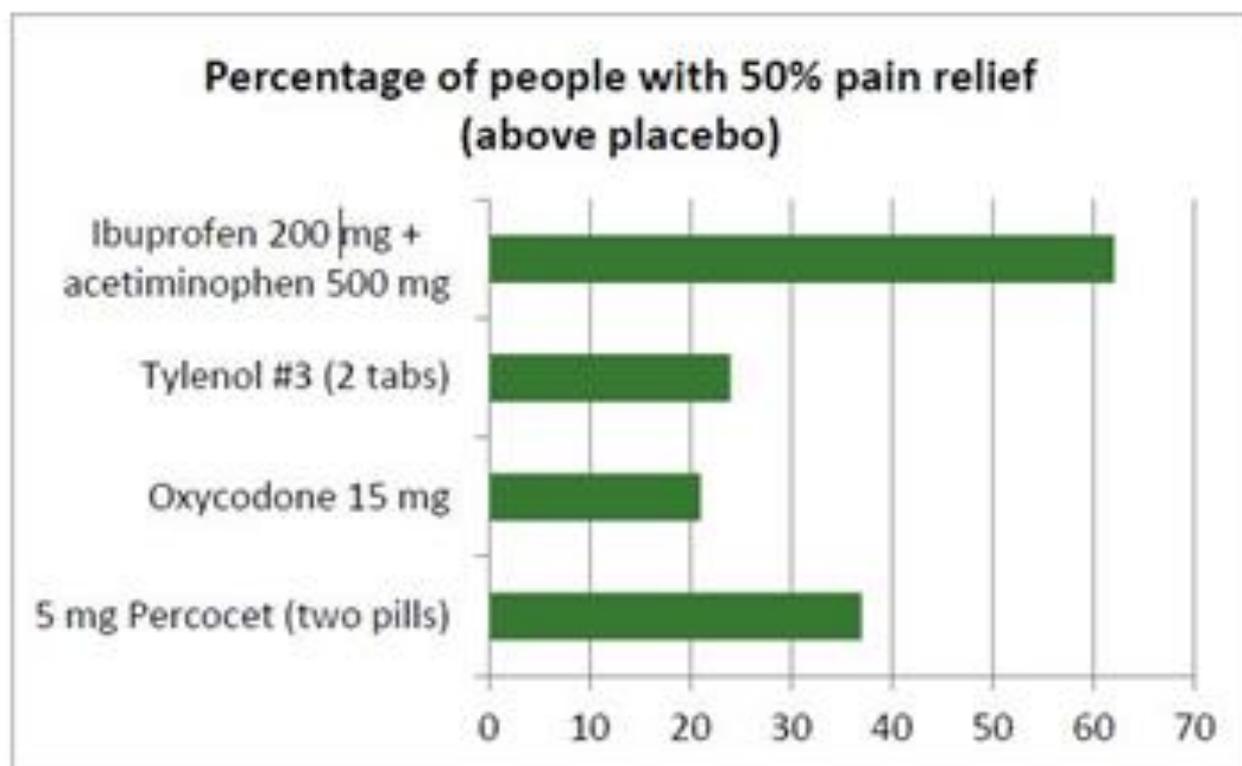


NSAIDs are stronger pain medications than opioids



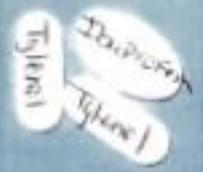
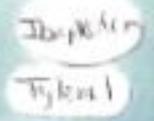
For more information, visit nsc.org/rxpainkillers

200 mg ibuprofen (Adult) - Maximum 2400 mg



Take up to 600 mg ibuprofen plus 1000 mg tylenol (acetaminofen) every 6 hours

600 mg prescription strength ibuprofen - Maximum 2400 mg



These tylenol pills are 500mg, but they also come in 350 mg (regular strength) or 650 mg (arthritis strength)

