## **SPEED™** QUESTIONNAIRE

Name:	Dat	te:/	/ Sex: 1	M F (Circle)	) DOB:/_	/
For the Standardized Patient Evaluation checking the box that best represents					er the following q	uestions by
1. Report the type of <u>SYMPTOMS</u> yo	u experience	and when th	ey occur:			
	At this visit		Within past 72 hours		Within past 3 months	
Symptoms	Yes	No	Yes	No	Yes	No
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						
2. Report the <u>FREQUENCY</u> of your sy Symptoms	0	1	2	3		
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						
<ul><li>0 = Never 1 = Sometimes 2 = 0</li><li>3. Report the <u>SEVERITY</u> of your symptoms</li></ul>		Constant  ne rating list	below: 2	3	4	
Dryness, Grittiness or Scratchiness					<del>-</del>	7
Soreness or Irritation						_
Burning or Watering						
Eye Fatigue						
<ul> <li>0 = No Problems</li> <li>1 = Tolerable - not perfect, but not uncon</li> <li>2 = Uncomfortable - irritating, but does n</li> <li>3 = Bothersome - irritating and interferes</li> <li>4 = Intolerable - unable to perform my da</li> </ul>	ot interfere with with my day	n my day				1
4. Do you use eye drops for lubricati	on?	YES [] I	NO If yes, h	ow often? _		
Cornea 2013 Sep. 32/0) 1204-10			;			

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For office use only Total SPEED score (Frequency + Severity) = \_\_\_\_/28