

SEDATION CONCERNS

Patient Name: _____

- 1. Does the patient smoke? **No Yes** How Much? _____
- 2. Does the patient drink caffeine? **No Yes Some A lot**
- 3. Is the patient taking oral contraceptives? **No Yes**
- 4. Is the patient taking any anti-depressants? No Yes
- 5. Is the patient on any anti-coagulants, (Coumadin, Heparin, Aspirin)? **No Yes**
- 6. Does the patient have seizures? **No Yes Few Some A lot**
- 7. Does the patient drink alcohol? **No Yes Daily Weekly Seldom A lot**
- 8. Patients current medications:

- 9. Does the patient take any herbs or supplements? **No Yes**
- 10. Has the patient had any negative/poor responses to sedation in the past? **No Yes**
- 11. Does the patient have glaucoma? **No Yes**
- 12. Has the patient has an organ transplant? **No Yes**
- 13. Is the patient diabetic? **No Yes**
- 14. Is the patient breast feeding? **No Yes**
- 15. Does the patient have any known allergies? **NO Yes**

Patient Signature _____

Date: _____

Assistant Signature _____

Date: _____