NEUROLENS®
RELIEF IS IN SIGHT

Patient Follow-Up

Patient Name: _____ Neurolens Value: _____

Delivery Date: _____ OD: _____

After wearing your Neurolenses, how have your symptoms changed?

☐ **Decreased:**

Fantastic! Tell us about your experience.

☐ **Have Not Changed:**

How often do you wear your Neurolenses?

Schedule an appointment to verify measurements and make adjustments.

Date: _____

☐ **Worsened:**

How often do you wear your Neurolenses?

Schedule an appointment to verify measurements and make adjustments.

Date: _____

1 Never 2 Rarely 3 Sometimes 4 Very Often 5 Always

Symptoms	Before	After
Headache		
Neck / Shoulder Pain		
Discomfort With Computer Use		
Tired Eyes		
Dry Eye Sensation		
Light Sensitivity		
Motion Sickness		

Possible Action:

- Problem with adaptation/visual clarity:
  - ○ Encourage continuous wear of Neurolenses
  - ○ Schedule follow-up appointment to verify measurements
  - ○ New Refraction / Rx / Add: _____
- Symptom related problem:
  - ○ Review with Doctor
  - ○ Symptoms unchanged = Adjust prism higher
  - ○ Symptoms aggravated = Adjust prism lower