

LINDY EYE CARE

651 N Wellwood Ave, Lindenhurst, NY 11757

(phone: 631-226-2020)

Dr. Mario J. Craig

(fax: 631-226-7371)

EYE & HEALTH HISTORY Name (last, first): _____ Exam date: / /

Occupation/eye demands: _____

Last eye examination: _____ years ago **Where?** _____

Hours/day on computer: _____ **Any special vision needs (sports/hobbies/piano/etc)?:** Y N **If yes, explain:**

Do you spend time in direct sunlight? Y N

Do you wear sunglasses? Y N

Do you wear contact lenses? Y N

Are you interested in getting contact lenses today? Y N

Are you interested in LASIK/refractive surgery? Y N

If yes, how interested? Very Just a little

Dry eye survey: Do your eyes often feel uncomfortable? Y N Do you feel the need for eye lubrication? Y N

Are you ever bothered by red eyes? Y N Does your vision quality change throughout the day? Y N

CIRCLE ALL THAT APPLY (if none apply, please circle NONE):

Chief eye concern(s): NONE Blur at far Blur at near Blur at all distances Eyes burn Dry Eye

Eyestrain Double vision Flashes Floaters Headache Injury Irritation Itching

Redness Tearing Eye Turn Fatigue/tired eyes Allergies Eye discomfort Eyelid crusting

Other:

Your eye health history: NONE Cataract Glaucoma Eye Allergies Eye Injury Eye Turn

Macular Degeneration Retinal Detachment Eye Infections Surgery (explain):

Other:

Please understand that all services must be paid for when received. Contact lens fees are separate from routine eye exam fees. We welcome and appreciate all comments, advice, and questions, either in our suggestion box, via our text-based surveys, at our email address: lindyeyes2020@gmail.com, or on our website: www.lindyeyecare.com.

Thank you for letting us serve you!