NEW PATH VISION

PERSONALIZED EYE CARE | POTTSTOWN, PENNSYLVANIA

1100 Heritage Drive, Pottstown, PA 19464

610-326-2754 | office@newpathvision.com

Contact Lens History & Evaluation Form

Complete before a contact lens fitting or evaluation.

PATIENT AND CURRENT LENSES

Patient name

Date of birth

Current lens brand / type (if known)

Current prescription (if known)

- ☐ Daily disposable
- ☐ 2-week
- ☐ Monthly
- ☐ Soft toric / astigmatism
- ☐ Multifocal
- ☐ Rigid / gas permeable
- ☐ Scleral
- ☐ Other

WEAR HABITS

Typical hours worn per day

Days worn per week

Replacement frequency

- ☐ I sometimes sleep / nap in lenses
- ☐ I swim / shower in lenses

Cleaning / disinfection solution (if applicable)

CURRENT EXPERIENCE

Comfort score (0-10)

Vision score (0-10)

End-of-day wear time before discomfort

- ☐ Dryness
- ☐ Redness
- ☐ Burning
- ☐ Blur / fluctuation
- ☐ Lens awareness
- ☐ Lens movement
- ☐ Headaches
- ☐ Allergy symptoms
- ☐ Difficulty removing lenses
- ☐ Poor near vision
- ☐ Poor distance vision
- ☐ Night-driving problems

Describe any prior contact lens complications, infections, corneal problems, or discontinued lenses

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Goals and preferences

WHAT DO YOU WANT FROM CONTACT LENSES?

- ☐ Everyday wear
- ☐ Occasional / social wear
- ☐ Sports / recreation
- ☐ Backup to glasses
- ☐ Better near vision
- ☐ Better distance vision
- ☐ Multifocal / presbyopia option
- ☐ Astigmatism correction
- ☐ Improved comfort
- ☐ Other

LIFESTYLE AND ENVIRONMENT

Average screen time per day

Occupation / main visual tasks

- ☐ Dry / heated / air-conditioned environment
- ☐ Frequent outdoor / windy exposure

QUESTIONS FOR THE CONTACT LENS TEAM

Anything else we should know about your lens experience or goals?

Bring to your visit

Bring your current lenses, lens packaging if available, glasses, and any lens-care solution you use. Contact lens prescriptions are based on an eye examination and fitting; brand, material, fit and power may all matter.