CONTACT LENS QUESTIONNAIRE

This questionnaire is designed to help us better evaluate your contact lens needs. Please print, answer as completely as possible, and bring to your appointment. Thank you, in advance, for your time.

Patient Name: ________________________ Occupation: ________________________ Age: _______

1. What type of lenses are you wearing? (If you are not a CL wearer, skip to #11)
   _____ Gas permeable _____ Soft _____ Disposable _____ Daily wear
   _____ Extended (Please indicate how often they are replaced ________________)

2. How old are your current contacts? ________________________________________

3. Who performed your most recent contact exam? ______________________________

4. How many hours per day, on average, do you wear contact lenses? _______ Days per week: __________

5. If you sleep in your lenses, how often do you remove them? ______________________________

6. What brand of contact lens cleaner do you use? ______________________________

8. What brand of contact lens disinfectant/soaking solution do you use? ______________________________

9. Do you clean after each wear in the evening or in the morning? _________________

10. How often do you enzyme? _____________________________________________

11. Have you ever worn or tried to wear contacts in the past? ......................... Y  N

12. If yes, for how long? (If no, skip to question 16) ______________________________

13. What type of lenses did you wear? _____ Gas permeable _____ Soft _____ Disposable
    _____ Extended wear _____ Daily wear

14. Why did you stop wearing them? __________________________________________

15. Have you had any infections related to contact lens wear? ......................... Y  N

16. Please check if you have or have had any of the following symptoms?
    _____ Allergies to CL solutions _____ Crusting on eyelids _____ Poor distance vision with CL’s
    _____ Discomfort wearing CL’s _____ Red eyes with CL’s _____ Short CL wearing time
    _____ Frequent CL deposits _____ Glare _____ Dry Eyes _____ Poor near vision with CL’s

17. Do you work in a dusty environment or around chemical fumes? ..................... Y  N

18. How would you describe your desire to wear contact lenses?
    _____ Mild _____ Moderate _____ Strong

19. Are you interested in wearing colored contact lenses? ............................. Y  N

I understand there is an additional fee for contact lens evaluation and services due the day of the evaluation.

Patient signature ________________________ Date _____________

10/24/11 OPTICAL MANUAL/KLP