Brookside Dental Care

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 t**obacco**? If yes, circle type: smoke chew vape 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*