## **Previous Contact lens patients**

Tell us about your current contact lens

\* Clear vision at distance and near

- ()YES
- ( ) NO

\* How often you replace your lens

- () Daily
- () Biweekly
- () Monthly

\* Comfortable (no issues wearing 8-10 hours/day)

- () YES
- ( ) NO

\* Please write here if you have any questions regarding your current contact lens.