11001 W 120th Ave STE 400
Broomfield, CO 80021
720-315-1319
www.milehighda.com

Patient Registration and Health History

Patient Name:______________________________ Parent:________________________

Mailing Address:___________________________ City/State:___________________

Zip:__________________ Phone:_______________________________

Medicaid # (if applicable):____

Patient Medical History

Date of Birth:___________________________ Gender:_______________________

Weight:______________________ Height:________________________

Allergies
(food/medicine/latex):____

Medications:____

Previous Surgeries:____

Family Anesthesia Problems:____

Recent Illness/ Upper respiratory Tract Infection:______________________________

Medical Problems/ Diagnosis:____

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Has the patient ever been diagnosed with (please circle):

None of the below

Asthma	Bronchitis	Sleep Apnea
Cerebral Palsy	Diabetes	Heart Murmur
Irregular heartbeat	Thyroid problems	ADHD/ADD
Autism	Down Syndrome	Hemophilia
Cystic Fibrosis	Muscular Disease	Muscular Dystrophy
Seizures	Sickle Cell Anemia	Heart Defect
Heart Burn	Kidney Disease	Liver Disease
Tracheomalacia	Malignant Hyperthermia	

Other syndrome or diagnosis:____________________________________

I certify that the above information is accurate and complete. I understand the importance of a detailed past medical history and the role it plays in the safe delivery of anesthesia.

Patient/ Parent Signature:_______________________________Date:___________