SPEED II Questionnaire

Name: __________________________ (Last) __________________________ (First) Date: ____/____/_____
Date of Birth: ____/____/_____
Sex: M  F  (Circle)

Dry Eye Disease is the most frequent reason that patients visit eye doctors. We are concerned that you may be suffering with this condition as well. Therefore, we ask that you take a few moments and thoughtfully complete the questionnaire below.

Report the FREQUENCY of dry eye symptoms you are experiencing by checking Never, Sometimes, Often or Constant using the numbering system below:

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

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<thead>
<tr>
<th>SYMPTOMS</th>
<th>0</th>
<th>1</th>
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Report the SEVERITY of your symptoms using the ratings list below:

- 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

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Please mark with an X if you have experienced symptoms:
1) Today _____ 2) Within the last past 72 hours_____ 3) Within past 3 months_____

Do you use eye drops and/or ointment? YES  NO  (Circle) Today?  Y  N
If yes, which drops do you use? __________________________ Last 4 hours?  Y  N
Any Gels Last 12 Hours?  Y  N Moisturizers, Lotion & Facial Creams Today?   Y  N
Have you touched/rubbed your eye(s) today?? If so when & show us how you rub them
How long ago did you touch/rub them? Any make up today?  Y  N

Have you been told that you have blepharitis or have you been treated for a stye?
Blepharitis  YES  NO  (Circle)
Stye  YES  NO  (Circle)

Do you have fluctuating vision problems? (That can be corrected with blinking)
Circle: Never  Sometimes  Frequently  A Lot/Always

For office use only:  **Total Speed Score** (Frequency + Severity) = ______

updated March 2013