For office use only
Total SPEED score (Frequency + Severity) = _____/28
1-5 Mild, 6-10, Moderate,11-28 Severe

Date:_____/____/____

SPEED Questionnaire

Name:_____

DOB:____/____/_____ Sex: M F (Circle)

How **FREQUENTLY** do you experience the following dry eye symptoms?

Symptoms	Never (0)	Sometimes (1)	Often (2)	Constant (3)
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

How **SEVERE** are your dry eye symptoms?

Symptoms	No problems (0)	Tolerable – not perfect but not uncomfortable (1)	Uncomfortable – irritating but does not interfere with my day (2)	Bothersome – irritating and interferes with my day (3)	Intolerable – unable to perform my daily tasks (4)
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

WHEN have you experienced these symptoms?
( ) Today ( ) Within the past 72 hours ( ) Within the past 3 months

Activities	Yes	No
Do you have difficulty reading?		
Do you have difficulty using a computer?		
Do you have difficulty driving?		
Do you have difficulty watching television?		
Do you have difficulty wearing contact lenses?		
Do you have difficulty being outdoors?		
Do your symptoms worsen throughout the day?		

1. How long have you had symptoms? _____
2. Do you use drops and/or ointment? Yes No (Circle) If yes, which drops and/or ointment do you use? _____How Frequently?_____
3. Do you experience blurred or fluctuating vision? Yes No (Circle)
4. Do you wear CL's? Yes No (Circle) How many hours can you wear comfortably? _____
   - Do you experience dry eye symptoms when you are not wearing your contact lenses? Yes No (Circle)

5. Do you experience any of the following signs or symptoms? (Circle all that apply)
    - Dry Mouth
    - Fatigue/Body Aches
    - GI Distress
    - Muscle weakness or numbness of your arms and legs
    - Inability to Concentrate
6. Have you or a family member ever been diagnosed with an autoimmune disease such as Lupus, Rheumatoid Arthritis, Sjogren's or other associated Autoimmune Disease? Yes No (Circle)

7. Ocular Medications: Please check all that apply
    - Glaucoma Drips
    - Allergy Drops
    - Restasis
    - Xiidra
    - Lotemax
    - Pred Forte
    - FML
    - Autologous Serum Tears
    - Other
8. Have you ever been diagnosed with any of the following conditions?
    - Thyroid Disease
    - Diabetes
    - Sleep Disorders
    - Rosacea
    - Seborrhea Dermatitis
    - High Blood Pressure
    - Arthritis
    - Depression
    - Acne
    - Psoriasis
    - Multiple Sclerosis
    - Facial Herpes Zoster (Shingles)
    - Scleroderma
    - Stevens-Johnson Syndrome
9. Occupation: _____
    - Air Travel more than twice per month
    - Computer use more than one hour per day
10. Special Considerations: Please check all that apply
    - Routinely use ceiling fan in bedroom
    - Eye Surgery: Lasik or PRK: Yes No When:_____ Cataract Surgery: Yes No When:_____
    - Other Eye Surgery: What type_____ When:_____
    - Smoke
    - Alcohol Use? How Often_____
    - Allergies
11. Do you take an Omega-3? If yes what brand_____
12. Facial Cosmetic Procedures: ☐ Yes ☐ No If Yes What procedure? _____When? _____
13. Do you get Botox Injections ☐ Yes ☐ No
14. Do you use a C-Pap Machine ☐ Yes ☐ No
15. Have you ever taken Accutane: ☐ Yes ☐ No
16. Do your eyes bother you upon awakening or at night? ☐ Yes ☐ No