Eyesight
Uncompromising Care

Ocular Surface and Wellness
SPEED QUESTIONNAIRE

NAME:_____ Date_____
Last First

DOB_____ Birth Sex: ☐ M ☐ F

Please explain the **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	☐	☐	☐	☐	☐	☐

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

SYMPTOMS	NEVER	SOMETIMES	OFTEN	CONSTANT
Enter the corresponding number in response	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	1	2	3	4
No problems	***Tolerable*** *– not perfect, but not uncomfortable*	***Uncomfortable*** *– irritating but does not interfere with my day*	***Bothersome*** *– irritating & interferes with daily tasks*	***Intolerable*** *– unable to perform 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?_____

How long have you been treated for dry eye disease: ☐ Less than 1 year ☐ More than 2 years

Besides eyedrops or ointments, have you had other treatments? If yes, please explain

_____

Have you or a family member ever been diagnosed with an autoimmune disease such as Lupus, Rheumatoid Arthritis, Sjogren's, etc.? ☐ No ☐ Yes. If yes, please explain

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