Aker Kasten Eye Center

SPEED Questionnaire

Office Use Only
Total SPEED Score (Frequency + Severity) _____ /28

Name: _____ DOB: _____ Sex: ☐ Male ☐ Female

How **FREQUENTLY** do you experience the following dry eye symptoms?

Symptoms	Never 0	Sometimes 1	Often 2	Constant 3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

How **SEVERE** are your dry eye symptoms?

Symptoms	No Problems 0	Tolerable 1	Uncomfortable 2	Bothersome 3	Intolerable 4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

WHEN have you experienced dry eye symptoms?

☐ Today ☐ Within the past 72 hours ☐ Within the past 3 months

Activities	Yes	No
Do you have difficulty reading?		
Do you have difficulty using a computer?		
Do you have difficulty driving?		
Do you have difficulty watching television?		
Do you have difficulty wearing contact lenses?		
Do you have difficulty being outdoors?		
Do your symptoms worsen throughout the day?		

Do you use drops and/or ointment? ☐ Yes ☐ No Name of Product: _____ Frequency: _____

Do you experience blurred or fluctuating vision? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No How long can you wear contacts comfortably? _____