettes a day \_\_\_\_ [RANGE: 1 - 99] [ ] Don’t Know / Refused

*If Question 1 is "No" then respondent is asked a modified question, Question 2b. This question is modified to reflect that the respondent did not formerly smoke everyday:*

2b. When you last smoked fairly regularly, on average how many cigarettes did you smoke each day?

Response:

Enter number of cigarettes a day \_\_\_\_ [RANGE: 1 - 99] [ ] Don’t Know / Refused

**Alcohol - Age of First Use**

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

\_\_\_Age

[ ] Never drank alcohol 🡪 STOP ALCOHOL ASSESSMENT

**Alcohol - Lifetime Abuse and Dependence**

1. At what age did you begin to drink regularly; that is, drinking at least once a month for 6 months or more?

IF NEVER, CODE 00.  
AGE: \_\_\_ \_\_\_  
[ ] DON’T KNOW / REFUSED

1. How old were you the first time you got drunk, that is, your speech was slurred or you were unsteady on your feet?

IF NEVER, CODE 00. AGE: \_\_\_ \_\_\_

[ ] DON’T KNOW / REFUSED

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

\_\_\_ \_\_\_ \_\_\_ DRINKS  
[ ] DON’T KNOW / REFUSED

IF QUESTION 3 = 3 DRINKS OR FEWER (LIFETIME) THEN NO ADDITIONAL QUESTIONS ARE ASKED. IF QUESTION 1 AND QUESTION 2 ARE BOTH CODED 00, NO ADDITIONAL QUESTIONS ARE ASKED. ALL OTHERS CONTINUE WITH QUESTION 4.

4. Did you ever become tolerant to alcohol; that is, you drank a great deal more in order to get an effect, or found you could no longer get high on the amount you used to drink?

SHOW RESPONDENT CARD E2 (see PDF). [ ] NO (SKIP TO Question 4.2) [ ] YES  
[ ] DON’T KNOW / REFUSED

4.1. WAS INCREASE 50% OR MORE?  
(INTERVIEWER SHOULD CHECK CARD E2 TO ASSESS IF RESPONSE IS A 50% INCREASE).

[ ] NO  
[ ] YES (MARK TALLY SHEET A AND SKIP TO Question 5) [ ] DON’T KNOW / REFUSED

4.2. Did you ever find you could drink a lot more before you got drunk? [ ] NO (SKIP TO Question 5)

[ ] Yes

[ ] DON’T KNOW / REFUSED

4.3. WAS INCREASE 50% OR MORE? CHECK CARD E2.

[ ] NO  
[ ] YES  
[ ] DON’T KNOW / REFUSED

1. Have you 3 or more times wanted to stop or cut down on drinking? DO NOT COUNT DIETING OR PREGNANCY.

[ ] NO  
[ ] YES (MARK TALLY SHEET A) [ ] DON’T KNOW / REFUSED

5.1 Have you ever tried to stop or cut down on drinking?

COUNT ANY REASON.  
[ ] NO (SKIP TO Question 6) [ ] YES  
[ ] DON’T KNOW / REFUSED

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

IF 3 OR MORE, MARK TALLY SHEET A AND SKIP TO Question 6. IF Don’t Know, ASK Question 5.2a. OTHERS SKIP TO Question 6.

\_\_\_ \_\_\_ TIMES  
[ ] DON’T KNOW / REFUSED

5.2a. Was it 3 or more times? [ ] NO

[ ] YES (MARK TALLY SHEET A) [ ] DON’T KNOW / REFUSED

1. Have you ever started drinking at times you promised yourself that you wouldn’t, or have you ever drunk more than you intended? For example, when you decided to drink 2 drinks and ended up drinking 4 or more?

[ ] NO (SKIP TO Question 7) [ ] YES

[ ] DON’T KNOW / REFUSED

6.1. Did this happen 3 or more times? [ ] NO

[ ] YES (MARK TALLY SHEET A) [ ] DON’T KNOW / REFUSED

1. Have you ever started drinking and become drunk when you didn’t want to? [ ] NO (SKIP TO Question 8)

[ ] YES (MARK TALLY SHEET A) [ ] DON’T KNOW / REFUSED

7.1 Did this happen 3 or more times? [ ] NO

[ ] YES  
[ ] DON’T KNOW / REFUSED

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

[ ] NO (SKIP TO Question 9) [ ] YES  
[ ] DON’T KNOW / REFUSED

8.1. Did this happen 3 or more times or for a month or more? [ ] NO

[ ] YES (MARK TALLY SHEET A) [ ] DON’T KNOW / REFUSED

1. 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?

