

Patient Name: \_\_\_\_\_

**SEDATION CONCERNS**

1. Do you smoke? **No Yes** If yes, how much? \_\_\_\_\_
2. Do you drink caffeine? **No Yes** If yes, how much? \_\_\_\_\_
3. Do you drink alcohol? **No Yes** If yes: Daily Weekly Seldom
4. Do you have a history of seizures? **No Yes** If yes, how often: \_\_\_\_\_
5. Are you taking oral contraceptives? **No Yes**
6. Are you taking any anti-depressants? **No Yes**
7. Do you take any anti-coagulants (Coumadin, Heparin or Aspirin)? **No Yes**
8. Do you take any herbs or supplements? **No Yes** If yes, please list: \_\_\_\_\_
9. List all your current medications:  
\_\_\_\_\_  
\_\_\_\_\_
10. Do you have any known allergies? **No Yes** If yes, please list: \_\_\_\_\_
11. Have you had any negative/poor responses to sedation in the past? **No Yes**
12. Do you have glaucoma? **No Yes**
13. Have you had an organ transplant? **No Yes**
14. Are you a diabetic? **No Yes**
15. Are you breast feeding? **No Yes**
16. Do you require pre-medication prior to dental procedures? **No Yes**

**Patient Signature** \_\_\_\_\_ Date: \_\_\_\_\_

**Assistant Signature** \_\_\_\_\_ Date: \_\_\_\_\_