Parosmia Follow Up

Please complete the survey below.

Thank you!

You have indicated you have experienced or are experiencing parosmia. Parosmia is defined as a change in the normal perception or smells, such as when the smell of something familiar is distorted, or when something that normally smells pleasant now smells foul.

Please complete this survey regarding your experience with parosmia.

Today's Date

__________________________________

First Name

__________________________________

Last Name

__________________________________

Age

__________________________________

Gender Identity

☐ Male
☐ Female
☐ Other
☐ Prefer not to answer

Has your change in smell improved since you first noticed it?

☐ Yes
☐ No

How long after you noticed a change in smell did your smell start to improve?

☐ 0-1 week
☐ 1-2 weeks
☐ 2-4 weeks
☐ 1-4 months
☐ 4-6 months
☐ >6 months

How long after your initial symptoms began did you notice a distortion of smell?

☐ 0-1 week
☐ 1-2 weeks
☐ 2-4 weeks
☐ 1-4 months
☐ 4-6 months
☐ >6 months

Please describe your distorted sense of smell.

________________________________________

Is your smell disturbance constant or intermittent (ie. comes and goes)?

☐ Constant  ☐ Intermittent
At any time, did you experience smell distortion with any of the following?  
- ☐ Phantom smells (perception of a smell in the absence of that object)  
- ☐ Burning smell  
- ☐ Rotten meat or flesh smell  
- ☐ Gasoline smell  
- ☐ Cigarette smoke smell  
- ☐ Chemical smell  
- ☐ Other

Please describe.

What are you ABLE to smell? (ex. gas, smoke, alcohol, etc.)

__________________________________

What are you UNABLE to smell? (ex. body odor, feces, etc.)

__________________________________

What smells or items trigger your distortion of smell?

__________________________________

AT ITS WORST, how would you rate the severity of your smell disturbance? 1 = normal, 10 = severe

1 5 10

(Place a mark on the scale above)

AT PRESENT, how would you rate the severity of your smell disturbance? 1 = normal, 10 = severe

1 5 10

(Place a mark on the scale above)

Have you tried any treatments (ex. irrigations, smell retraining, etc.) to recover your sense of smell?  
- ☐ Yes  
- ☐ No

Please describe the treatments you have been using.

__________________________________

Have you taken any medications or supplements (ex. omega-3 fatty acids) to recover your smell?  
- ☐ Yes  
- ☐ No

Please describe the medications and/or supplements you have been using.

__________________________________