Patient Information (Contact Lens)	R : :
	ID

※① Mark all that apply with a check (✔) or ○
※② In case of emergencies, please insert your cellphone number
※③ All minors must include guardian contact numbers.
Seniors, please include family contacts or assisted living facility information

Name		Male Female
Birth date	Age:	
Telephone number		
Cellphone number		
Other contact number		
Address		

★ After the initial evaluation, there maybe complications such as scratches to the eye, which may result in not able to prescribe contact lenses.
Do you acknowledge and accept ? Yes No

(2) Are you using glasses or contacts now? Yes No

☐glasses ☐contacts ☐both ☐first time contacts

※If yes, continue to the following

1) Regarding glasses, is it ( ) fine ( ) normal ( ) difficult to see

2) How long have you used glasses? ( )years

3) Regarding contacts: Is it ( ) fine ( ) normal ( ) difficult to see

4) How long have you used contacts? ( ) years

5) How long has it been since you used contacts? ( ) years ( ) non applicable

6) How long do you use contacts in a day? ( ) hours ( ) When necessary ( ) sports

7) Name / maker of the contact you are using now ( )
( ) one day lens ( )soft lens ( ) hard lens ( ) other

8) Eye frequency Right eye ( ) Left eye ( )

9) Name of previous Optometrist office(s)

10) Are you wearing contacts now? ( ) Yes ( ) No

(2) What type of contacts are you interested in?
( ) Hard ( ) Soft (1M, 2W, 1 day, Color, Other)

(3) Is it for sports activities? ( ) Yes ( ) No

(4) Is it for Driving? ( ) Yes ( ) No

(5) Is it for computer use? ( ) Yes ( ) No

(6) Do you have any of the following? Yes No

☐Hyperemia ☐Eye discharge ☐Watery eyes ☐Dry eyes ☐ Itchy eyes
☐Pain ☐Blurry vision ☐Light sensitivity ☐Double vision
☐Impaired vision (long distance, short distance, both) ☐Tired/heavy eyes
☐Shoulder pain/ tightness ☐migraines ☐Swollen eye lids ☐Other