

CONTACT LENS QUESTIONNAIRE

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

Patient _____ Age ____ Occupation _____ Date _____

- 1) Do you presently wear contact lenses? Y N (If, no, skip to # 4)
What type? Gas permeable _____ Daily wear _____
Soft _____ Extended wear _____
Disposable _____ How often do you replace them? _____

How old are your current contacts?

Which Doctor examined you most recently for contact lenses?

- 2) How many hours a day, on average, do you wear contact lenses? How many days a week?

When did you begin wearing contact lenses?

If you sleep with your lenses, how often do you remove them?

- 3) What contact lens solutions do you use? Cleaner _____ Disinfectant/Soaking _____
Do you clean after each wear in the evening, or in the morning?
How often do you enzyme?

- 4) If you are not currently wearing contact lenses, have you ever worn, or tried to wear contacts in the past? Y N

If yes, for how long? _____ What type of lenses?

Why did you stop wearing them?

- 5) Have you had any infections related to CL wear? Y N

Do you have any systemic allergies or asthma? Y N

- 6) Please check if you have any of the following conditions or symptoms. (CL = contact lenses)

Dry eyes _____	Crusting on eyelids _____
Discomfort wearing CL's _____	Red eyes with CL's _____
Short CL wearing time _____	Frequent CL deposits _____
Allergies to CL solutions _____	Glare _____
Poor vision with CL's at distance? _____	at near? _____

- 7) Do you work in a dusty environment, or around chemical fumes? Y N

- 8) How would you describe your desire to wear contact lenses?
Mild _____ Moderate _____ Strong _____

- 9) Are you interested in wearing colored contact lenses, or special effects contact lenses?

I understand there is an additional fee for a contact lens evaluation & services

Signature _____

Date _____