This form must be returned prior to your intavenous sedation appointment

Name (Please Print) ______________________________

Please list all medications and supplements you are taking.	FOR OFFICE USE ONLY	For office use only: Type of Medication	
		☐ ACE Inhibitor ☐ Beta Blocker ☐ CA Channel ☐ Diabetes ☐ Depression ☐ Thyroid ☐ Arthritis	
		☐ ACE Inhibitor ☐ Beta Blocker ☐ CA Channel ☐ Diabetes ☐ Depression ☐ Thyroid ☐ Arthritis	
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		☐ ACE Inhibitor ☐ Beta Blocker ☐ CA Channel ☐ Diabetes ☐ Depression ☐ Thyroid ☐ Arthritis	
		☐ ACE Inhibitor ☐ Beta Blocker ☐ CA Channel ☐ Diabetes ☐ Depression ☐ Thyroid ☐ Arthritis	

☐ I currently do not take any medications or supplements

______________________________ ______________________________

Patient Signature Date