

# SPEED™ QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Sex: M F (Circle) DOB: \_\_\_/\_\_\_/\_\_\_

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionnaire, 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 past 72 hours		Within 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	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

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

## 3. 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

4. Do you use eye drops for lubrication?     YES     NO    If yes, how often? \_\_\_\_\_