S. TRACY RHODES, M.D., P.A.
5558 Lake Howell Road
Winter Park, FL 32792

LUCILLE BELNICK, M.D., P.A.
Phone: 407-679-3400
Fax: 407-679-3412

HEALTH HISTORY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Drug Allergies: _____

_____

Medical History:

Please check any conditions below that you have been diagnosed with.

ACID REFLUX		CANCER OF THE COLON		HEART DISEASE (CAD)		MULTIPLE SCLEROSIS	
AIDS		CANCER OF THE LUNG		HEART MURMUR		OSTEOPOROSIS	
ALCOHOLISM		CANCER OF THE OVARIES		HERPES		PACEMAKER	
ALZHEIMER'S DISEASE		CANCER OF THE SKIN		HEMORRHOIDS		PNEUMONIA	
ANEMIA		CATARACTS		HEPATITIS		PROSTATE DISEASE	
ANGINA		COLON PROBLEMS		HYPOGLYCEMIA		STD	
ANXIETY		COPD		HIGH BLOOD PRESSURE		STROKE	
ARTHRITIS		DEPRESSION		HIGH CHOLESTEROL		THYROID DISEASE	
ASTHMA		DIABETES		KIDNEY PROBLEMS		TIA	
ATRIAL FIBRILLATION		GALL BLADDER		LIVER DISEASE		TUBERCULOSIS	
BLOOD CLOTS		GLAUCOMA		LYMPHOMA		ULCERS, STOMACH	
BLOOD TRANSFUSION		HEART ATTACK		MIGRAINES		UTERINE FIBROID	

Other conditions not listed: _____

_____

_____

Year of Last:

TEST	YEAR OF LAST	RESULTS
COLONOSCOPY		
DEXA (BONE SCAN)		
PAP SMEAR		
MAMMOGRAM		
CHOLESTEROL		
PSA		

VACCINES	YEAR OF LAST
TETANUS	
FLU	
PNEUMONIA / PREVNAR	
SHINGLES (SHINGRIX)	
OTHER	

WOMEN ONLY	ANSWERS
LAST MENSTRUAL PERIOD	
AGE AT MENOPAUSE	
ARE YOU PREGNANT?	
NUMBER OF PREGNANCIES	
NUMBER OF CHILDREN	
DESIRE STD TESTING?	

Current Medications:

MEDICATION	DAILY DOSE

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HEALTH HISTORY

Patient Name: _____ Today's Date: _____

Hospitalizations/Surgeries:

HOSPITALIZATION/SURGERIES	REASON	DATE

Health Habits:

QUESTIONS	ANSWERS
DESCRIBE YOUR EXERCISE ROUTINE	
MARITAL STATUS (OPTIONAL)	
WHO LIVES IN YOUR HOME	
ANY PETS?	
OCCUPATION/ TIME IN POSITION	
DESCRIBE YOUR DIET	

Social History:

TYPE	YES OR NO	TYPE AND FREQUENCY/ QUIT YEAR IF APPLICABLE
ALCOHOL	Y N	
TOBACCO	Y N	
DRUGS	Y N	
CAFFEINE	Y N	

Family History:

DISEASE	FATHER	MOTHER	CHILDREN	SIBLINGS	OTHER: _____
ALCOHOLISM					
CANCER OF BREAST					
CANCER OF COLON					
CANCER OF OVARIES					
CANCER OF PROSTATE					
OTHER CANCERS					
DIABETES					
HEART DISEASE					
HIGH BLOOD PRESSURE					
MENTAL ILLNESS					
OSTEOPOROSIS					
STROKE					
THYROID DISEASE					
OTHER					
AGE AT DEATH (IF DECEASED)					
CAUSE OF DEATH					

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HEALTH HISTORY

Patient Name: _____ **Today's Date:** _____

Systems Review:
Please check any symptom(s) that apply to you.

GENERAL/EMOTIONAL	
FATIGUE	
ANXIETY	
DEPRESSION	
FAINTING/DIZZINESS	
FEVER/CHILLS	
MEMORY PROBLEMS	
HEADACHE	
LOSS OF SLEEP	
NERVOUSNESS	
EXCESSIVE THIRST	

GASTROINTESTINAL	
STOMACHACHE	
POOR APPETITE	
BLOATING	
DIARRHEA	
CONSTIPATION	
WEIGHT GAIN	
WEIGHT LOSS	
NAUSEA	
GAS	
HEMORRHOIDS	
RECTAL BLEEDING	
VOMITING	
GERD /HEARTBURN	

VISION, EAR, NOSE, THROAT	
SORE THROAT	
HOARSENESS	
DIFFICULT SWALLOWING	
BLEEDING GUMS	
EAR PROBLEMS	
SINUS PROBLEMS	
NOSEBLEEDS	
CHANGES IN VISION	
ALLERGIES OR HAY FEVER	

SKIN	
CHANGE IN MOLES	
SORE THAT WONT HEAL	
RASH	
SCARS	
EASY BRUISABILITY	
ITCHING/HIVES	

URINARY ISSUES	
BLOOD IN URINE	
FREQUENT URINATION	
INCONTINENCE	
PAINFUL URINATION	

CARDIOVASCULAR	
CHEST PAIN	
ELEVATED BLOOD PRESSURE	
IRREGULAR HEART BEAT	
LOW BLOOD PRESSURE	
RAPID HEART BEAT	
SWELLING OF ANKLES	

PULMONARY	
FREQUENT/CHRONIC COUGH	
HISTORY OF ASTHMA	
OTHER LUNG PROBLEMS	
SHORTNESS OF BREATH	

MEN ONLY	
ERECTION DIFFICULTIES	
LUMP IN TESTICLES	
PENIS DISCHARGE	
DESIRE STD TESTING?	Y N

WOMEN ONLY	
PREMENSTRUAL SYNDROME	
BLEEDING BETWEEN PERIODS	
BREAST PROBLEMS	
VAGINAL PROBLEMS	
HOT FLASHES	
PELVIC PAIN	

Medical specialist(s) you see regularly:
