



Name: _____, _____
(Last) (First)

Date: ___/___/___

Date of Birth: ___/___/___ Sex: M F (Circle)

Dry Eye Disease is the most frequent reason that patients visit eye doctors. We are concerned that you may be suffering with this condition as well. Therefore, we ask that you take a few moments and thoughtfully complete the questionnaire below.

Report the **FREQUENCY** of dry eye symptoms you are experiencing by checking Never, Sometimes, Often or Constant using the numbering system 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				

Report the **SEVERITY** of your symptoms using the ratings below:

- 0=No problems
- 1=tolerable - not perfect, but not uncomfortable
- 2=Uncomfortable - irritation, but does not interfere with my day
- 3=Bothersome - irritating and interferes with my day
- 4=Intolerable - unable to perform my daily tasks

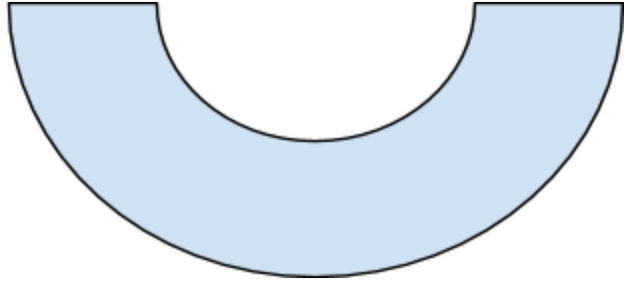
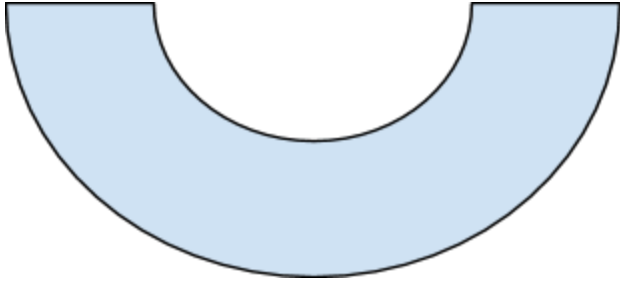
Symptoms	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					

Please mark with an X of you have experienced symptoms:

- 1) Today _____
- 2) Within the past 72 hours _____
- 3) Within past 3 months _____

Do you use eye drops and/or ointment? YES NO (Circle) If yes, which drops/ointment do you use?
Have you been told that you have blepharitis or have you been treated for a sty? Blepharitis YES NO (Circle) Sty YES NO (Circle)
Do you have fluctuating vision problems? (That can be corrected with blinking) Circle: Never Sometimes Frequently A Lot/Always

For office use only: Total SPEED score (Frequency + Severity)=



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For office use only:
Total SPEED score (Frequency + Severity)=