LINDY EYE CARE

Dr. Mario J. Craig
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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 updating or renewing your contact lens script today?*** Y N

(**A yearly contact lens evaluation applies to all contact lens wearers.)**

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, 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!