Attachment 42

Additional Audition Olfaction Taste Questions

OMB: 0925-XXXX
Expiration Date: XX/XX/XXXX

Additional Audition Olfaction Taste Questions

Estimated time burden: 3 minutes

Additional Audition Olfaction Taste Questions - Adults and Children 10-17

[**00-ATO-self**]

On the next screens, we will ask you questions about your health and health-related behaviors. Consider each question by itself, then choose or type in an answer that best shows your experience.

After you make your choice, click on the NEXT button to go on to the next question. If you want to change your last answer, click on the GO BACK button to return to the previous question and then choose or type in a different answer.

Click on the CONTINUE button when you are ready to begin.

[**01- ATO- Self**]

Please select all that apply.

Has a doctor, nurse, or other medical professional told you that you have...

- ☐ Glucose-6-phosphate dehydrogenase deficiency?
- ☐ Myasthenia gravis?

[**02- ATO- Self**]

Please select all that apply.

Have you ever experienced any of the following?

- ☐ Head injury
- ☐ Loss of consciousness associated with head injury
- ☐ Facial injury
- ☐ Amnesia (memory loss of events surrounding injury)

- ☐ Jaw surgery
- ☐ Third molars (wisdom teeth) removed
- ☐ Mouth or throat cancer
- ☐ Chemotherapy
- ☐ 3 or more ear infections
- ☐ Earaches or plugged feeling in ears
- ☐ Ear tubes inserted
- ☐ Dental trauma
- ☐ Tonsillectomy
- ☐ Severe gastrointestinal illness, as indicated by frequent vomiting, diarrhea, or dehydration
- ☐ Sneezing, itchy nose
- ☐ Prolonged, abnormal nasal discharge
- ☐ Trouble breathing through nose
- ☐ Postnasal drip
- ☐ Sinus pain or headache
- ☐ Nasal polyps
- ☐ Deviated septum
- ☐ Nosebleeds
- ☐ Broken nose
- ☐ Persisting allergic rhinitis (nasal allergy)
- ☐ Vasomotor rhinitis
- ☐ Other nasal or sinus problems
- ☐ Injury of the nose or face

[**03- ATO- Self**]

Do you currently smoke?

- ☐ No
- ☐ Yes

[**03a- ATO- Self**]

If yes, how many cigarettes per day?

[**05- ATO- Self**]

Do you drink caffeinated beverages?

- ☐ No
- ☐ Yes

[**06- ATO- Self**]

How many hours did you sleep last night?

[**07- ATO- Self**]

Are you taking the sleep aid Lunesta®?

- ☐ No
- ☐ Yes

[**08- ATO- Self**]

Are you taking any medications that may interfere with your taste?

- ☐ No
- ☐ Yes

[**09- ATO- Self**]

Have you been to the dentist in the last 48 hours?

- ☐ No
- ☐ Yes

[**10- ATO- Self**]

Select ALL of the following statements that apply to you now:

- ☐ I have a normal sense of smell
- ☐ My sense of smell is distorted, that is, things smell peculiar
- ☐ I experience a smell when nothing is there (phantom smell)
- ☐ My sense of smell is heightened (hypersensitive)
- ☐ My sense of smell is diminished (partial loss)
- ☐ My sense of smell is absent (complete loss)

[**11- ATO- Self**]

Compared to others your age, how would you rate your sense of smell?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

[**12- ATO- Self**]

Have you noticed any recent change in your ability to detect odors?

- ☐ No change in my ability to detect odors
- ☐ Slight decrease in my ability to detect odors
- ☐ Moderate decrease in my ability to detect odors
- ☐ Severe decrease in my ability to detect odors

[**14-ATO-self**]

How often do you find it difficult to follow a conversation if there is background noise, for example, when other people are talking, TV or radio is on, or children are playing?

- ☐ Always
- ☐ Usually
- ☐ About half the time
- ☐ Seldom
- ☐ Never
- ☐ Don't know

[**17-ATO-self**]

Have you ever used assistive listening devices (ADLs), such as FM systems, closed-captioned television, amplified telephone, relay services or a sign-language interpreter?

- ☐ Yes
- ☐ No
- ☐ Don't know

[**18-ATO-self**]

In the past 12 months, have you been bothered by ringing, roaring, or buzzing in your ears that lasts for 5 minutes or more?

- ☐ Yes
- ☐ No
- ☐ Don't know

[**18a -ATO-self**]

How long have you been bothered by this ringing, roaring, or buzzing in your ears or head?

- ☐ Less than three months

- ☐ Three months to a year
- ☐ One to four years
- ☐ Five to nine years
- ☐ Ten or more years
- ☐ Don't know

[**18b-ATO-self**]

In the past 12 months, how often have you had this ringing, roaring, or buzzing in your ears or head?

- ☐ Almost always
- ☐ At least once a day
- ☐ At least once a week
- ☐ At least once a month
- ☐ Less frequently than once a month
- ☐ Don't know

[**18c-ATO-self**]

How much of a problem is this ringing, roaring, or buzzing in your ears or head?

