Advanced Eyecare Center Vision Source

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

Date:_____/____/____

SPEED Questionnaire

Name:_____

DOB:____/____/_____ Sex: M F (Circle)

How **FREQUENTLY** do you experience the following dry eye symptoms?

Symptoms	Never (0)	Sometimes (1)	Often (2)	Constant (3)
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

How **SEVERE** are your dry eye symptoms?

Symptoms	No problems (0)	Tolerable – not perfect but not uncomfortable (1)	Uncomfortable – irritating but does not interfere with my day (2)	Bothersome – irritating and interferes with my day (3)	Intolerable – unable to perform my daily tasks (4)
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

WHEN have you experienced these symptoms?
( ) Today ( ) Within the past 72 hours ( ) Within the past 3 months

Activities	Yes	No
Do you have difficulty reading?		
Do you have difficulty using a computer?		
Do you have difficulty driving?		
Do you have difficulty watching television?		
Do you have difficulty wearing contact lenses?		
Do you have difficulty being outdoors?		
Do your symptoms worsen throughout the day?		

Do you use drops and/or ointment? Yes No (Circle)
If yes, which drops and/or ointment do you use? _____How Frequently?_____
Do you experience blurred or fluctuating vision? Yes No (Circle)
Do you wear contact lenses? Yes No (Circle) How long can you wear comfortably? _____