SPEED™ QUESTIONNAIRE

Name:	Dat	te:/	/ Sex:	M F (Circle)) DOB:/_	/
For the Standardized Patient Evaluation checking the box that best represents					er the following q	guestions 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						
0 = Never 1 = Sometimes 2 = 03. Report the <u>SEVERITY</u> of your symptoms		Constant ne rating list	below: 2	3	4	
Dryness, Grittiness or Scratchiness		<u> </u>		T	<u> </u>	7
Soreness or Irritation						1
Burning or Watering						-
Eye Fatigue						-
 0 = No Problems 1 = Tolerable - not perfect, but not uncon 2 = Uncomfortable - irritating, but does n 3 = Bothersome - irritating and interferes 4 = Intolerable - unable to perform my da 	ot interfere with with my day	h my day				
4. Do you use eye drops for lubricati	on?	YES I	NO If yes, h	ow often? _		
Cornea 2013 Sept32(0):1204-10			;			

Cornea. 2013 Sep;32(9):1204-10
© 2011 TearScience, Inc. All rights reserved.
13-ADV-123 A

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