

Contact Lens History

Date _____

Check one: _____ I currently wear contacts.
_____ I have worn contacts in the past.
_____ I have never worn contacts (**Go to Part B**).

Part A - For current and past contact lens wearers

Type of lens worn: _____ Hard/RGP _____ Soft

Brand of lens? _____

Prescription? Right Eye _____
Left Eye _____

How many years have you been wearing contacts? _____

Wearing Schedule (check one):

- _____ Daily Wear: remove lenses every night
- _____ Flexible Wear: occasionally sleep in lenses
- _____ Extended Wear: sleep in lenses for _____ consecutive nights

Name of cleaning & disinfecting system used? _____

Clean lenses how often? _____ Dispose lenses every _____

How old are your current lenses? _____

Any complaints with your lenses with respect to:

Vision	_____	No	_____	Yes:	_____
Lenses	_____	No	_____	Yes:	_____
Care System	_____	No	_____	Yes:	_____
Handling	_____	No	_____	Yes:	_____

Part B - To be completed by everyone

Your Occupation: _____

Hobbies/Sports: _____

You would like to wear contacts: _____ full time _____ occasionally

Would you like to try colored contacts? _____ No _____ Yes

Would you like to order on our Web site? _____ No _____ Yes

Do you ever have sore, scratchy, dry, gritty, or burning eyes?
_____ No _____ Yes How often? _____

Have you ever been told to use artificial tears? _____ No _____ Yes