MICHAEL GETTELFINGER, OD, FAAO
PATIENT INFORMATION AND MEDICAL HISTORY

Name_____________________________**Date of Birth**____________**Gender**_____ **Today's Date**____________

Address____City_______________State_____Zip_________

Telephone: Hm______________________Wk________________________Cell_________________________

Race___________ Ethnicity____________ Preferred Language_____________ Occupation________________

Emergency Contact: ___________________________________Telephone:______________________________

Circle your preferred method of Communication with us: home phone cell phone e-mail no preference

When you are due to come in again, please circle how you would like your reminder sent to you: postcard e-mail

E-mail____

Name of person(s) you authorize to talk to us about your health information: __________________________________

____

Personal Health History: *Please circle conditions you have:*

Diabetes – Type____________ Diabetic Doctor Name____

High Blood Pressure High Cholesterol Pain Arthritis Anxiety /Depression Allergies

Other____

Medicine(s) you're taking: ____

____

Medicine(s) you're allergic to:____

Other Allergies?____

Do you use: Tobacco / Cigarettes

Personal Eye Information: *Please circle conditions you have:*

Glaucoma Cataract Retinal/Macular Floaters Dry Eye Blur Discomfort Headache

Other: ____

Do you wear: Glasses: Yes No Contact Lenses: Yes No If yes, are you wearing contacts today? Yes No

Have you had any Eye operations? _________________________________Date__________

Eye injury? ____Date___________

Signature: _____________________________________**Relationship to Patient:** ______________ **Date:** ___________