Susan Andracchi, M.D.

Patient Information

Have you ever been a patient of Dr. Andracchi in the past? (circle one) YES NO

Name Mr. Mrs. Ms. Dr. Rev. Date of Birth Mo/Da/Year Age Sex

Address City State Zip

Home Phone Work Phone **Mobile Phone**

Email Social Security # Employer

Primary Care Physician Eye Physician Referred By

Marital Status (Circle One)
Single Married Widowed Divorced

Spouse's Name Date of Birth Mo/Da/Year Phone

Next of Kin/Emergency Contact Relationship Phone

Spoken Language (Circle One)
English Spanish Other

Race (Circle One)
Hispanic Non-Hispanic

Ethnic Group (Circle One)
Asian Black Caucasian Hispanic
Middle Eastern Pacific Islander Other

Individual/Guarantor Responsible for Payment

Last Name First MI Date of Birth

Stree Address City State Zip

Home Phone Work Phone Mobile Phone Social Security #

Please complete and make sure all information is accurate

Susan Andracchi, M.D.

Patient History Information

Name Date Date of Birth

Family Doctor: Eye Doctor: Referring Doctor (if applicable):

Please answer the following questions about your medical status and history.

Have you ever been treated for any of the following medical conditions?
Please check yes or no and circle all that apply. Explain further in the space provided if necessary.

Yes No **Arthritis** (rheumatoid, osteo-degenerative)
Yes No **Blood Diseases** (anemia, leukemia, clotting problems)
Yes No **Ear, Nose, Throat** (hearing loss, sinus disease)
Yes No **Diabetes** (type, how controlled, and when diagnosed)
Yes No **Thyroid Disease** (hypo, hyper, Graves disease)
Yes No **Lung Disease** (asthma, emphysema, COPD, chronic bronchitis)
Yes No **Heart Disease** (heart attack, angina, arrhythmia, heart failure, heart valve disease, bypass surgery)
Yes No **High Blood Pressure**
Yes No **Gastrointestinal Disease** (ulcers, esophageal reflux, intestinal or liver disease)
Yes No **Genito-Urinary Disease** (kidney disease, dialysis, kidney stones)
Yes No **Neurological Problems** (stroke, mini strokes, seizures, paralysis)
Yes No **Skin Diseases** (eczema, psoriasis, acne rosacea)
Yes No **Mental Health** (depression, anxiety, schizophrenic, bipolar)
Yes No **Cancer** (list type or location and date)
Yes No **Infectious Disease** (TB, syphilis, gohorrhea, AIDS, HIV, hepatitis)
Yes No **Other Problems**
Yes No **Previous Surgery** (date/reason)

Review of Symptoms Do you currently have any of the following problems? Check all that apply.

Yes No **Joint Pain** (Musculoskeltal)
Yes No **Easy Bruising** (Hematological)
Yes No **High Blood Pressure**
Yes No **High/Low Blood Sugar**
Yes No **Abnormal Thyroid Level**
Yes No **Shortness of Breath, Wheezing, Coughing** (Respiratory)

Yes No **Sore Throat, Ear Pain, Sinus Problems**
Yes No **Heartburn, Abdominal Pain, Diarrhea, Vomiting**
Yes No **Pain with Urination,Blood in Urine**
Yes No **Weakness, Numbness,Headache**
Yes No **Rashes, Excessive Dryness**
Yes No **Depression/Anxiety**

☐ **No Known Drug Allergies** Please list any allergies and reactions you have (including medications, food or other)

Eye Disease

Have you ever had an eye disease? If yes, please explain and include the year diagnosed.

Yes No **Cataract**

Yes No **Corneal Disease or Transplant**

Yes No **Diabetic Eye Disease**

Yes No **Glaucoma**

Yes No **Lazy Eye** (Amblyopia)

Yes No **Macular Degeneration**

Yes No **Muscle Disorder** (Crossed Eye)

Yes No **Retinal Detachment or Hole**

Yes No **Injury**

Yes No **Surgery or Laser**

Yes No **Other**

Comments:

Family History of Disease

Do you have a family history of any of the following diseases? Please indicate which relative is affected (example: mother, father, sister, brother).

Yes No **Cancer**

Yes No **Diabetes**

Yes No **Glaucoma**

Yes No **Heart Disease**

Yes No **Retinal Disease**

Social History

Marital Status: Single Married Widowed Divorced

Do you live alone? Yes No **Do you live in a nursing/assisted living home?** Yes No

Do you smoke? Yes No If yes, in the past when did you quit?

Do you drink alcohol? Yes No If yes, how many drinks per day?

Are you employed? Yes No If yes, please list occupation:

If female, are you pregnant? Yes No **Breastfeeding?** Yes No

What is the reason for your visit?

When was your last eye exam?

Patient Signature Date:

For Office Use Only

Technician Signature Date:

Reviewed by Dr. Andracchi Date:

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Medication List

Please list all medications you take (including over-the-counter medications, birth control pills and aspirin).

Name of Medicine	**Dosage** (Mg, etc.)	**How Often** (once a day, twice a day, etc.)

Patient Name: **Date of Birth:**