SPEED DRY EYE QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

1. Do you regularly experience any of the following symptoms?
   - ❑ Dryness
   - ❑ Grittiness / Scratchiness
   - ❑ Burning / Stinging
   - ❑ Watering
   - ❑ Eye fatigue
   - ❑ Soreness / Irritation
   - ❑ Redness
   - ❑ Fluctuating vision
   - ❑ Contact lens discomfort
   - ❑ Light sensitivity
   - ❑ Stringy mucus in or around the eye

2. When did you first experience these symptoms? (Circle one)
   Today Within the last 72 hours Within the past 3 months

3. Report the **FREQUENCY** of your symptoms using the rating below:

Symptoms	(Circle one)
Dryness, Grittiness, or Scratchiness	**0** **1** **2** **3**
Soreness or Irritation	**0** **1** **2** **3**
Burning or Watering	**0** **1** **2** **3**
Eye Fatigue	**0** **1** **2** **3**

0 = Never **1** = Sometimes **2** = Often **3** = Constantly

4. Report the **SEVERITY** of your symptoms using the rating below:

Symptoms	(Circle one)
Dryness, Grittiness, or Scratchiness	**0** **1** **2** **3** **4**
Soreness or Irritation	**0** **1** **2** **3** **4**
Burning or Watering	**0** **1** **2** **3** **4**
Eye Fatigue	**0** **1** **2** **3** **4**

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

5. Do you use eye drops for lubrication? Yes No If yes, how often? _____

6. Please list, if any, all treatments that you have previously done for dry eye.
   _____

For office use only: Total SPEED score (Frequency + Severity) = _____ / 28

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