Dental Effects of HPP Registry

Please complete this form and return it to us.

Instructions for sending it back to us:

Fax to **614-292-1125**

OR

Mail to **Dr. Ann Griffen**
Division of Pediatric Dentistry
305 W. 12th Avenue
Columbus, OH 43210.

Information about person with HPP

Last Name	First Name	Eye color	Hair color

Date of Birth	☐ Female ☐ Male	Person completing form	Relationship to patient

Height	Weight

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other (please specify: _____)

Street address	
Zip Postal	**City, State**
Phone	**Email**

HPP HISTORY

Age at first signs of HPP	Age at diagnosis

Diagnosis

☐ Known ☐ In Progress ☐ Probable ☐ Other

If known, please specify form

- ☐ perinatal
- ☐ infantile
- ☐ childhood
- ☐ adult
- ☐ odontohypophosphatasia

Drug Treatment(s) for HPP

☐ No

☐ Yes*

*If yes please specify below:

☐ Replacement Therapy: Asfotase alfa (Strensiq®)

☐ Bisphosphonates (For example: Fosamax, Zomata, Reclast, Alendronate)

☐ Vitamin D

☐ Other (Please specify: _____)

History of Bone Fractures

☐ No

☐ Yes*

*If yes please specify below:

Age of 1st fracture: _____

Which Bone? _____

Check all that apply:

☐ Frequent fractures

☐ Fractures that heal poorly or recur

☐ Stress fractures

☐ Fractures that occurred with minimal or no trauma

☐ Other (Please specify: _____)

History of muscle weakness or low muscle tone

☐ No

☐ Yes, a little

☐ Yes, a lot

History of being easily fatigued or having generally low energy

☐ No

☐ Yes, a little

☐ Yes, a lot

History of Chronic Pain

☐ No

☐ Yes*

*If yes, how often do you take medication for your chronic pain?

- ☐ Never
- ☐ Sometimes
- ☐ Always

What sorts of pain do you have? *Check all that apply:*

- ☐ Bone pain
- ☐ Joint pain
- ☐ Muscle pain
- ☐ Other pain (Please specify: _____)

Miscellaneous HPP History (*please check all that apply)*

- ☐ Osteoporosis (bone easily breaks)
- ☐ Osteopenia (low bone density)
- ☐ Headaches
- ☐ Back problems
- ☐ Foot problems
- ☐ Short arms or legs
- ☐ Depression
- ☐ Knock-knees
- ☐ Bowed legs
- ☐ Gait problems (limping)
- ☐ Seizures
- ☐ Calcification of eyes, kidneys, or other organs or glands
- ☐ other (*please describe below*)

HPP Laboratory Tests for ALP (serum alkaline phosphatase):

(*You may fill out the form below or attach laboratory reports.)*

Date	Levels

HPP Genetic Testing:

☐ **No**

☐ **Yes (***Please describe in the space below or attach a copy of the report.)*

DENTAL HISTORY

Age when first tooth erupted:	**Age when first tooth lost:**

Dental problems (*please check all that apply*)

☐ Lost teeth ☐ Crooked teeth ☐ Cavities ☐ Tooth Pain

☐ Jaw Pain ☐ Bite looks/feels "off" ☐ Trouble Chewing ☐ Dark Teeth

☐ Soft teeth ☐ Chalky White Teeth ☐ Worn teeth ☐ other (*please describe*)

FAMILY DENTAL HISTORY

Relationship	**Please Describe Below**
Mother	
Father	
Siblings	
Children	
Other	

Dental Effects of Hypophosphatasia Study

Dental Records Release Form

Please complete and sign this Release Form. Your signature gives us permission to contact your dentist and gives your dentist permission to send us your dental records. A Notice of Privacy Practices is included in your information packet.

I, _____ hereby authorize Dr. _____
(name of parent or patient) *(name of dentist)*

Dentist address: _____

City, State ZIP: _____

Phone number: _____

to release the following information for _____, _____.
(name of patient) *(date of birth)*

- Dental records
- X-Rays
- Photos
- Information requested on the HPP Study Dental Form
- Laboratory test results
- Other (*please specify*) _____

Please release and furnish information to:

Dr. Ann Griffen
Division of Pediatric Dentistry
305 W. 12th Avenue
Columbus, OH 43210

Purpose of Disclosure: Dental Effects of Hypophosphatasia Research Study

I understand and acknowledge that this authorization extends to all or any part of the information designated above. I expressly consent to the release of information designated above. This consent is valid unless revoked by my written notice, provided said notice is received prior to release of the above information.

_____ _____
(Relationship to Patient) *(Printed name)*

_____ _____
(Signature of Patient or Parent/Legal Guardian if Patient under the age of 18) *(Date)*