The Eyewear Gallery
at Reston Town Center

We Care About Your Contact Lens Satisfaction

Patient Name: _____ Date: _____

1. How do your lenses feel right after you put them in?

   Poor ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Excellent

   What time do you put your contacts in? _____ ◯AM ◯PM

2. How do your lenses feel at the end of the day?

   Poor ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Excellent

   What time do you take your contacts out? _____ ◯AM ◯PM

3. Would you like to comfortably wear your lenses longer than you do now?

   ☐ Yes ☐ No

4. Do you use re-wetting drops?

   ☐ Yes ☐ No