BRENART EYE CLINIC

Specialty Contact Lens Clinic

History and Lifestyle Questionnaire

Patient Name: _____ Date: _____

Instructions:

Please fill out this questionnaire to the best of your ability. This form is meant to assist your doctor in their medical decision making and best professional recommendations regarding your contact lens and eye health.

Contact Lens History:

*Please circle **YES** or **NO** for the following questions. Feel free to explain in further detail if prompted.*

Do you currently wear contact lenses? **YES NO** If you do, are you happy with them? **YES NO**

If you answered NO to either of the above questions, please explain why below.

_____

_____

Do you wear your contacts daily? **YES NO** If not daily, how often? _____

Do you experience dry or itchy eyes with your contact lenses? **YES NO**

Do you experience eye discomfort with your contact lenses? **YES NO**

Do you have difficulty driving due to glare with your contact lenses? **YES NO**

Do you have difficulty performing close activities with your contact lenses? **YES NO**

Do you experience fluctuations in your vision throughout the day with your contact lenses? **YES NO**

Do you experience focusing difficulties with your contact lenses? **YES NO**

Do you experience your eyes feeling strained or tired while wearing your contact lenses? **YES NO**

Do you feel unable to have good, comfortable vision all day with your contact lenses? **YES NO**

Do you ever fall asleep with your contact lenses in? **YES NO**

Do you feel confident and happy wearing your contact lenses? **YES NO**

If you answered NO to the above question, please provide us with more detail below.

_____

_____

Are you concerned about the initial and ongoing cost of your contact lenses? **YES NO**

Occupation and Lifestyle:

Please answer the below questions to the best of your ability. You do not have to answer any questions that you do not feel comfortable with. These questions are simply meant to give the doctor more information to make the most appropriate and informed decisions regarding your care.

What is your occupation? _____

Do you:

Work at a computer? **YES NO** How many hours a day? _____

Drive frequently for work? **YES NO** How many hours a day? _____

Work in a hazardous environment? **YES NO** Please explain: _____

Perform fine or close-up work? **YES NO**

Perform work outdoors all or part of the time? **YES NO**

Wear or have in your possession polarized sunglasses? **YES NO**

Understand the serious eye conditions that can develop from over exposure to UV rays? **YES NO**

Do you participate in any sports or recreational activities (e.g. golf, gardening, cycling etc.)? **YES NO**

Please provide more detail about sports or recreational activities you enjoy:

_____

_____

What hobbies do you enjoy? _____

Is there anything else you would like to share with us? _____

_____