S. Tracy Rhodes, M.D., P.A. **Lucille Belnick, M.D., P.A.**

5558 Lake Howell Road
Winter Park, Florida, 32792

Phone: (407) 679-3400
Fax: (407) 679-3412

HEALTH HISTORY

Name: _____ Today's date: _____

Birth date: _____ Drug allergies: _____

_____

What is the reason for your visit? _____

_____

MEDICAL HISTORY:

In the past, have you ever been diagnosed with any of the following?

Abnormal blood clots	Y	N	Fibromyalgia			Pacemaker		
AIDS	Y	N	Glaucoma	Y	N	Pneumonia	Y	N
Arthritis	Y	N	Gout	Y	N	Prostate disease	Y	N
Asthma	Y	N	Heart disease	Y	N	Rheumatic Fever	Y	N
Anorexia/Bulimia	Y	N	Heart murmur	Y	N	Stroke	Y	N
Alcoholism	Y	N	High blood pressure	Y	N	Skin Disease	Y	N
Allergies/Hay fever	Y	N	Hepatitis/Jaundice	Y	N	History of severe sunburns	Y	N
Abnormal Pap smear	Y	N	High cholesterol	Y	N	Other (type): _____		
Bleeding disorder	Y	N	Herpes	Y	N	Thyroid disease	Y	N
Breast disease	Y	N	Hemorrhoids	Y	N	Tuberculosis	Y	N
Bone fracture	Y	N	Hypoglycemia	Y	N	Ulcers, stomach	Y	N
Cancer	Y	N	Hiatal hernia	Y	N	Uterine fibroids	Y	N
Type: _____			Irritable Bowel Syndrome	Y	N	Vaginal infection/STDs	Y	N
Cataracts	Y	N	Kidney disease	Y	N	Other:_____		
Chemical dependency	Y	N	Kidney stones	Y	N	Other: _____		
Diabetes	Y	N	Liver disease	Y	N	Other: _____		
Diverticulosis/itis	Y	N	Migraine headaches	Y	N	Other: _____		
Emphysema	Y	N	Multiple Sclerosis	Y	N	Other: _____		
Endometriosis	Y	N	Osteoporosis	Y	N	Other: _____		
Epilepsy/Seizures	Y	N	Pacemaker	Y	N	Other: _____		

HOSPITALIZATIONS/SURGERIES:

Please list dates and reasons for hospitalizations/surgeries

_____ _____

_____ _____

_____ _____

CURRENT MEDICATIONS AND DAILY DOSAGES:

_____ _____

_____ _____

_____ _____

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Name: _____ Today's date: _____

WELLNESS/PREVENTIVE MEDICINE HISTORY:

VACCINE:	Year of last	**VACCINE**:	Year of last
Tetanus	_____	Pneumonia	_____
Flu	_____	Shingles (Zostavax)	_____

TEST:	Year of last	Results
Colonoscopy	_____	_____
Bone density test	_____	_____
Pap smear	_____	_____
Mammogram	_____	_____
Cholesterol	_____	_____
PSA	_____	_____

FAMILIAL HISTORY:

	Father	Mother	Children	Siblings
Alcoholism	____	____	____	____
Abnormal blood clots	____	____	____	____
Cancer				
Breast	____	____	____	____
Prostate	____	____	____	____
Colon	____	____	____	____
Other: _____	____	____	____	____
Diabetes	____	____	____	____
Heart Disease	____	____	____	____
High blood pressure	____	____	____	____
Kidney disease	____	____	____	____
Mental illness	____	____	____	____
Osteoporosis	____	____	____	____
Stroke	____	____	____	____
Thyroid disease	____	____	____	____
Other: _____	____	____	____	____
Age at death (if deceased)	____	____	____	____
Cause of death	____	____	____	____

HEALTH HABITS/SOCIAL HISTORY:

Alcohol	Y	N	Amount: _____
Tobacco	Y	N	Type and amount: _____
Drugs	Y	N	Type and amount: _____
Caffeine	Y	N	Amount: _____

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Name: _____ Today's date: _____

Describe your exercise routine: _____

Personal status (optional): Married_____ Single or Divorced_____ Widowed_____ Other_____

Who lives in your home? _____

Do you have pets? _____

What is your occupation? _____Length of time in position? _____

SYSTEMS REVIEW:

Circle your symptoms from the following list:

GENERAL/EMOTIONAL:
Fatigue
Chills
Depression
Dizziness
Fainting
Fever
Memory loss
Headache
Loss of sleep
Nervousness

GASTROINTESTINAL:
Stomachache
Poor appetite
Bloating
Diarrhea
Constipation
Weight gain
Weight loss
Nausea
Gas
Excessive thirst
Hemorrhoids
Rectal bleeding
Vomiting
Vomiting blood
GERD symptoms
Heartburn

EYE, EAR, NOSE, THROAT:
Sore throat
Hoarseness
Difficulty swallowing
Bleeding gums
Earache
Ear discharge
Loss of hearing
Ringing in ears
Sinus problems
Cough
Nosebleeds
Change in vision
Allergies or hay fever

SKIN:
Change in moles
Sore that won't heal
Rash
Scars
Easy bruisability
Itching
Hives

GENITOURINARY:
Blood in urine
Frequent urination
Poor bladder control/incontinence
Painful urination

CARDIOVASCULAR:
Chest pain
Elevated blood pressure
Irregular heart beat
Low blood pressure
Rapid heart beat
Swelling of ankles
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 lump
Nipple discharge
Painful discharge
Vaginal discharge
Hot flashes
Pelvic pain
LAST MENSTRUAL PERIOD: _____
DATE OF LAST PAP SMEAR: _____
DATE OF LAST MAMMOGRAM: _____
Age at menopause _____
Are you pregnant? Y N
Number of pregnancies: _____
Number of children: _____
Desire STD testing? Y N

Please list any medical specialists you see regularly:

NAME	**SPECIALTY**
_____	_____
_____	_____
_____	_____