

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.

● 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

● 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

● Do you use eye drops for lubrication? YES NO If yes, how often? _____

For office use only
 Total SPEED score (Frequency + Severity) = ___/28