Px Name	**Date**	**Time**
Address		**Phone**
Referred by GP Pharmacist Other Walk-in Phone Letter Y / N **Px Normal Optometrist**		
Px Symptoms / Complaint		
Eye R L Both	**Time/Date of Onset**	Getting Worse / Same / Better
Pain Yes / No Severe Moderate Mild		**Redness** Yes / No
If **Floaters** are there **Flashes** Yes / No		**Is Vision affected** Severely Moderately No
Has the Px had similar symptoms before, if so when and what happened?		
Action Appointment made …….. Optom informed…….. Referred to another practice ……		
Optom Person contacted in person / phone Action		