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		☐ ACE Inhibitor ☐ Beta Blocker ☐ CA Channel ☐ Diabetes ☐ Depression ☐ Thyroid ☐ Arthritis	
2		☐ ACE Inhibitor ☐ Beta Blocker ☐ CA Channel ☐ Diabetes ☐ Depression ☐ Thyroid ☐ Arthritis	
3		☐ ACE Inhibitor ☐ Beta Blocker ☐ CA Channel ☐ Diabetes ☐ Depression ☐ Thyroid ☐ Arthritis	
4		☐ ACE Inhibitor ☐ Beta Blocker ☐ CA Channel ☐ Diabetes ☐ Depression ☐ Thyroid ☐ Arthritis	
5		☐ ACE Inhibitor ☐ Beta Blocker ☐ CA Channel ☐ Diabetes ☐ Depression ☐ Thyroid ☐ Arthritis	
6		☐ ACE Inhibitor ☐ Beta Blocker ☐ CA Channel ☐ Diabetes ☐ Depression ☐ Thyroid ☐ Arthritis	
7		☐ ACE Inhibitor ☐ Beta Blocker ☐ CA Channel ☐ Diabetes ☐ Depression ☐ Thyroid ☐ Arthritis	
8		☐ ACE Inhibitor ☐ Beta Blocker ☐ CA Channel ☐ Diabetes ☐ Depression ☐ Thyroid ☐ Arthritis	
9		☐ ACE Inhibitor ☐ Beta Blocker ☐ CA Channel ☐ Diabetes ☐ Depression ☐ Thyroid ☐ Arthritis	
10		☐ ACE Inhibitor ☐ Beta Blocker ☐ CA Channel ☐ Diabetes ☐ Depression ☐ Thyroid ☐ Arthritis	
List anything you are allergic to:			
1			
2			
3			
4			
5			

FOR OFFICE USE ONLY

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☐ **I currently do not take any medications or supplements**

_____ _____

Patient Signature Date