# Recurrent unexplained smell or taste experiences

Please print this form, check **one box per question**, and bring the completed form to your appointment. These are the questions your neurologist is most likely to ask about this symptom — answering them on paper first makes the visit faster and more accurate. If you are unsure of an answer, check "Not sure".

| Your name | Date of birth | Today's date |
|---|---|---|
| | | |

## 1A. Safety screen

*Answer every question. If any answer is "Yes" or "Not sure", follow the instruction shown below the question — these can be emergencies.*

**Has shaking lasted five minutes or longer, have episodes repeated without recovery, or is the person still unresponsive?**

☐ No ☐ Yes ☐ Not sure

If yes: Call emergency services now. Time the episode and do not put anything in the person's mouth.

**Did serious injury, breathing difficulty, blue lips, or pregnancy occur with the episode?**

☐ No ☐ Yes ☐ Not sure

If yes: Call emergency services now and follow dispatcher instructions.

**Is there persistent new weakness, severe headache, confusion, double vision, or difficulty speaking after the episode?**

☐ No ☐ Yes ☐ Not sure

If yes: Seek emergency assessment now, even if the shaking or spell has stopped.

**Was this the first convulsion, or did it occur in water, with diabetes, or with a known serious medical condition?**

☐ No ☐ Yes ☐ Not sure

If yes: Arrange emergency or same-day medical assessment; do not drive or swim alone.

## 1B. Timeline

*Use the first occurrence for recurrent episodes and the current episode for a changing symptom.*

**How did the symptom begin?**

☐ Suddenly, over seconds or minutes ☐ Over hours to days ☐ Gradually over weeks or months

☐ Longstanding or since childhood ☐ Not sure

*Use the first occurrence for recurrent episodes; use the current episode for a changing symptom.*

**What is the overall course?**

☐ One persistent episode ☐ Separate recurrent episodes ☐ Steadily worsening ☐ Fluctuating or variable

☐ Currently resolved

**Has this exact pattern been assessed before?**

☐ Definitely new ☐ The same pattern occurred before ☐ Present and stable for a long time ☐ Not sure

## 1C. Discriminating features

**How do the experiences occur?**

☐ Stereotyped episodes lasting seconds to minutes ☐ Persistent or long-lasting perception

☐ Variable episodes without a fixed pattern ☐ Not sure

**Is there altered awareness, déjà vu, fear, rising stomach sensation, or unresponsiveness during an episode?**

☐ Yes ☐ No ☐ Not observed

**Is there confusion, sleepiness, headache, weakness, or another symptom afterward?**

☐ Confusion or sleepiness ☐ Headache or sensory sensitivity ☐ No after-effect ☐ Not sure

**Is there persistent nasal/sinus disease, oral disease, a new medicine, or chemical exposure?**

☐ Nasal or sinus symptoms ☐ Oral or dental symptoms ☐ Medication or chemical exposure ☐ None

## 1D. Associated findings

*Record other clues and the effect on usual activities. New associated symptoms can change urgency.*

**Are there other neurological symptoms—weakness, numbness, speech change, double vision, swallowing difficulty, or severe imbalance?**

☐ Yes ☐ No ☐ Not sure

**Are there systemic clues—fever, weight loss, cancer, infection risk, pregnancy/postpartum status, or a new medication?**

☐ Yes ☐ No ☐ Not sure

**How much does this affect daily activity?**

☐ Noticeable but activities continue ☐ Some activities are limited ☐ Cannot perform usual activities ☐ Not sure

## 1E. Clinical context

*These answers help distinguish medication, medical, neurological, and pre-existing contributors.*

**Who is being assessed?**

☐ Adult or adolescent ☐ Child under 12 ☐ Adult aged 65 or older

**Could a medicine, substance, withdrawal, or recent dose change be relevant?**

☐ No plausible contributor ☐ Yes or possibly ☐ Not reviewed

*Include sedatives, dopamine-blocking drugs, stimulants, decongestants, anticholinergics, alcohol, and non-prescribed substances when relevant.*

**Is there a relevant neurological, muscular, metabolic, cardiovascular, autoimmune, or sleep disorder?**

☐ No known relevant condition ☐ Yes ☐ Not sure

**What prior information is available?**

☐ A previous examination or investigation ☐ Prior records but no clear explanation ☐ No useful prior assessment ☐ Not sure

## 1F. Additional history

Use the lines below to record exact dates and times, witness details, current medications and any recent dose changes, prior tests or investigation reports, and what your usual baseline function is.

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This form collects your history only. It cannot diagnose, triage, or exclude an emergency, and it is not medical advice. Call 911 for severe, sudden, or worsening symptoms.