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## Contact Lens Visit Information Sheet

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Which kind of contact lens you wear? **Soft** | **Scleral** | **Gas Permeable**
2. Approximate age of current contact lenses? \_\_\_\_\_
3. At what time did you put in your contact lenses today? \_\_\_\_\_
4. Circle how long you normally keep your contact lenses in per day:  
**1-2 hrs.** | **2-4 hrs.** | **8-12 hrs.** | **12+ hrs.**
5. Describe vision with your right contact lens: **Poor** | **Fair** | **Good** | **Excellent**
6. Describe vision with your left contact lens: **Poor** | **Fair** | **Good** | **Excellent**
7. Describe your comfort with your right contact lens: **Poor** | **Fair** | **Good** | **Excellent**
8. Describe your comfort with your left contact lens: **Poor** | **Fair** | **Good** | **Excellent**
9. Do you need a new glasses prescription today? **Yes** | **No**
10. Do you have a copy of your current contact lens prescription? **Yes** | **No**
11. If you use a deep cleaner (Boston Adv., or Progent) how often? \_\_\_\_\_

### Circle the solutions/eye drops you use for:

**Cleaning:** Boston Advance Cleaner | Progent | NONE

**Disinfecting:** Clear Care | Unique pH | Boston Simplus | Bio True | Other: \_\_\_\_\_

**Rinsing:** Purilens | Addipak | Lacri Pure | Scleralfil, | Bausch & Lomb Sensitive Eyes Saline

### Filling Insertion:

Addipak | Lacri-Pure | Scleral Fil | Artificial Tears Preservative-Free (P.F) | Nutrifill

**Back-Up Solution:** Tangible | Unique pH | Boston Simplus | None | Other: \_\_\_\_\_

### Lubricating Eye Drops P.F Unit Dose Vials:

Refresh | Thera Tears (day) | Thera Tears Gel Drops | Systane Ultra | Other: \_\_\_\_\_

### Lubricating Eye Drops (Preserved Multi-Use Bottle):

Systane Ultra | Soothe XP | Blink Tears | Refresh

**Other:** \_\_\_\_\_

Please list any concerns or questions you may have today:

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