- ☐ No problem
- ☐ A small problem
- ☐ A moderate problem
- ☐ A big problem
- ☐ A very big problem
- ☐ Don't know

[**19-ATO-self**]

Have you ever used firearms for any reason?

- ☐ Yes
- ☐ No

[**20-ATO-self**]

Have you ever had a job where you were exposed to loud sounds or noises for 4 or more hours a day, several days a week? Loud means so loud that you must speak in a raised voice to be heard.

- ☐ Yes
- ☐ No
- ☐ Don't know

[**20a-ATO-self**]

For how many months or years have you been exposed to loud sounds or noises for four or more hours a day, several days a week?

- ☐ Less than 3 months
- ☐ Three to eleven months
- ☐ One to two years
- ☐ Three to four years
- ☐ Five to nine years
- ☐ Ten to fourteen years
- ☐ Fifteen or more years
- ☐ Don't know

[**21-ATO-self**]

In your work, were you exposed to a very loud noise? Very loud noise is a noise that is so loud you have to shout to be understood or heard by someone standing three feet away from you.

- ☐ Yes
- ☐ No
- ☐ Don't know

[**21a-ATO-self**]

How many months or years did you work in jobs where you were exposed to very loud noise, several days a week?

- ☐ Less than 3 months
- ☐ Three to eleven months
- ☐ One to two years
- ☐ Three to four years
- ☐ Five to nine years
- ☐ Ten to fourteen years
- ☐ Fifteen or more years
- ☐ Don't know

[**22-ATO-self**]

Outside of a job, have you ever been exposed to very loud noise or music for 10 or more hours a week? This is noise so loud that you have to shout to be understood or heard by someone standing three feet away from you. Examples are noise from power tools, lawn mower, farm machinery, cars, trucks, motorcycles, motorboats or loud music.

- ☐ Yes
- ☐ No
- ☐ Don't know

[**23-ATO-self**]

In the past 12 months, how often did you wear protection devices (ear plugs, ear muffs) when exposed to very loud sounds or noise? Please include both on-the-job and off-the-job exposures.

- ☐ Always
- ☐ Usually
- ☐ About half the time
- ☐ Seldom
- ☐ Never

- [ ] No noise exposure in the past 12 months
- [ ] Don't know

[**25-ATO-self**]

Have you ever had a job or a hobby where you were regularly exposed to any of the following? Check all that apply.

- [ ] Herbicides/Pesticides
- [ ] Acid or welding fumes
- [ ] Industrial solvents or cleaning products
- [ ] Cigarette smoke
- [ ] Metal dusts
- [ ] Wood dusts
- [ ] Formaldehyde
- [ ] Glues or adhesives

[**26-ATO-self**]

During the past 12 months, how would you rate your sense of taste for salty, sour, sweet or bitter things?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ I have lost my sense of taste
- ☐ Don't know

[**27-ATO-self**]

During the past 12 months, have you had any of the following problems with your sense of taste? Check all that apply.

- ☐ Can't taste some things
- ☐ Can't taste most things
- ☐ Some things don't taste right
- ☐ Taste things when nothing should be there
- ☐ Things taste stronger than they should
- ☐ None of these problems

[**27a-ATO-self**]

(if answered anything other than none of these or don't know)

How long have you had a problem with your sense of taste?

- ☐ Less than three months
- ☐ Three to eleven months
- ☐ One to four years
- ☐ Five to nine years
- ☐ Ten or more years
- ☐ Don't know

[**28-ATO-self**]

In the last 12 months, have you had pain or burning in the mouth or tongue not due to mouth sores?

- ☐ Yes
- ☐ No
- ☐ Don't know

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Additional Audition Olfaction Taste Questions - Proxy Report for Children 10-17

[**00-ATO proxy**]

On the next screens, we will ask you to answer questions about your child and his/her health and health-related behaviors. Consider each question by itself, then choose or type in an answer that best shows your child's experience.

After you make your choice, click on the NEXT button to go on to the next question. If you want to change your last answer, click on the GO BACK button to return to the previous question and then choose or type in a different answer.

Click on the CONTINUE button when you are ready to begin.

[**01- ATO- Proxy**]

Please select all that apply.

Has a doctor, nurse, or other medical professional said that your child has...

- ☐ Glucose-6-phosphate dehydrogenase deficiency
- ☐ Myasthenia gravis

[**02- ATO- Proxy**]

Please select all that apply.

Has your child ever experienced any of the following?

