GILL, LADNER & PRIEST, PLLC
403 South State Street
Jackson, MS 39201-5020

FOSAMAX QUESTIONNAIRE

Referred by:______________________________ Today's date:__________________________

COMPLETED BY:____

CLIENT'S NAME:____

ADDRESS: ____

____

TELEPHONE NUMBER:

Home______________________ Work_____________________ Cell_________________

DATE OF BIRTH:_______________________ DRIVER'S LICENSE NO: _________________

SOCIAL SECURITY NO.: ________________

EDUCATION: HIGH SCHOOL.: ____

COLLEGE: ____

ADVANCED DEGREES: _______________________________________

IF YOU ARE MARRIED, NAME OF SPOUSE: ____________________________________

PRIOR NAMES YOU HAVE USED: ____

____

IF YOU HAVE CHILDREN:

Name: ____ Birthdate: ______________ M / F

Name: ____ Birthdate: ______________ M / F

Name: ____ Birthdate: ______________ M / F

Name: ____ Birthdate: ______________ M / F

NEAREST RELATIVE/FRIEND *(for purpose of another contact if unable to reach you)*

Name: ____

Address: ____

Telephone: ____

Relationship: ____

PRODUCT INFORMATION

Date Fosamax prescribed: ________________________ Dosage:_________________________

Date Fosamax prescription was filled:____

Date Fosamax stopped: ________________________ Dosage:_________________________

How often did you take the drug and at what dosage?:_____________________________________

Doctor who prescribed: ____

Reason drug was prescribed: ____

____

Do you currently have your prescription bottles or pharmacy records? *(circle one)* Yes No

If so, please hold on to all prescription bottles. DO NOT DESTROY.

Which pharmacy(s) have you had you prescriptions filled:

Name: ____

Address: ____

Telephone: ____

Name: ____

Address: ____

Telephone: ____

Please describe any oral or dental surgery performed **BEFORE** taking Fosamax.

____

____

____

Name and address of doctor(s) who treated you for these problems:__________________________

____

____

____

Please describe any oral or dental surgery performed **AFTER** taking Fosamax. _______________

____

____

____

Name and address of doctor(s) who treated you for these problems:________________________

____

Since taking Fosamax have you experienced jaw pain or been told you have osteonecrosis? If you sought treatment, list the doctor and a brief description of what you were told:

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____

Please list **ALL** medications you have taken **BEFORE** taking Fosamax.

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____

Please list **ALL** medications are you currently taking:

____

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Please check if you have had any of the following symptoms **BEFORE** or **SINCE** taking Fosamax.

	BEFORE	**SINCE**	**DATE**
Severe pain in jaw	_______	_______	_______
Swelling in jaw line or gum	_______	_______	_______
Infection of gums or poor healing	_______	_______	_______
Bone degeneration or bone death in jaw	_______	_______	_______
Anemia	_____________	_______	_______
Oral or gum disease	_____________	_______	_______

Please check if you have had any of the following CONDITIONS OR MEDICATIONS OR TREATMENTS **BEFORE** or **SINCE** taking Fosamax.

	BEFORE	**SINCE**	**DATE**
Radiation therapy	_______	_______	_______
Chemotherapy	_______	_______	_______
Steroid therapy	_______	_______	_______
Cancer	_______	_______	_______
Anemia	_______	_______	_______
Oral or gum disease (infections)	_______	_______	_______
Poor dental health	_______	_______	_______

PAST MEDICAL HISTORY BEFORE USE OF FOSAMAX

Please give dates when you became aware of any of the following health problems, if possible:

Problem	**Date**
Anemia	______________________
Cancer	______________________
Periodontal or gum disease	______________________
Paget's disease	______________________

Tobacco use (ever): ____

History of any illegal IV drug use:____

History of **any** illegal drug use: ____

History of **any** alcohol use: ____

Past medical history (include medical and surgical illness, hospitalizations, etc):

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