# SPEED QUESTIONNAIRE

NAME: ________________________________________ DATE: ________________

DOB: _____________________________ Sex: M F

*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.*

Do you have the following symptoms? (check all that may apply)

___ Dryness rate:
___ Grittiness / Scratchiness
___ Burning / Stinging
___ Watering
___ Eye Fatigue
___ Soreness/ Irritation
___ Redness
___ Itching
___ Fluctuating Vision
___ Contact Lens Discomfort
___ Light Sensitivity
___ Stringy mucus in / around eyes

Report the FREQUENCY of the symptoms you are experiencing:
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:
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 circle if you have experienced symptoms:
1) Today 2) Within the last 72 hours 3) Within the past 3 months

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

1. How long have you had discomfort or “felt your eyes? ________________
2. Describe how your eyes feel when you first wake up in the morning (and still in bed).
   ______________________________________________________________________
   ______________________________________________________________________
3. Describe how your eyes feel midday.
   ______________________________________________________________________
   ______________________________________________________________________
4. Describe how your eyes feel in the evening.
   ______________________________________________________________________
   ______________________________________________________________________
5. How do you spend your day (ex. Outdoors, reading, computer, etc.)
   ______________________________________________________________________
   ______________________________________________________________________
6. How many hours do you spend viewing a device per day (computer, TV, Phone)? ________________
7. List all products and treatments you have tried in the past. Put a *STAR* next to anything you are still using and indicate frequency.
   ______________________________________________________________________
   ______________________________________________________________________

| **Please rate the following symptoms*:*** | | **Rate 1-10 (*10 being the worst):*** |
|---|---|---|
| 1. Eyes are hard to open | Seldom/ Frequent / Daily | _______ |
| 2. Have to blink frequently | Seldom/ Frequent / Daily | _______ |
| 3. Must blink to see better | Seldom/ Frequent / Daily | _______ |
| 4. Tearing | Seldom/ Frequent / Daily | _______ |
| 5. Weepy discharge | Seldom/ Frequent / Daily | _______ |
| 6. Crusty discharge | Seldom/ Frequent / Daily | _______ |
| 7. Gritty | Seldom/ Frequent / Daily | _______ |
| 8. Itching | Seldom/ Frequent / Daily | _______ |
| 9. Burning | Seldom/ Frequent / Daily | _______ |
| 10. Redness | Seldom/ Frequent / Daily | _______ |
| 11. Foreign body sensation | Seldom/ Frequent / Daily | _______ |
| 12. Other: ____________ | Seldom/ Frequent / Daily | _______ |

*Continue on the back* →

**Select each condition you are treating:**

- ☐ Sjogren's
- ☐ Bell's Palsy
- ☐ Dermatitis
- ☐ Rosacea
- ☐ Lupus
- ☐ Insomnia
- ☐ Hepatitis C
- ☐ Fibromyalgia
- ☐ Sarcoidosis
- ☐ Chemo/ Radiation
- ☐ Herpes Simplex or Shingles
- ☐ Sleep Apnea / CPAP
- ☐ Allergies/ Hypersensitivities
- ☐ Rheumatoid Arthritis
- ☐ Other Autoimmune Disease

**Select each environment and activity that irritates your eyes:**

- ☐ Reading
- ☐ Device Use
- ☐ Contact Lenses
- ☐ Ceiling Fans
- ☐ Smoke
- ☐ Wind
- ☐ AC / Heat (home or car)
- ☐ Work setting
- ☐ Big Stores

| **Please rate the following systemic symptoms:** | | **Rate: 1-10 *(10 being the worst)*** |
|---|---|---|
| Dry Mouth | Never Seldom Frequent Always | ___________ |
| Joint Pain | Never Seldom Frequent Always | ___________ |
| Unexplained Fatigue | Never Seldom Frequent Always | ___________ |
| New or Undiagnosed Issue | Never Seldom Frequent Always | ___________ |