SPEED Questionnaire

Optometry Times
PRACTICAL CHAIRSIDE ADVICE

Name: _____, _____ Date: ___/___/_____
(Last) (First)

DOB: ___/___/_____ **Sex:** M F

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

SYMPTOMS	AT THIS VISIT		WITHIN PAST 72 HRS		WITHIN 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 as Never, Sometimes, Often or Constant using the numbering system below:

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

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

Report the **SEVERITY** of your Symptoms using the rating list below:

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

0 = No problems
1 = Tolerable – not perfect but not uncomfortable
2 = Uncomfortable – irritating but does not interfere with my day
3 = Bothersome – irritating and interferes with my day
4 = Intolerable – unable to perform my daily tasks

Do you use drops and/or ointment? _____ What drops do you use?_____