

Marion Eye Center & Optical

Patient Questionnaire

Patient Name: _____ DOB: _____

Address: _____ SSN: _____

Phone #: _____ PCP: _____

Pharmacy: _____

• 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.)