Primary Eye Care
Optical Gallery
Contact Lenses
Vision Therapy
Dry Eye Disease
Macular Health
Myopia Management

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SPEED DRY EYE DISEASE QUESTIONNAIRE

Patient Name: ______________________________ Date: M / D / Y CONTACTS:

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:

	Right now		Within 72 hrs		Within 3 months	
	YES	NO	YES	NO	YES	NO
Dry, Gritty, or Scratchy						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2) Report the FREQUENCY of your symptoms using the rating list below:

	0	1	2	3
Dry, Gritty, or Scratchy				
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:

	0	1	2	3	4
Dry, Gritty, or Scratchy					
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

(SPEED SCORE: ____)
(0-4 / 5-7 / 8+)