



SEDATION HEALTH HISTORY
ADDITIONAL INFORMATION

WOMEN: Are you pregnant? No Yes
 If no, are you planning a pregnancy in the near future? No Yes
 Are you a nursing mother? No Yes
 Are you taking birth control pills? No Yes

ARE YOU TAKING ANY OF THESE MEDICATIONS?

Antibiotic pre-medication for dental treatment?	No	Yes	Tagamet (cimetidine) or Prilosec (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem (diltiazem) or Calan, Isoptin (Verapamil)?	No	Yes
St. John's Wort or Kava-Kava ?	No	Yes	Serzone (nefazodone)	No	Yes
Dilantin or Tegretol	No	Yes	Diflucan (fluconazole) or Sporonox (itraconazole)	No	Yes
Barbiturates (any)	No	Yes	Biaxin (clarithromycin)	No	Yes
Are you taking any herbal supplements/medications ? If yes, list				No	Yes
Do you consume grapefruit juice , grapefruits or grapefruit extract?				No	Yes

TOBACCO, ALCOHOL, DRUGS

Do you use tobacco ? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol ? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

WEIGHT AND DIET CONSIDERATIONS

Weight	Meals per Day	Dietary Restrictions	Food Allergies

How much **Sugar** is in your diet (circle one): *none slight moderate high*

Can you take **Ibuprofen and Tylenol**? No Yes
 Do you have R.LS (**Restless Leg Syndrome**)? No Yes
 Do you use a **CPAP** machine to treat Sleep Apnea? No Yes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (**Print Name**)

Patient Signature

Date

Doctor Signature

Date