Speed II Questionnaire for Dry Eye Disease/Ocular Surface Disease

Name: ________________________________ **Date of Birth**: ___/____/_____ Male/Female **Date:** ___/___/___

Dry Eye Disease is the most frequent reason the 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 questions below.

Repot the **FREQUENCY** of the dry eye symptoms. How many times are you experiencing the symptoms?

SYMPTOMS	Never 0	Sometimes 1	Often 2	Constant 3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

Report the **SEVERITY** of the dry eye symptoms

Never = No problems
Tolerable= not perfect but not uncomfortable
Uncomfortable = irritating but does not interfere with my day
Bothersome = irritating and interferes with my day
Intolerable= unable to perform my daily tasks

SYMPTOMS	Never 0	Tolerable 1	Uncomfortable 2	Bothersome 3	Intolerable 4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

Please mark and **X** if you have experienced these symptoms"
Today __________ Within the past 72 hours __________ Within past 3 months __________

Do you use eye drops and/or ointments? YES NO Have you used them today? YES NO
Name of drops:____________________________ How long are they effective?_____________________
Do the drops last 4 hours? YES NO Do any gels last 12 hours? YES NO

Did you use Moisturizer, lotions or creams around eyes today? YES NO
Did you use makeup today? YES NO
Have you touched/rubbed your eye(s) today? YES NO If yes, when? __________ , How?______________________

Have you ever been told you have BLEPHARITIS? YES NO STYE? YES NO

Do you have fluctuating vision problems (that's gets better with BLINKING)
Never, Sometimes, Frequently, A lot/always

OFFICE USE ONLY Total Speed Score (Frequency + Severity) =