

Contact Lens Patients:

Do You Sleep In Contacts? Yes No If Yes, How Often? _____

How Often Do You Replace Your Lenses? _____

Type of Contact Lenses? _____

What Solution(s) Do You Use? _____

When Did You Last Wear Your Contact Lenses? _____

Are You Interested In Colored Contact Lenses? Yes No

Patient/Guardian Signature: _____

Guardian Name (Print) _____

Dilation Refusal

I do not want my eyes dilated. I understand that the doctor feels that it is necessary for a complete eye examination. I elect to omit this procedure and will not hold Drs. Gieske and/or Schechter responsible for any complications that may occur by the lack of this procedure. Dilation helps detect optic nerve disease, retinal pathology and brain dysfunction.

Patient Signature _____

Patient or Guardian Signature (if applicable) _____