HEARTLAND EYE CONSULTANTS

Patient Name: ______________________________ Date: ________________

DRY EYE QUESTIONNAIRE – SPEED

Please answer the following questions by checking the box that best represents your answer.
Select only **one** answer per question.

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

SYMPTOMS	TODAY		WITHIN PAST 72 HOURS		WITHIN PAST 3 MONTHS	
	YES	NO	YES	NO	YES	NO
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2. Report the **FREQUENCY** of your symptoms using the rating list 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

3. 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

4. Do you use eye drops for lubrication? ☐ YES ☐ NO **If yes, how often?** ___________________

SCORE:____________