SPEED Questionnaire

Date: ____/____/_____

Name: _______________________________ DOB: ____/____/____ Sex: **M** **F** **N/A** (please circle)

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 FREQUENCY of the following symptoms (if applicable) using the rating list 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				

2) Report the SEVERITY of your symptoms using the rating 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					

3) Do you use eye drops for Lubrication: ☐ NO ☐ YES IF yes, how often? __________________

Total Speed Score (Frequency + Severity): _________________