Eye Center of NEW YORK

SPEED II© DRY EYE QUESTIONNAIRE

Patient Name: _____ Date: _____

Dry Eye Disease is a common reason that patients visit eye doctors.
Please take a moment to thoughtfully complete the questionnaire.

1. Report the FREQUENCY of your symptoms by checking the box:

0 = Never **1** = Sometimes **2** = Often **3** = Constant

SYMPTOMS	0	1	2	3
Dryness, Grittiness or Scratchiness	☐	☐	☐	☐
Soreness or Irritation	☐	☐	☐	☐
Burning or Watering	☐	☐	☐	☐
Eye Fatigue	☐	☐	☐	☐

2. Report the SEVERITY of your symptoms using the rating list below:

0 = No Problems
1 = Tolerable - not perfect, but not uncomfortable
2 = Uncomfortable -irritating, but doesn't interfere with my day
3 = Bothersome - irritating and interferes with my day
4 = Intolerable - unable to perform my daily tasks

SYMPTOMS	0	1	2	3	4
Dryness, Grittiness or Scratchiness	☐	☐	☐	☐	☐
Soreness or Irritation	☐	☐	☐	☐	☐
Burning or Watering	☐	☐	☐	☐	☐
Eye Fatigue	☐	☐	☐	☐	☐

3. Please check if you have experienced above symptoms: ☐ Today ☐ Within Last 3 Days ☐ Within Past 3 Months

Do you use eye drops for lubrication? ☐ YES ☐ NO If yes, how often? _____

If yes, which drops do you currently use? _____

Do you have fluctuating vision? (that is corrected with blinking) ☐ Never ☐ Sometimes ☐ Frequently ☐ A Lot/Always

Have you been told you have ***blepharitis***? ☐ Yes ☐ No Have you been treated for a ***stye***? ☐ Yes ☐ No

Have you had any of these symptoms recently? ☐ Eyelid redness ☐ Crusting around lashes ☐ Lid irritation

For office use only: **Total Speed Score** (Frequency + Severity) =_____