ALTITUDE ANESTHESIA

Anesthesia Request Form

Name of office ________________________________

Treating doctor ________________________________

Treatment plan ________________________________

Estimated Duration ________________________________

Patient / Gender ______________________/__M__F__

DOB ________________________________

Patient Phone Number ________________________________

Patient Email ________________________________

Patient Zip Code ________________________________

email/fax requests to:

Email - info@altitudeanesthesia.com

Fax - 720 259 8495

Patient General Information

Height: _______feet _______inches Weight: _____lbs.

Primary Physician: ____________________________________ Phone:________________________________

Practice Name: ____

Specialist Physician: ___________________________________ Specialty:______________________________

Practice Name: _______________________________________ Phone: ________________________________

1. Do you have any allergies to drugs, food, or latex? NO YES

Type of allergy: ____

2. List all medications and supplements you currently take ____

____

____

3. Have you ever had surgery? NO YES (explain)____

____

____

Have you ever been treated for, or diagnosed with, any of the following conditions?

Heart Diseases	NO	YES	**Explain**
Heart murmur	_______	_______	
High blood pressure	_______	_______	
Irregular heart beat	_______	_______	
Congenital heart defect	_______	_______	
Heart failure/ Heart attack / Other heart problem	_______	_______	

Lung Diseases	NO	YES
Wheezing/bronchiolitis	_______	_______
Asthma	_______	_______
COPD	_______	_______
Obstructive sleep apnea	_______	_______
Other lung problem	_______	_______

Other Conditions	NO	YES
Shortness of breath	_______	_______
Kidney disease	_______	_______
Liver disease	_______	_______
GERD/ulcer/hernia	_______	_______
Diabetes	_______	_______
Seizure disorder	_______	_______
Genetic syndrome	_______	_______
On blood thinners	_______	_______

Other medical conditions ____