Sparta Optometry

Compassionate Care
Excellence in Service

"SPEED" QUESTIONNAIRE

Date: _____/_____/_____

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

*For the **Standardized Patient Evaluation of Eye Dryness (SPEED)** Questionnaire, please answer the following questions by checking the box that best represents your answer. Select only one answer per question.*

1. Report the FREQUENCY of the following symptoms (if applicable) 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

2. Report the SEVERITY 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 = 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

3. Do you use eye drops for lubrication? Yes / No (Circle) If yes, how often? _____

Total Speed Score (Frequency + Severity): _____

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