PremierVision
Center for Dry
Eye Relief

SPEED Questionnaire

Name: _____ **Date**:_____/_____/_____

Date of Birth: _____/_____/_____ **Sex:** M F (Circle)

Dry Eye Disease is the most frequent reason that patients visit eye doctors. We are concerned that you may be suffering with this condition as well. Therefore, we ask that you take a few moments and thoughtfully complete the questionnaire below.

Report the **FREQUENCY** of dry eye symptoms you are experiencing by checking Never, Sometimes, Often or constant using the numbering system below:

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

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

Report the **SEVERITY** of your symptoms using the ratings list below:

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

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

Total Speed Score (Frequency + Severity) =_____

Please mark with an X if you have experienced symptoms:

1) Today _____ 2) Within the last past 72 hours _____ 3) Within past 3 months_____

What time of day do you notice symptoms the most? Morning Evening During the night
Other:_____
Do you use eye drops and/or ointment? YES NO Today? YES NO
If yes, which drops do you use? Retaine Systane Visine Clear Eyes Other:_____
Do you have fluctuating vision problems? (blurry vision that comes and goes)
Circle: Never Sometimes Frequently A lot/Always
Additional Comments about symptoms:_____