SPEED QUESTIONAIRE

Name: _____ **Date:** _____

DOB: _____ **Sex:** ☐ Male ☐ Female

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionaire,
Please answer the following 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:

Symptoms:	At this Visit		Within the Past 72 Hours		Within the Past 3 Months	
	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:	Never	Sometimes	Often	Constant
	0	1	2	3
Dryness, Grittiness, or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

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

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

4. Do you use eye drops for lubrication? ☐ YES ☐ NO **If yes, how often?** _____

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