

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**DRY EYE QUESTIONNAIRE – SPEED**

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:

SYMPTOMS	TODAY		WITHIN PAST 72 HOURS		WITHIN PAST 3 MONTHS	
	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? \_\_\_\_\_

SCORE: \_\_\_\_\_