



- 1) Have you ever worn or tried to wear contact lenses? Yes No
- 2) Do you have any problems with your ears, nose, or throat? Yes No
- 3) Have you ever had surgery on your eyes? Yes No
- 4) Have you ever had an injury to your eyes? Yes No
- 5) Have you ever had an eye infection? Yes No
- 6) Are you a diabetic? Yes No Do you take insulin? Yes No
- 7) Do you have sinusitis, hayfever or allergies? Yes No
- 8) Do you experience burning, redness or itching with your eyes? Yes No
- 9) Please list all medications. (Including birth control) _____
- 10) Do you plan to wear contact lenses every day? Yes No
- 11) Are you active in any particular sport? Yes No
- 12) Do you use a computer more than 10 hours a week? Yes No
- 13) Do you live or work in a dry, dusty, or smoky environment? Yes No
- 14) Do you work in an environment that requires safety eyewear protection? Yes No

Please answer below if you currently wear or have previously worn contact lenses!

- 1) Do you currently wear contact lenses? Yes No
- 2) What year did you start wearing contact lenses? _____
- 3) How old are your current contact lenses? _____
- 4) What frequency do you replace your lenses? _____
- 5) Please circle all types of lenses previously worn: **Hard** **Gas Permeable** **Soft**
- 6) Have you ever had a problem or sensitivity to a lens care system? Yes No
- 7) Is there anything that you particularly like about your current lenses? _____
- 8) If you could improve your present lenses, what could be better? _____
- 9) Are your current lenses dry toward the end of the day? Yes No
- 10) Do you sleep (overnight or nap) with your lenses on? Yes No
- 11) When wearing contact lenses, do you experience:
 Redness **S**ecretion, Tearing **V**ision, loss or distortion **P**ain, light sensitivity
- 12) Are you interested in "retainer" type lenses that are worn only during sleep to correct your vision during the day? Yes No
- 13) Are you interested in lenses that are worn continuously including sleep? Yes No
- 14) Do you wear eyeglasses over your contact lenses for near or far vision? Yes No

Signature/Date: _____ Parent/Guardian: _____