For office use only
Total SPEED score (Frequency + Severity) = /28
1-5 Mild, 6-10, Moderate,11-28 Severe

Date:____/____/____

SPEED Questionnaire

Name:_____

DOB:___/___/_____ Sex: M F (Circle)

How **FREQUENTLY** do you experience the following dry eye symptoms?

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

How **SEVERE** are your dry eye symptoms?

Symptoms	No problems (0)	Tolerable – not perfect but not uncomfortable (1)	Uncomfortable – irritating but does not interfere with my day (2)	Bothersome – irritating and interferes with my day (3)	Intolerable – unable to perform my daily tasks (4)
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

Do you use drops and/or ointment? Yes No (Circle)

If yes, which drops and/or ointment do you use? _____How Frequently?_____

Do you experience blurred or fluctuating vision? Yes No (Circle)

Do you wear CL's? Yes No (Circle) How long can you wear comfortably? _____