Contact Lens Survey

This form is used to help us understand how well your current contact lenses are working for you. By giving us this information, we can find a product that will best suit your needs.

Patient name: _____ Date: _____

Name of your contact lenses: _____

What is your Rx?: _____

Place where you purchased them: _____

Please circle the best answer:

1. Do you need improvement in vision in your current contact lenses?

Yes No Not Sure

2. Is this brand of contacts comfortable on your eyes?

Yes No Not Sure

3. What is your average wearing time per day?

0-4 hrs 4-8 hrs 8-12 hrs 12-16 hrs 16+ hrs Overnight

4. What is your actual replacement schedule?

Daily 2 Weeks Monthly 2-3 Months When they hurt Yearly

5. What bottle do you use to disinfect/soak your lenses overnight?

Opti-Free (Green) BioTrue (Green) RevitaLens (Blue) Clear Care (Peroxide) Generic Not Sure

6. Do you rub your lenses to clean them?

Yes No Sometimes

7. Do you use rewetting drops/ artificial tears with your contacts?

Yes No Sometimes

8. Would you like to wear the same brand again?

Yes No Maybe

9. Do you wear sunglasses over your contacts?

Yes No Sometimes