Eyesight
Uncompromising Care

Ocular Surface and Wellness
SPEED QUESTIONNAIRE

NAME:_____ Date_____
Last First

DOB_____ Birth Sex: ___M ___F

Report the type of **SYMPTOMS** you experience and when they occur:

SYMPTOMS	AT THIS VISIT		WITHIN THE PAST 72 HOURS		WITHIN THE PAST 3 MONTHS	
	YES	NO	YES	NO	YES	NO
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

Report the **FREQUENCY** of the above checked symptoms using the numbering system below:

SYMPTOMS	NEVER	SOMETIMES	OFTEN	CONSTANT
Number to enter	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

Report the **SEVERITY** of your symptoms using the rating listing below:

0 = No problems
1 = Tolerable – not perfect, but not uncomfortable
2 = Uncomfortable – irritating but does not interfere with my day-to-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					

Do you use eyedrops and/or ointment? ___Y ___N

If so, what drops/ointment do you use?_____