Maximum 4000 mg/day

**Dr. Theresa E. Madden
& Assoc., PLLC
304 West Bay Dr NW, Suite 201
Olympia, WA 98502**



**PRE-OPERATIVE
AND
POST-OPERATIVE
INSTRUCTIONS**

360-459-5900

Health History

Name: _____ SSN: _____ Date of Birth: _____

Mailing address (if we don't already have it on file) _____

Preferred Phone#: _____ Secondary Phone#: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Do you like email contact? _____ Email Address: _____

We routinely use email to facilitate communication concerning patient care. This email may contain your name, X-rays and treatment details. Although we cannot guarantee the security or privacy of emails due to the nature of the internet, we can communicate with you and on your behalf via email. With the understanding that your personal service may not be secure, please sign below if you give us permission to communicate using your regular email address. Signature: _____

Reason for seeing us: _____

Have you ever had periodontal treatment? _____ Are you having mouth, head or face pain now? _____

Have you ever had a trauma to the face or mouth? _____ Has it been hard for the dentist to get you numb? _____

If you usually take antibiotics for your dental visits, could you tell us why? _____

On a scale of 1 to 10, how physically and/or emotionally comfortable are you in a dental office? _____

(1 = Love Being Here) _____ (10 = Maximum Discomfort)

Primary care provider's name: _____ Provider's phone #: _____

Date, results of last physical examination: _____

Under the care of other physicians? If so, please list:

Physician	Phone #	Reason
_____	_____	_____
_____	_____	_____

List all hospitalizations and surgeries: _____

Any difficulty with previous general anesthesia or intravenous sedation? _____

Please provide your medication & supplement list here, electronically or on a separate paper:

Prescribed _____

"Over-the-counter" _____

"Natural/herbal" supplements _____

Preferred Pharmacy: _____

What medications and strategies do you use when in pain (headache, arthritis, post-surgery etc.)? _____

Bisphosphonates ever (Fosamax)? _____ Steroids in the past 2 years? _____

Do you completely abstain from alcohol? _____

How many alcoholic drinks do you average per occasion? (circle) >12, 7-10, 3-6, 1-2 (1 standard drink= 12 oz regular 4-5% beer, 6 oz of wine or 1.5 oz of liquor) _____ How many in the last 24 hours? _____

Do you use tobacco? _____ What type of tobacco? _____ If yes, would you like to quit? _____

How long have you used tobacco? _____

Are you on a special diet? _____ Ever taken diet pills (fen-phen, dexedrine etc)? _____

Do you take antidepressant medications? _____ Do you ever need a tranquilizer to sleep or relax? _____

How many cups of caffeinated beverages do you consume per day? _____ Do they contain sugar? _____

Do you smoke or chew tobacco? _____ Previous tobacco use? _____ How much and for how many years? _____

Would you like to quit? _____ Do others in your household smoke? _____

Women: Could you be pregnant? _____ Nursing? _____ Taking contraceptives or HRT? _____ Post-menopausal? _____

Does your intestinal tract react poorly to antibiotics? _____ Ever had C. difficile infection? _____

(over)

Opioid Risk Tool

Introduction

The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behavior. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations.

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Allergies:		
Acrylics	Y	N
Anaphalaxis	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
Sulpha	Y	N
Others:	Y	N
List: _____		

Cardiovascular:		
Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain or Angina	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N

Endocrine:		
Diabetes	Y	N
Gout	Y	N
Hormonal Change	Y	N
Thyroid Problems	Y	N

Gastrointestinal:		
Acid Reflux	Y	N
GERD	Y	N
Soft or Special Diet	Y	N
Ulcers	Y	N

Hematological:		
Bleeding Problems	Y	N
Hepatitis	Y	N

Musculoskeletal:		
Back Pain	Y	N
Fibromyalgia	Y	N
Joint Pain	Y	N

Eyes, Ears, Nose and Throat:		
Changes in Hearing	Y	N
Change in Vision	Y	N
Dysphagia	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeds	Y	N
Sinus Problems	Y	N
Tonsillectomy	Y	N
Tinnitus (ear ringing)	Y	N

