

Contact Lens Survey

This form is used to help us understand how your current contact lenses are working for you. By having all the data collected, we can come up with a plan of action that will best suit your needs.

Name of your contact lenses: _____

What is your Rx? _____

Place where you purchased them: _____

Please circle which answer is best.

1. Do you need improvement in vision in your current contact lenses?
a. Yes b. No c. Not sure

2. Is this brand of contacts comfortable on your eyes?
a. Yes b. No c. Not sure

3. What is your average wearing time per day?
a. 0-4 hrs b. 4-8 hrs c. 8-12 hrs d. 12-16 hrs e. 16+ hrs f. Overnight

4. What is your actual replacement schedule?
a. Daily b. 2 weeks c. Monthly d. 2-3 Months e. Whenever
they hurt f. Yearly

5. What bottle do you use to disinfect/soak your lenses overnight?
a. Opti-Free (green) b. Renu (blue) c. Complete (blue) d. Clear care (peroxide)
e. Generic f. Not Sure

6. Do you rub your lenses to clean them?
a. Yes b. No c. Sometimes

7. Do you use rewetting drops/ artificial tears with your contacts?
a. Yes b. No c. Sometimes

8. Would you like to wear the same brand again?
a. Yes b. No c. Maybe

9. Do you wear sunglasses over your contacts?
a. Yes b. No c. Sometimes