

## SPEED Questionnaire

Name: \_\_\_\_\_, \_\_\_\_\_  
(Last) (First)

Date: \_\_\_/\_\_\_/\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_

Sex: M F

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

SYMPTOMS	AT THIS VISIT		WITHIN PAST 72 HRS		WITHIN PAST 3 MONTHS	
	YES	NO	YES	NO	YES	NO
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

Report the **FREQUENCY** of the above-checked symptoms as Never, Sometimes, Often or Constant using the numbering system 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**

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

Do you use drops and/or ointment? \_\_\_\_\_ What drops do you use? \_\_\_\_\_