

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