SACRAMENTO
OPTOMETRIC GROUP
"TRUSTED VISION AND EYE HEALTH CARE"

Date: _____
Patient Name: _____ Birthdate/Age: _____

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contact lenses? Yes No

Have you ever tried contact lenses? Yes No If yes, how long ago? _____ Reason for stopping? _____

Do you currently wear contact lenses? Yes No Since_____

Type and Brand of current contact lenses: _____ _____

What are your current contact lens powers (if known*) or Last contact lens prescription:

Right Eye _____ Left Eye_____

*If unknown, please bring a copy of your last contact lens prescription or any boxes with you to your appointment.

How many days/week do you wear your contacts? _____ Hours/day? _____

What solutions do you use to clean/store your contacts? _____

Have you had a contact lens related eye infection or complication? Yes No Date: _____ Type:_____

Do you experience any dryness in your contact lenses that affects how often or how long you wear your contact lenses? Yes No

Could anything be better with your contact lenses? Yes No If yes, please circle all that apply:

COMFORT CONVENIENCE INCREASED WEAR TIME DISTANCE VISION NEAR VISION Other _____

Are you interested in laser surgery to reduce your dependence on your glasses/contacts? Yes No