Park Cities EYE ASSOCIATES

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SPEED QUESTIONAIRE

Name: _____ Date: _____

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionnaire, please answer the following questions by checking the one box that best represents your answer.

Report the type of SYMPTOMS you experience and when they occur:

	At this visit		Within past 3 days		Within past 3 months	
Symptoms	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Dry, Gritty, Scratchy						
Stinging or Soreness						
Watery or Teary						
Eye Fatigue or Blur						

Report the FREQUENCY of your symptoms using the rating list below:

	0	**1**	**2**	**3**
Dry, Gritty, or Scratchy				
Sore or Irritated				
Burning or Watery				
Eye Fatigue				

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

Report the SEVERITY of your symptoms using the rating list below:

	0	**1**	**2**	**3**	**4**
Dry, Gritty, or Scratchy					
Sore or Irritated					
Burning or Watery					
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