Marion Eye Center & Optical

Patient Questionnaire

Patient Name: _____ **DOB:** _____

Address: _____ **SSN:** _____

Phone #: _____ **PCP:** _____

- Do you use tobacco products? Yes/No Quit Date: _____
- Are you currently being treated for High Blood Pressure/Hypertension? Yes/No If yes what medication? _____

  _____
- Have you received a Flu Vaccine? Yes/No Date: _____
- Have you received a Pneumonia Vaccine? Yes/No Date: _____
- Are you Diabetic? Yes/No Are you insulin Dependent? Yes/No
- Please list any new medications since last visit.

  _____

  _____
- Please list your email below. This will allow you to access to our Patient Portal. The Patient Portal can be used for viewing your medical records.

  Email Address: _____

  *****We will not share your email or use it for any solicitation.*****

  Please visit our website at www.marioneye.com and click New Patient Information to make any demographic changes. (Address, Phone, Etc.)