General:		
Current Weight: _____ lbs		
Height: _____ ft _____ in		
Cancer	Y	N
Fatigue/Tired	Y	N
General Weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
Joint Replacement	Y	N
Liver Problems	Y	N
Pain Contract	Y	N
Rheumatic Fever	Y	N
Radiation Treatments	Y	N
Weight Changes	Y	N

Psychiatric:		
ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating Disorder	Y	N
Excessive Stress	Y	N
Memory Problems	Y	N

Sleep:		
Daytime Sleepiness	Y	N
Morning Headaches	Y	N
Obstructive Sleep Apnea	Y	N
Do you use a CPAP	Y	N
Have you been told that you snore?	Y	N

Oral:		
Bleeding Gums:	Y	N
Dry Mouth	Y	N
Jaw Problems (TMJ)?	Y	N
Clicking?	Y	N
Pain?	Y	N
Difficulty Swallowing?	Y	N
Difficulty Chewing?	Y	N
Orthodontics/Invisalign	Y	N
Periodontal Disease	Y	N
Teeth Clenching/grinding	Y	N
Tooth pain	Y	N
Antibiotics before dental procedures?	Y	N

Neurological:		
Alzheimer's Disease	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory Loss	Y	N
Multiple Sclerosis (MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N
Tremors	Y	N

Respiratory:		
Asthma	Y	N
Breathing Problems	Y	N
Chest Pressure	Y	N
Congestion	Y	N
Emphysema	Y	N
Orthopnea	Y	N
Pneumonia	Y	N
Pulmonary Embolism	Y	N
Tuberculosis	Y	N

Other Health Challenges? Y N
Please list:

If you are under a pain contract can you please provide us with whom this is with? _____

Family history of any of the above? _____

Please list your current vaccinations: _____

I attest that the information provided is accurate & truthful. I will promptly inform Dr. Madden of any future changes in my health & medication list.
Patient Signature _____ Date _____ Reviewed by _____ ASA Class I II III IV



AT&T 10:20 AM 87%

< 2  i

+1 (253) 201-1489

Text Message
Today 10:19 AM

You have been added as a patient.
Please text the name of your
medication each time you take it.

Dianna Koeller - ibuprofen

Thank you, I have recorded your
medication(s). Please rate your
pain management on a scale from 0
(Well managed) to 10 (Immense
Pain, Need Help Managing)

  | Text Message 

Sure Sorry no Tomorrow

Q W E R T Y U I O P
A S D F G H J K L
↑ Z X C V B N M 

123   space return

Edit

MessageLog

Patient ID

Medication(s)

Pain Level

Reported Symptoms

Time Received

Save

[Back to List](#)

Message Log

Search records: [Clear](#)

Patient Name	Medication(s)	Pain Level	Symptoms	Message Received	
[REDACTED]	Ibuprofen acetaminophen	2	Slight swelling	12/7/2017 11:02:46 PM	Edit Delete
[REDACTED]	Ibuprofen	0	Swelling slight bruising	12/7/2017 5:58:35 PM	Edit Delete
[REDACTED]	Ibuprofen	1	Swelling	12/7/2017 1:34:59 PM	Edit Delete
[REDACTED]	Ibuprofen acetaminophen	2	Swelling	12/7/2017 8:57:47 AM	Edit Delete
[REDACTED]	Ibuprofen acetaminophen	1	Swelling	12/6/2017 10:06:23 PM	Edit Delete
[REDACTED]	Ibuprofen	1	Swelling	12/6/2017 1:54:29 PM	Edit Delete
[REDACTED]	Ibuprofen	2	Swelling	12/6/2017 8:00:05 AM	Edit Delete
[REDACTED]	Ibuprofen	2	Swelling	12/5/2017 5:34:34 PM	Edit Delete
[REDACTED]	Ibuprofen	2	Swelling	12/5/2017 12:57:39 PM	Edit Delete
[REDACTED]	Ibuprofen acetaminophen	3	Swelling soreness	12/5/2017 7:46:58 AM	Edit Delete

