# 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.*

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

| | At this visit | | Within past 72 hours | | Within past 3 months | |
|---|---|---|---|---|---|---|
| **Symptoms** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** |
| Dryness, Grittiness or Scratchiness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Soreness or Irritation | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Burning or Watering | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Eye Fatigue | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**2. 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

**3. 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

**4. Do you use eye drops for lubrication?** ☐ **YES** ■ **NO** **If yes, how often?** _____

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