BONNER GENERAL HEALTH
Bonner General Orthopedics

Patient History

PATIENT NAME: _____ **DATE:** _____

Check NO or YES to each question - If Yes, Enter year when occurred (circle if more than one choice):

Heart/Circulation	No	Yes /Year
Heart problems?		
Congestive Heart Failure		
Pacemaker/auto defibrillator?		
Irregular heart beat?		
Heart murmur?		
Rheumatic Fever?		
High blood pressure?		
Do you become short of breath with exertion?		
Fainting or blackout spells?		
Lung/Breathing		
Breathing problems? (asthma, emphysema, COPD, pneumonia)		
Do you use oxygen at home? _____ liters/minute		
Does child use respiratory medications, inhalers?		
Tuberculosis?		
Has anyone told you that you stop breathing @ night?		
Has anyone told you that you snore loudly?		
Do you use CPAP or BiPAP?		
Smoking: ☐ Never ☐ Currently ☐ Past Packs per day _____ Number of years _____		
Neurologic		
Stroke or paralysis? (Multiple Sclerosis, polio, Muscular Dystrophy)		
Seizure disorder?		
Sciatica, pinched nerves, curved spine?		
Alzheimer's, Parkinson's?		
Developmentally delayed?		
Panic / anxiety attacks?		
Mental illness? (bipolar, schizophrenia)		
Depression, suicidal thoughts, attempts?		
Have you had previous surgeries? ☐ No ☐ Yes – if yes, please list on back		

Stomach/Digestion	No	Yes /Year
Heartburn / hiatal hernia?		
Hepatitis/jaundice, or serious liver disease?		
Ulcer/stomach problems?		
Blood in stool?		
Current diarrhea?		
Bladder/Kidney		
Kidney failure?		
Bladder/kidney/prostate problem?		
Endocrine		
Diabetes?		
Thyroid disorder?		
Low blood sugar?		
Musculoskeletal		
Arthritis?		
Cervical fusion, Back & Disc problems?		
Fractures?		
Blood		
Anemic?		
Problem with blood clotting?		
Previous blood transfusion?		
Would you agree to a blood transfusion if needed?		

Allergies to:
☐ Tape ☐ Pollen/Dust
☐ Iodine ☐ Shellfish
☐ Latex ☐ Other _____
☐ Foods _____

Reactions: _____

_____

Medication Allergy:
☐ No ☐ Yes

List:	Reaction:

Other	No	Yes /Year
(Oct. – Dec.) Have you had a flu shot?		
Had pneumonia vaccine?		
Recent international travel?		
Sensory impairment? (speech/vision/hearing)		
Glaucoma?		
Skin problems?		
Cancer?		
HIV positive or AIDS?		
Anesthesia		
Your Age _____ Height ____ft _____in. Weight_____		
Do you have motion sickness?		
Nausea/vomiting related to anesthesia?		
Personal or family history of high fever during anesthesia (Malignant hyperthermia)?		
Have you used steroids within the last six months?		
Females: Are you or could you be pregnant?		
When was the last time you used recreational drugs?		
How many beers/cocktails/wine do you drink per week?		

Current Medications: (include prescription, patches, nebulizers, sprays, drips, non-prescription, herbs, vitamins, minerals, & supplements)	**Dose**	**Time you take them:**

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Please list all past surgeries:	Year
1.	
2.	
3.	
4.	
5.	
6.	

List any other medical problems:

1. _____
2. _____
3. _____
4. _____
5. _____

Completed by: ☐ Patient

☐ Staff _____

Staff Signature