- ☐ Head injury
- ☐ Loss of consciousness associated with head injury
- ☐ Facial injury
- ☐ Amnesia (memory loss of events surrounding injury)
- ☐ Jaw surgery
- ☐ Third molars (wisdom teeth) removed

- ☐ Mouth or throat cancer
- ☐ 3 or more ear infections
- ☐ Earaches or plugged feeling in ears
- ☐ Ear tubes inserted
- ☐ Dental trauma
- ☐ Tonsils or adenoids removed
- ☐ Severe gastrointestinal illness, as indicated by frequent vomiting, diarrhea, or dehydration
- ☐ Radiation treatment
- ☐ Chemotherapy
- ☐ Used firearms for target shooting, hunting, or for any other purposes
- ☐ Had a job where he/she was exposed to loud noise for 5 or more hours a week (loud noise meaning noise so loud that you had to speak in a raised voice to be heard)
- ☐ Outside of a job, been exposed to steady loud noise or music for 5 or more hours a week (examples are noise from power tools, lawn mowers, farm machinery, cars, trucks, motorcycles or loud music)
- ☐ Worn hearing protection when exposed to these loud noises
- ☐ Sneezing, itchy nose
- ☐ Prolonged, abnormal nasal discharge
- ☐ Trouble breathing through nose
- ☐ Postnasal drip
- ☐ Sinus pain or headache
- ☐ Sinus infection
- ☐ Nasal polyps
- ☐ Deviated septum
- ☐ Nosebleeds
- ☐ Broken nose

- ☐ Allergic rhinitis (nasal allergy)
- ☐ Vasomotor rhinitis
- ☐ Other nasal or sinus problem

[**03- ATO- Proxy**]

Does your child currently smoke?

- ☐ No
- ☐ Yes
- ☐ Don't know

[**03a- ATO- Proxy**]

If yes, how many cigarettes per day?

_____

[**05- ATO- Proxy**]

Does your child drink caffeinated beverages?

- ☐ No
- ☐ Yes
- ☐ Don't know

[**06- ATO- Proxy**]

How many hours did your child sleep last night?

(If you do not know, please enter 99)

_____

[**07- ATO- Proxy**]
Is your child taking the sleep aid Lunesta®?

- ☐ No
- ☐ Yes

[**08- ATO- Proxy**]
Is your child taking any medications that may interfere with his/her taste?

- ☐ No
- ☐ Yes

[**09- ATO- Proxy**]
Has your child been to the dentist in the last 48 hours?

- ☐ No
- ☐ Yes
- ☐ Don't know

[**10- ATO- Proxy**]
Select ALL of the following statements that apply to your child now:

- ☐ He/she has a normal sense of smell
- ☐ His/her sense of smell is distorted, that is, things smell peculiar
- ☐ He/she experiences a smell when nothing is there (phantom smell)
- ☐ His/her sense of smell is heightened (hypersensitive)
- ☐ His/her sense of smell is diminished (partial loss)
- ☐ His/her sense of smell is absent (complete loss)

[**11- ATO- Proxy**]
Compared to others his/her age, how would you rate your child's sense of smell?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

[**12- ATO- Proxy**]

Has your child noticed any recent change in his/her ability to detect odors?

- ☐ No change in his/her ability to detect odors
- ☐ Slight decrease in his/her ability to detect odors
- ☐ Moderate decrease in his/her ability to detect odors
- ☐ Severe decrease in his/her ability to detect odors

[**14-ATO-proxy**]

How often does your child find it difficult to follow a conversation if there is background noise, for example, when other people are talking, TV or radio is on, or children are playing?

- ☐ Always
- ☐ Usually
- ☐ About half the time
- ☐ Seldom
- ☐ Never
- ☐ Don't know

[**15-ATO-proxy**]

Has your child ever used assistive listening devices (ADLs) such as FM systems, closed-captioned television, amplified telephone, relay services or a sign-language interpreter?

- ☐ Yes
- ☐ No
- ☐ Don't know

[**16-ATO-proxy**]

In the past 12 months, has your child been bothered by ringing, roaring, or buzzing in his/her ears?

- ☐ Yes
- ☐ No
- ☐ Don't know

[**16a-ATO-proxy**]

How long has your child been bothered by this ringing, roaring, or buzzing in his/her ears or head?

- ☐ Less than 3 months
- ☐ Three months to a year
- ☐ One to four years
- ☐ Five to nine years
- ☐ Ten or more years
- ☐ Don't know

[**16b-ATO-proxy**]

How much of a problem is this ringing, roaring, or buzzing in the ears or head to your child?

- ☐ No problem
- ☐ A small problem
- ☐ A moderate problem
- ☐ A big problem
- ☐ A very big problem
- ☐ Don't know

[**19-ATO-proxy**]

Has your child had regular exposure to any of the following? Check all that apply.

- ☐ Herbicides/Pesticides
- ☐ Acid or welding fumes
- ☐ Industrial solvents or cleaning products
- ☐ Cigarette smoke
- ☐ Metal dusts
- ☐ Wood dusts
- ☐ Formaldehyde
- ☐ Glues or adhesives
- ☐ Don't know

[**21-ATO-proxy**]

In the last 12 months, has your child had pain or burning in his/her mouth or tongue that was not due to mouth sores?

- ☐ Yes
- ☐ No
- ☐ Don't know

[**20-ATO-proxy**]

During the past 12 months, how would rate your child's sense of taste for salty, sour, sweet, or bitter things?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ My child has lost his/her sense of taste
- ☐ Don't know
