

# SPEED QUESTIONNAIRE – Standard Patient Evaluation of Eye Dryness



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 & 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 last 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 you symptoms worsen throughout the day?		

Do you use eye drops and/or ointments?       Yes       No

If yes, which drops do you use? How frequently do you use them?

\_\_\_\_\_

Have you been told you have blepharitis or have you been treated for a sty?

Blepharitis       Yes       No

Stye       Yes       No

In what way is dry eye negatively impacting your lifestyle the most? \_\_\_\_\_

\_\_\_\_\_