SPEED II Questionnaire

Name: _____, _____ Date: ____/____/____
(Last) (First)

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 eyes symptoms you are experiencing by checking Never, Sometime, 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					

Please mark with an X if your have experienced symptoms:
1) Today _____ 2: Within the last past 72 hours _____ 3: Within the past 3 months _____

Do you have fluctuating vision problems? (That can be corrected with blinking)
Circle: Never Sometimes Frequently A lot/Always

(For Internal Use Only)

Do you use eye drops and /or ointment YES NO (Circle) Today? Y N
If yes, which drops do you use? _____LAST 4 HOURS? Y N
Any Gels last 12 Hours? Y N Moisturizers, Lotion & Facial Creams Today? Y N
Have you touched/rubbed your eye(s) today? If so when & show us how you rub them.
How long ago did you touch/rub them?_____ Any make up today? Y N

Have you been told that you have blepharitis or have you been treated for a stye?
Blepharitis Yes No (Circle) Stye Yes No (Circle)