

# EYE REDEEM UK

<b>Patient Name</b>	<b>Date of Birth</b>	<b>Phone number</b>	<b>Customer number</b>
<b>What is the problem?</b>			
<b>How long have you had this problem</b>			
1-2-3 Days	Less than 1 week	Less than 1 month	Over a month
<b>Which eye is affected</b>			
Right eye only	Left eye only	Affecting both eyes	
<b>Is there any pain</b>			
No discomfort	Irritable	Uncomfortable	Painful
<b>Is there any redness?</b>			
No redness	Mild redness	Moderate redness	Severe redness
<b>Any Flashes?</b>			
Yes		No	
<b>Any Floaters</b>			
Yes		No	

<b>Is there any discharge</b>			
Yes		No	
<b>Is the discharge</b>			
Gunky		Watery	
<b>Double Vision</b>			
Yes		No	
<b>Is your vision blurred?</b>			
Yes, right eye	Yes, left eye	Yes, both eyes	No
<b>Is there any discomfort or pain when looking at lights of bright places (photophobia)?</b>			
None	Mild	Moderate	Severe