Glasses and Contact Lens History

When was your last eye exam? _____

Do you currently wear glasses? (Circle One) Yes No

If yes, how often do you use them (Check one) Full Time ___ Part Time___

Do you currently wear contacts? (Circle One) Yes No

If **yes**, what brand of contacts do you wear? _____

Are you happy with the comfort and vision of your contacts? (Circle One) Yes No

How often do you replace your contact lenses? _____

What solution do you use? _____

Do you need a contact lens fit to update your contact lens RX today? Yes No

If you do not wear contacts, are you interested in learning more about them? Yes No

Visual Needs

How many hours per day do you use a computer? _____

Do you struggle with glare? Yes No

Do you struggle with night vision? Yes No

Do you wear sunglasses? Yes No

Do your eyes get fatigued? Yes No

Do you have any of the following special eyewear needs? (Check all that apply):

Computer_____ Occupational_____ Safety_____ Sports/Hobbies_____