DRY EYE SPEED QUESTIONNAIRE

Name: _____ Date: _____ Sex: _____ DOB _____

For the Standard Patient Evaluation of Eye Dryness (SPEED) Questionnaire, please answer the flowing questions by checking the box that best represents your answer. Select only one answer per question.

1. Report the type of SYMPTOMS you experience and when they occur:

	At This Visit		Within past 72 hrs		Within past 3 mos	
Symptoms	Yes	No	Yes	No	Yes	No
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2. Report the FREQUENCY of your symptoms using the rating list below:

Symptoms	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0=Never 1=Sometimes 2= Often 3= Constant

3. Report the SEVERITY of your symptoms using the rating list below:

Symptoms	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

0=No Problems
1= Tolerable- not perfect, but not uncomfortable
2= uncomfortable- irritating, but does not interfere with my day
3= Bothersome- irritating and interferes with my day
4= Intolerable- unable to perform my daily tasks

4. **Do you use eye drops for lubrication?** ___YES ___NO If yes, how often? _____

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Total SPEED Score (Frequency + Severity) = _____ / 28