[ ] NO (SKIP TO Question 10) [ ] YES  
[ ] DON’T KNOW / REFUSED

9.1. Did this period last for a month or more or did you have 3 or more periods like that? [ ] NO

[ ] YES (MARK TALLY SHEET A)

[ ] DON’T KNOW / REFUSED

10. There are several health problems that can result from long stretches of drinking. Did drinking ever cause you to have:

Liver disease or yellow jaundice? [E31\_1]

Stomach disease or make you vomit blood? [E31\_2]

Pancreatitis? [E31\_3]

Damage to your heart (cardiomyopathy)? [E31\_4]

Memory problems even when you weren’t drinking (so, not counting blackouts)? [E31\_6]

Any other physical health problems? IF YES, SPECIFY. [E31\_7]

SPECIFY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IF ALL CODED NO, SKIP TO Question 11. OTHERS CONTINUE.

10.1. Did you continue to drink knowing that drinking caused you to have health problems? [ ] NO

[ ] YES (MARK TALLY SHEET A) [ ] Don’t Know/Refused

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

[ ] NO (SKIP TO Question 12)  
[ ] YES (MARK TALLY SHEET A) [ ] DON’T KNOW / REFUSED

12. 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? [E33\_1]

Feeling jumpy or easily startled or nervous for more than 24 hours to the point that it interfered with your functioning? [E33\_2]

Having such trouble thinking clearly for more than 24 hours that it interfered with your functioning? [E33\_3]

**No Yes DK/REF**

**No Yes DK/REF**

Feeling paranoid or suspicious of people for more than 24 hours to the point that it interfered with your relationships? [E33\_4]

Hearing, seeing, or smelling things that weren’t really there? [E33\_5]

IF ALL ARE CODED NO, SKIP TO Question 13. OTHERS CONTINUE.

12.1. Did you continue to drink after you knew it caused you any of these problems? [ ] NO (SKIP TO Question 13)

[ ] YES (MARK TALLY SHEET A) [ ] DON’t Know/Refused

13. People who cut down, 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? **REPEAT INTRODUCTORY TEXT OFTEN. CODE IN COLUMN 1.**

**No Yes DK/ REF**

**No**

**Yes DK/ REF**

1. Did you have the shakes (hands trembling)? 2. Were you unable to sleep?  
3. Did you feel anxious?  
4. Did you feel depressed or irritable?

5. Did your heart beat fast or did you sweat? 6. Did you have nausea or vomiting?  
7. Did you feel physically weak?  
8. Did you have headaches?

9. Did you see or hear things that weren’t there? 10. Were you fidgety or restless?

IF NO YES’S CODED IN COLUMN 1, SKIP TO Question 14. IF ONLY ONE SYMPTOM IS CODED YES IN Question 13, parts 1-10, SKIP TO Question 13.3. OTHERS CONTINUE.

13.1. Was there ever a time when two or more of these problems occurred together? [ ] NO

[ ] YES  
[ ] DON’T KNOW / REFUSED

IF RESPONDENT ANSWERS "No" TO QUESTION 13.1 THEN END PROTOCOL. IF RESPONDENT ANSWERS "Yes" THEN CONTINUE TO QUESTION 13.2.

13.2. Which ones?

**CODE IN COL. 2  
IF 2+ SYMPTOMS IN COL. 2, MARK TALLY SHEET A. NOTE QUESTIONS 3 AND 4 ARE NOT PART OF THE DSM-IV CRITERIA.**

13.3. Have you ever taken a drink to keep from having any of these problems (or to make them go away) (**REVIEW ALL YES’S CODED IN COL. 1**)?

[ ] NO  
[ ] YES  
[ ] DON’T KNOW / REFUSED

IF RESPONDENT ANSWERS "No" TO QUESTION 13.3 THEN END PROTOCOL. IF RESPONDENT ANSWERS "Yes" THEN CONTINUE TO QUESTION 13.4.

13.4. Did this happen 3 or more times? [ ] NO

[ ] YES (MARK TALLY SHEET A) [ ] DON’T KNOW / REFUSED

1. 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?

[ ] NO (SKIP TO Question 15)  
[ ] YES (MARK TALLY SHEET A) [ ] DON’T KNOW / REFUSED

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

[ ] NO  
[ ] YES (MARK TALLY SHEET A) [ ] DON’T KNOW / REFUSED

1. When you stopped, cut down, or went without drinking, did you ever have the DT’s, that is, where you were very confused, extremely shaky, felt very frightened or nervous, or saw things that weren’t really there?

[ ] NO  
[ ] YES (MARK TALLY SHEET A) [ ] DON’T KNOW / REFUSED

IF RESPONDENT ANSWERS "No" TO QUESTION 15 THEN END PROTOCOL. IF RESPONDENT ANSWERS "Yes" THEN CONTINUE TO QUESTION 15.1.

15.1. On 3 or more different occasions have you taken a drink to keep from having the DT’s or to make them go away? [E39C]

[ ] NO  
[ ] YES (MARK TALLY SHEET A) [ ] DON’T KNOW / REFUSED