MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Recurrent unexplained smell or taste experiences

Structured history, interpretation & clinical review

Symptom 81 of 94
Clinical educational workbook
Version 1.0 · October 2026

Not for clinical use. This guide cannot diagnose, triage, or exclude an emergency. Seek emergency care for severe, sudden, or worsening symptoms.

Contents

Scope and safe use 3

Section 1: Input form 4

- 1A. Immediate safety screen 4
- 1B. Timeline 4
- 1C. Discriminating features 5
- 1D. Associated findings 5
- 1E. Clinical context 5

Section 2: Interpreting the input form 7

Section 3: Clinical review 9

Selected references 11

> **Document purpose**
> A structured educational history and diagnostic-reasoning workbook. Treatment is outside its scope.

Scope and safe use

Recurrent unexplained smell or taste experiences require event stereotypy, duration, awareness, associated neurological features, nasal/oral disease, and exposure review.

Not for clinical use.
This educational workbook does not diagnose, triage, estimate probability, replace examination, or exclude an emergency. If a safety-screen answer is Yes or uncertain, follow the stated action rather than continuing routine interpretation.

How to complete the workbook

- Record the current episode and the person’s usual baseline; use a witness account for events with impaired awareness.
- Check one option per question unless a clinician documents a different combination. “Not sure” is unresolved information, not a negative answer.
- Complete the safety screen before all other sections. Record exact onset or last-known-well time for sudden deficits.
- Use Section 2 only after the form is complete. More than one pattern may be relevant; urgency takes precedence.
- Use Section 3 to plan focused examination and clinician-selected investigations. No test is automatic or universally required.

Specific escalation rule

New severe headache, new focal weakness or numbness, new speech/language difficulty, reduced consciousness, a prolonged seizure, severe breathing or swallowing difficulty, sudden visual loss, or rapidly progressive weakness requires emergency assessment. Call 911 in the United States.

Section 1: Input form

Checkbox history for Recurrent unexplained smell or taste experiences

1A. Immediate safety screen

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.

> **Stop rule:** Any Yes answer triggers the action printed under that question. Any Not sure answer requires prompt in-person clarification; do not treat it as No.

1B. Timeline

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

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

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

Additional history and documentation

Record exact dates/times, witness details, relevant medication doses and changes, prior investigation reports, and the person’s baseline function.

Section 2: Interpreting the input form

Answer combinations generate a differential and an assessment pathway—not a diagnosis.

> **Precedence:** Emergency safety answers override every pattern below. Otherwise, the highest-urgency fully matched pattern takes precedence. If entries are incomplete, contradictory, or match no pattern, use the unresolved-information pathway.

Pattern 1: Stereotyped focal-event pattern

How do the experiences occur? Stereotyped episodes lasting seconds to minutes
Is there altered awareness, déjà vu, fear, rising stomach sensation, or unresponsiveness during an episode? Yes

Urgent assessment pattern — Same day

Brief stereotyped smell/taste episodes with altered awareness require seizure-pathway assessment.

Differential to review:

- Focal seizure with olfactory or gustatory aura

Action: Arrange same-day medical assessment. If symptoms are rapidly worsening or severe, call 911.

Pattern 2: Post-event neurological pattern

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

Urgent assessment pattern — Same day

Confusion or sleepiness after an episode raises concern for a neurological event.

Differential to review:

- Focal seizure with olfactory or gustatory aura
- Migraine or another neurological sensory phenomenon

Action: Arrange same-day medical assessment. If symptoms are rapidly worsening or severe, call 911.

Pattern 3: Persistent local chemosensory pattern

How do the experiences occur? Persistent or long-lasting perception
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

Prompt clinical review pattern — Promptly

Persistent perceptions with local disease or exposure follow an ENT, oral, and medication assessment.

Differential to review:

- Phantosmia, parosmia, or persistent gustatory phantom
- Medication, toxic, metabolic, or psychiatric perceptual disorder

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Pattern 4: Headache-linked sensory pattern

Is there confusion, sleepiness, headache, weakness, or another symptom afterward? Headache or sensory sensitivity

Prompt clinical review pattern — Promptly

Time-linked headache or sensory sensitivity requires migraine and other neurological causes to be distinguished.

Differential to review:

- Migraine or another neurological sensory phenomenon
- Focal seizure with olfactory or gustatory aura

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Unresolved-information pathway: The entries need structured in-person characterization.

Prompt clinical review pattern — Promptly

Do not guess missing answers or convert uncertainty into reassurance. Document what is unknown, perform an in-person examination, clarify the timeline with a witness or records when available, and reassess if any new feature appears.

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Section 3: Clinical review

Diagnostic modules and focused investigation logic

The examination comes before a test list. Select investigations only after localization, urgency, comorbidity, pregnancy status, renal function, anticoagulation, and prior results have been considered.

3.1 Focal seizure with olfactory or gustatory aura

Discriminating features: Brief stereotyped episodes, sometimes with déjà vu, fear, altered awareness, automatisms, or postictal symptoms.

Logical investigations: Prompt neurological event assessment with EEG/MRI when seizure features are present.

3.2 Phantosmia, parosmia, or persistent gustatory phantom

Discriminating features: Persistent or variable perceptions without impaired awareness, often after infection or with sinonasal/oral disease.

Logical investigations: ENT/oral assessment, smell/taste examination, and exposure review.

3.3 Migraine or another neurological sensory phenomenon

Discriminating features: Time-linked headache, sensory sensitivity, or other aura symptoms may accompany atypical chemosensory experiences.

Logical investigations: Neurological headache/event assessment; imaging when onset or examination is atypical.

3.4 Medication, toxic, metabolic, or psychiatric perceptual disorder

Discriminating features: Exposure, systemic illness, mood/psychotic context, or broader perceptual disturbance may contribute.

Logical investigations: Medication, medical, toxicology, and mental-health assessment according to associated features.

Reassessment and documentation

- If the symptom pattern changes, repeat the safety screen and timeline rather than carrying forward an earlier interpretation.
- If a test is unrevealing but the deficit persists or progresses, revisit localization and seek specialist review; a normal result does not automatically end assessment.
- If symptoms resolve, document duration, completeness of recovery, recurrence, and any residual deficit. Resolved sudden focal symptoms can still require urgent vascular assessment.
- If the history and examination conflict, obtain collateral information and in-person review rather than forcing a single diagnostic label.

Selected references

Sources provide background standards and do not replace local emergency pathways or current specialist guidance. Accessed October 2026.

1. National Institute for Health and Care Excellence. (2022, updated 2025). *Epilepsies in children, young people and adults (NG217)*. https://www.nice.org.uk/guidance/ng217

2. National Institute for Health and Care Excellence. (2010, updated 2023). *Transient loss of consciousness (“blackouts”) in over 16s (CG109)*. https://www.nice.org.uk/guidance/cg109