

# 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:

| Symptoms                            | At this visit |    | 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? \_\_\_\_\_