# Contact Lens Intake Form

Established Wearer ☐ New Wearer☐

**DOCTOR RECOMMENDS:**

**Level 1** - Spherical ☐ **Level 2** -Astigmatism ☐ **Level 3** - Multifocal ☐

**Brand** _____ No Contacts ☐

**Supply** Annual ☐ Six Month ☐ Trial ☐ Other_____

**Follow-up Contact Lens Fitting**

One Year ☐ Six Months ☐ Next Availability ☐ Other_____

Dailies ☐
Bi-Weekly ☐
Monthly ☐

Solution Brand:_____

**Vision:**

Can you see distance and near comfortably with your contact lenses? Yes☐ No ☐

**Comfort:**

Do you experience dryness with your contact lenses? Yes☐ No ☐
Do you have difficulty with seasonal allergies? Yes☐ No☐

**Hygiene:**

Do you have a backup pair of glasses? Yes☐ No ☐
Do you rub your contact lenses with solution when cleaning? Yes☐ No ☐
How often do you change your contact lens case? _____
How often do you change your contact lenses?
Every Day ☐ Bi-Weekly ☐ Monthly ☐ Longer ☐ _____

**Life Style:**

How many days a week do you wear your contact lenses? _____days / week
How many hours a day do you wear your contact lenses? _____hours / day
If you store your lenses in solution, do you discard your solution every morning? Yes☐ No ☐
Do you sleep overnight in your contact lenses? Yes ☐ No ☐
If you sleep in your contacts, for how many nights? _____nights
Do you swim in your contact lenses? Yes ☐ No ☐
Do you shower in your contact lenses? Yes ☐ No ☐

**Contact Lens Health History:**

Have you had a contact lens related eye infection or complication? Yes☐ No ☐
If yes, please explain: _____

**Please rank from most important to least important so that the doctor can prescribe to enhance your contact lens experience (1 – Most important, 5- Least important):**

_____ Convenience _____Comfort _____ Clarity _____ Cost
How can we improve your experience with your contact lenses?
_____
_____