Patient Name: _____ Date:_____

Contact Lens Patient Questionnaire

- Current brand of contact lenses: _____ Solution: _____
  How long have you been wearing this type of contact lens? _____

- Daily wear _____ Extended wear _____
  How many hours per day do you wear contact lenses? _____
  Do you ever sleep in your lenses? _____ If "yes", how often? _____
  If you sleep in your lenses regularly, how often do you remove them overnight? _____

- How often do you replace your current contact lenses with new lenses? _____
  How often do you replace lens case? _____

- Is there a particular time of day your lenses become uncomfortable? _____

- Do you experience tired eyes? _____

- Are you satisfied with the performance of your lenses after 12 hours of wear? _____

- Do you have dry eyes? _____

- Do you use re-wetting drops? If YES _____ times/day? _____ times/week?
  What kind? _____

- Do you have back- up eyeglasses? _____ How old are they? _____

- Contact lens feature (s) important to you: (check all that apply)

___ UV Protection ___ New lens material/ technology
___ Color ___ End-of-day comfort/ help with dry eyes
___ Beauty enhancement

- On a scale of 1 to 10, 1= Least satisfied; 10= Most satisfied, Rate for COMFORT/ VISION
  - How satisfied are you with your contacts? ____ _____
  - How satisfied at the end of the day? ____ _____
  - How satisfied are you at the end of wearing schedule? ____ _____

- Are you interested in the eye health advantages and convenience of a daily disposable contact lens?

_____

Any additional concerns? Questions? Comments?

_____