

**This form must be returned prior to your intravenous sedation appointment**

Name (Please Print) \_\_\_\_\_

List all medications and supplements you are taking.	FOR OFFICE USE ONLY	
	Type of Medication	
1	<input type="checkbox"/> ACE Inhibitor <input type="checkbox"/> Beta Blocker <input type="checkbox"/> CA Channel <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Thyroid <input type="checkbox"/> Arthritis	
2	<input type="checkbox"/> ACE Inhibitor <input type="checkbox"/> Beta Blocker <input type="checkbox"/> CA Channel <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Thyroid <input type="checkbox"/> Arthritis	
3	<input type="checkbox"/> ACE Inhibitor <input type="checkbox"/> Beta Blocker <input type="checkbox"/> CA Channel <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Thyroid <input type="checkbox"/> Arthritis	
4	<input type="checkbox"/> ACE Inhibitor <input type="checkbox"/> Beta Blocker <input type="checkbox"/> CA Channel <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Thyroid <input type="checkbox"/> Arthritis	
5	<input type="checkbox"/> ACE Inhibitor <input type="checkbox"/> Beta Blocker <input type="checkbox"/> CA Channel <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Thyroid <input type="checkbox"/> Arthritis	
6	<input type="checkbox"/> ACE Inhibitor <input type="checkbox"/> Beta Blocker <input type="checkbox"/> CA Channel <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Thyroid <input type="checkbox"/> Arthritis	
7	<input type="checkbox"/> ACE Inhibitor <input type="checkbox"/> Beta Blocker <input type="checkbox"/> CA Channel <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Thyroid <input type="checkbox"/> Arthritis	
8	<input type="checkbox"/> ACE Inhibitor <input type="checkbox"/> Beta Blocker <input type="checkbox"/> CA Channel <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Thyroid <input type="checkbox"/> Arthritis	
9	<input type="checkbox"/> ACE Inhibitor <input type="checkbox"/> Beta Blocker <input type="checkbox"/> CA Channel <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Thyroid <input type="checkbox"/> Arthritis	
10	<input type="checkbox"/> ACE Inhibitor <input type="checkbox"/> Beta Blocker <input type="checkbox"/> CA Channel <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Thyroid <input type="checkbox"/> Arthritis	
<b>List anything you are allergic to:</b>		
1		
2		
3		
4		
5		

**F  
O  
R  
O  
F  
F  
I  
C  
E  
U  
S  
E  
O  
N  
L  
Y**

I currently do not take any medications or supplements

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date