Contact Lens Evaluation and Follow-Up

07.2012 CLEV

Patient _____ Age _____ Date _____

Type of Contacts: 1-Day 2wk 1mo Toric Multi RGP _____

How are your contacts? Doing Well Blurry Uncomfortable

Explain _____

When does it occur? Driving TV Reading Computer _____

Explain _____

Which Eye? Right Left Both

How long have you had your contacts in today? _____ hours

Do you sleep in your contacts? Yes No Sometimes

Explain _____

Other comments? _____

Doctor's Evaluation:

VA's: w/o OD 20/___ OS 20/___ OU 20/___
w/ D OD 20/___ OS 20/___ OU 20/___
w/ N OD 20/___ OS 20/___ OU 20/___

Over Rx: OD _____ 20/____
OS _____ 20/____

SLE: **OD** Fit / Centering / Rotation / Edge
OD Fit / Centering / Rotation / Edge

Assess: Good Progress Change Lens: OD OS OU

Trial Lenses: #1 #2 #3 OD _____
#1 #2 #3 OS _____

Plan: Order Boxes Pt to Call RTO: 1D 3D 1wk 1yr

Doctor _____ Date _____