Pain Management Agreements:

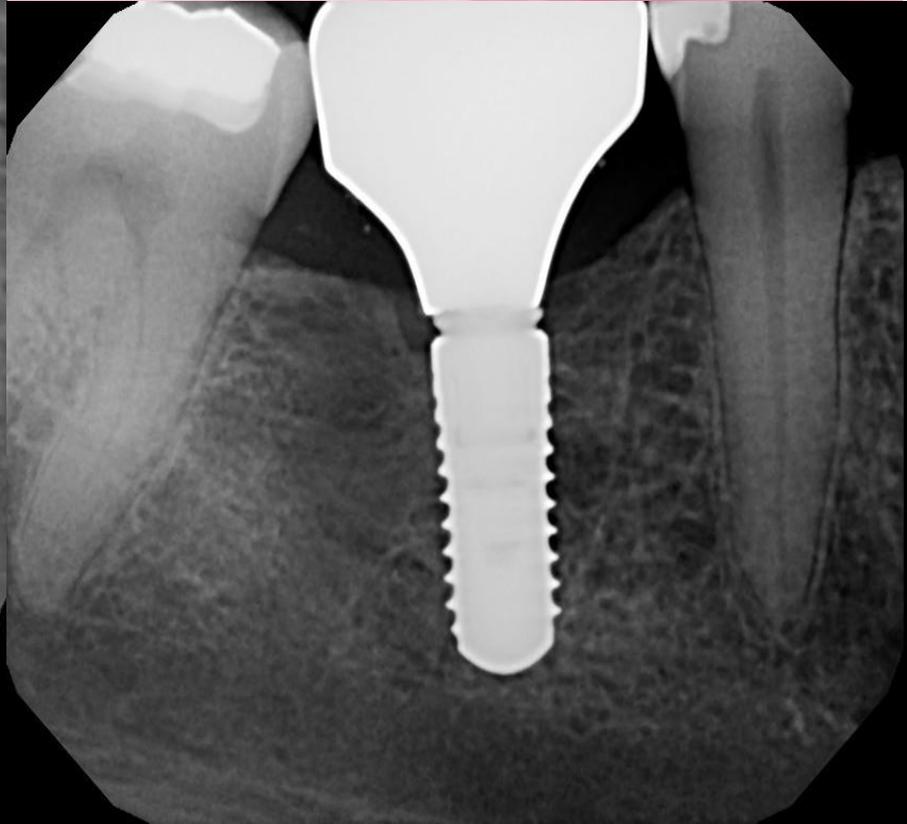
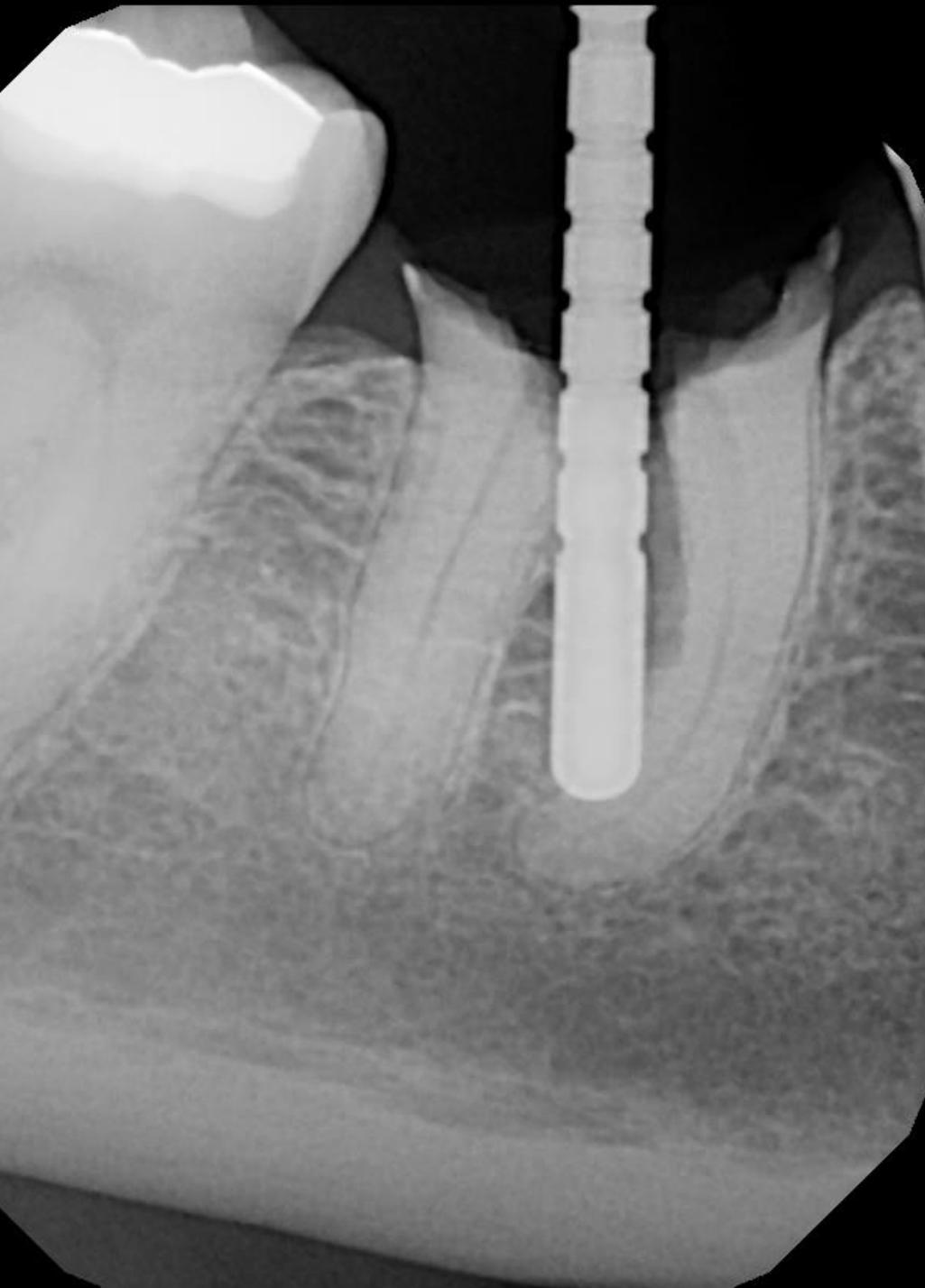
Dr. Madden welcomes patients who are receiving treatment and supervision from Pain Specialists and Addiction Medicine Specialists. However, as a condition of being a patient in this practice, such patients agree to disclose this important but sensitive Health Information, including the existence of any medication contracts with other specialists. By signing here, you are agreeing to disclose such information that is presently in effect or becomes in effect at a future date. The purpose of this policy is to protect you from adverse side effects (including unintentional overdoses) of opioid pain medications. *Your signature does not imply that you have either disorder.*

Signature: _____

On Office Policy Intake Form

What will help you make the switch

- Staff training, “buy-in/beliefs”, participation



What should help you make the switch

- Staff training, “buy-in/beliefs”, participation
- Communicate evidence-based policy
 - Intake form, reception room, website, pamphlets, verbally
- PMP, eRx external drug history, screening tools
 - All new patients, Any opioid prescriptions
- Know your community resources
 - Drug disposal sites, treatment clinics, prevention information, dental 911 emergency clinics, etc.
- Ask for our assistance
- Your willingness to change (out of your comfort zone)
 - Practice what words to use

THANK YOU

- finetunehealth@yahoo.com
- talk2us@finetunegums.com
- 360-459-5900

- Theresa E. Madden, DDS, MS, PhD, FICD
- Board-certified Periodontist
- 304 W Bay Dr. Olympia WA 98502