Pre-Sedation Intake Form

Name:	DOB:	Weight:	Height:
*Designee:	Relationship:		#:
Primary Care Physician:		Last Visit:	#:
Specialist(s):		Last Visit:	#:

*A designee is an elected individual who may make decisions on your behalf. This field may be left blank. The doctor and operative team reserve the right to change treatment as deemed medically/professionally necessary.

Do you suffer from or have you been treated for any of the following? ***(check any that apply)***

Cardiovascular	✓	**Nervous System**	✓	**Respiratory**	✓	**Endocrine**	✓
CAD (angina, heart attack)		Seizures/Epilepsy		COPD		Thyroid Disorders	
Heart Failure (weak heart)		Depression or Panic Attacks		Emphysema		Diabetes Melitus	
High Blood Pressure		Psychosis or Mania		Chronic Bronchitis		Immune Disorder	
Low Blood Pressure		Multiple Sclerosis		Asthma		Pregnant	
Arrhythmias (irregular beat)		Headaches/Migraine		Sinus/Hay Fever		Breast-feeding **Pump & dump day of sedation*	
Congenital Heart Defect		Substance Abuse		Obstructive Sleep			
Valve Disease or Murmur		Physical/Mental Impairment		Smoking		**Excretory**	✓
Artificial Heart Valve		Alheimer's/ other Dementia		**Misc**	✓	Liver Disorder	
Endocarditis (heart infection)		**Infections**	✓	Cancer		Kidney Disease	
Stroke or TIA		Hepatitis		Joint Replacements		Bladder Disease	
Bleeding Problems		HIV/AIDS		Organ Transplant		Ulcers or GERD	
Blood Cell Disorders		Tuberculosis		Glaucoma		Intestinal Problems	

Please list any medical problems you have that are not listed in this table:

Please list any allergies to medications, food, or any other substances:

What pharmacy would you like your medications called into? Please provide name & phone number.

Please list ALL medications /drugs/supplements you are taking, including non-prescription & recreational:

Medication/Drug/Supplement	Dose/Amount, Frequency	Use/Medical Condition