

Scleral Wear & Care Questionnaire

Name & Date: _____

- 1. How old are your current set of lenses? _____
- 2. What time do you typically insert & remove your lenses? _____
- 3. Do you ever reapply your lenses in the middle of the day? If so, for what reason and how often?

4. What time did you first insert your lenses today? Have you re-applied them today? If so, at what time(s)?

5. What do you use to fill your lenses?

- Addipak (pink vials)
- PuriLens Mini/Plus
- Other: _____
- Lacripure
- Scleralfil _____
- Nutrifill
- VibrantVue _____

6. When are you discarding the saline used to fill your lenses? _____

7. How do you insert your lenses? **Large DMV plunger** / **Fingers** / **Other tool:** _____

8. Do you experience any difficulty inserting your lenses? **Always** **Sometimes** **Rarely** **Never**

9. How do you remove your lenses? **Small DMV plunger** / **Fingers** / **Other tool:** _____

10. Do you experience any difficulty removing your lenses? **Always** **Sometimes** **Rarely** **Never**

11. Which of the following products do you use to care for your lenses? Check all that apply.

- Multi-Purpose Solution
- Tangible Clean
- Unique pH
- Boston Simplus
- Hydrogen Peroxide System
- Clear Care
- Clear Care Plus
- Daily Cleaner
- Boston Advance Cleaner (Step 1)
- Daily Conditioner
- Boston Advance Conditioner (Step 2)
- Protein Remover
- Progent
- Coating Restoration
- Tangible Boost
- Other product(s) not listed above: _____

12. What do you use to rinse your lenses? _____

13. Other than your current pair of lenses, what other forms of correction do you have?

- Other contact lenses (what type? how old? _____)**
- Glasses (how old? _____)**

14. Does wearing your lenses cause any discomfort to your eyes? If so, please explain:

15. Do you have any questions about wearing & caring for your scleral lenses? **Yes** **No**