Patient Name _____Date:_____

pacific medical centers
FIND WHAT YOU'RE LOOKING FOR

SPEED (Standard Patient Evaluation of Eye Dryness) Questionnaire

1. SYMPTOMS : Please check the box that best represents your experience.

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

2. FREQUENCY: How FREQUENT are your symptoms?

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

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

3. SEVERITY: How SEVERE are your symptoms?

0 = No problem **1** = tolerable **2** = uncomfortable, doesn't interfere with my day
3 = bothersome, interferes with my day **4** = Intolerable, unable to perform daily tasks

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

Do you use eyedrops for lubrication? **NO** **YES** _____ times per day

SPEED Score: _____