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.
   _____
   _____

3. Describe how your eyes feel in the evening.
   _____
   _____

4. How do you spend your day (ex. Outdoors, reading, computer, etc.)
   _____
   _____

5. How many hours do you spend viewing a device per day (computer, TV, Phone)? _____

6. List all products and treatments you have tried in the past. Put a *STAR* next to anything you are still using and indicate frequency.
   _____
   _____
   _____

7. Are you taking any Omega 3 Vitamins? If so, please list brand and dosage: _____

8. How much water do you drink per day? _____ oz

Are you being treated for any of the following? Please check any of the following if they apply to you:

- o Sjogren's
- o Bell's Palsy
- o Dermatitis
- o Rosacea
- o Lupus
- o Fibromyalgia
- o Sarcoidosis
- o Chemotherapy/Radiation
- o Herpes Simplex or Shingles
- o Sleep Apnea
- o Allergies / Hypersensitivities
- o Rheumatoid Arthritis
- o Other Autoimmune Disease