IV CONSCIOUS SEDATION
PATIENT SCREENING QUESTIONNAIRE

Please answer every question completely. Your answers help us determine whether IV sedation can be safely provided in our office.

Patient Name: _____ **Date of Birth:** _____

Procedure Planned: _____ **Date:** _____

1. MEDICAL HISTORY

Have you ever been diagnosed with or treated for any of the following?		
Heart attack	☐ Yes	☐ No
Chest pain or angina	☐ Yes	☐ No
Heart failure	☐ Yes	☐ No
Irregular heartbeat or heart rhythm problem	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Stroke or TIA ("mini-stroke")	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
COPD, emphysema, or other lung disease	☐ Yes	☐ No
Sleep apnea	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No
Liver disease or hepatitis	☐ Yes	☐ No
Seizures or epilepsy	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Bleeding or clotting disorder	☐ Yes	☐ No
Severe acid reflux / GERD	☐ Yes	☐ No

If YES to any above, please explain:

_____

_____

2. SEDATION & ANESTHESIA

Have you ever received IV sedation or general anesthesia before?	☐ Yes	☐ No
Have you ever had a problem or serious reaction to anesthesia or sedation?	☐ Yes	☐ No
Has anyone in your family ever had a serious reaction to anesthesia?	☐ Yes	☐ No
Do you have any medication or drug allergies?	☐ Yes	☐ No

If yes, please list allergies/reactions:

_____

_____

3. BREATHING & SLEEP

Do you have sleep apnea?	☐ Yes	☐ No
Do you use a CPAP or BiPAP machine?	☐ Yes	☐ No
Do you snore loudly?	☐ Yes	☐ No
Has anyone told you that you stop breathing or gasp while sleeping?	☐ Yes	☐ No
Do you frequently feel very tired or sleepy during the daytime?	☐ Yes	☐ No

4. MEDICATIONS

Are you currently taking any prescription medications?	☐ Yes	☐ No
Are you taking any blood thinners?	☐ Yes	☐ No
Are you taking medication for diabetes?	☐ Yes	☐ No
Are you taking a GLP-1 medication (such as Ozempic, Wegovy, Mounjaro, Zepbound, Trulicity, or Rybelsus)?	☐ Yes	☐ No

List ALL medications, supplements, and vitamins:

5. ALCOHOL, TOBACCO & OTHER SUBSTANCES

Do you smoke, vape, or use nicotine products?	☐ Yes	☐ No
Do you drink alcohol?	☐ Yes	☐ No
Do you use marijuana / cannabis?	☐ Yes	☐ No
Do you use recreational drugs or medications that were not prescribed to you?	☐ Yes	☐ No

If yes, please explain frequency/use:

6. ADDITIONAL QUESTIONS

Are you currently pregnant or is there a possibility you may be pregnant?	☐ Yes	☐ No
Have you been hospitalized or had a major medical problem within the past year?	☐ Yes	☐ No
Have you had a recent cold, cough, fever, flu, COVID-19, respiratory infection, or difficulty breathing?	☐ Yes	☐ No
Have you had any recent changes in your health?	☐ Yes	☐ No
Is there anything about your health that you think the doctor should know before giving you IV sedation?	☐ Yes	☐ No

If yes, please explain:

_____

_____

PATIENT ACKNOWLEDGMENT

I certify that the information provided above is complete and accurate to the best of my knowledge. I understand that withholding or providing incorrect medical information may increase the risks associated with IV sedation.

Patient / Guardian Signature: _____ **Date:** _____

FOR OFFICE USE ONLY

Height _____ **Weight** _____ **BMI** _____

☐ APPROVED FOR IV MODERATE SEDATION ☐ PROVIDER REVIEW REQUIRED

☐ MEDICAL CONSULTATION / CLEARANCE REQUIRED ☐ NOT APPROVED FOR OFFICE IV SEDATION

Provider Signature: _____ **Date:** _____