GOOD EYE OPTOMETRY

Speed II® Dry Eye Questionnaire

Dry Eye Disease is more common than most people realize. Please take a moment to carefully complete this questionnaire to better enable your eye care provider to help you.

NAME

DATE

1 How OFTEN do you have these symptoms? (Check 1 box per row)

SYMPTOMS	0 Never	1 Sometimes	2 Often	2 Constant
Dryness, grittiness or scratchiness				
Soreness or irritation				
Burning or watering				
Eye fatigue				

2 How SEVERE are your symptoms? (Check 1 box per row)

SYMPTOMS	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 Irritating Unable to perform my daily tasks
Dryness, grittiness or scratchiness					
Soreness or irritation					
Burning or watering					
Eye fatigue					

3 Please check if you have experienced the above symptoms:

❑ Today ❑ Within the last 3 days ❑ Within the last 3 months

4 Do you use eye drops for lubrication?

❑ No ❑ Yes - How often? _____ What brand? _____

5 Do you have fluctuating vision (corrected with blinking)?

❑ Never ❑ Sometimes ❑ Frequently ❑ Almost Always

6 Have you been diagnosed with blepharitis?

❑ No ❑ Yes

7 Have you been treated for a stye?

❑ No ❑ Yes

8 Have you had any of the following symptoms recently?

❑ Eyelid redness ❑ Crusting around lashes ❑ Lid irritation

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