

# 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.

Report 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

<b>OFFICE USE ONLY</b> Total Speed Score (Frequency + Severity) =
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