GENEVA EYE CLINIC is assessing the severity of dry eyes in our clinic. We would appreciate it if you would take a moment and complete this short questionnaire. Thank you!

Patient Name: ______________________________

Date: ______________________ **Age:** ____________

DRY EYE QUESTIONNAIRE – SPEED

Please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

1. Report the **TYPE** of symptoms you experience and when they occur:

SYMPTOMS	At this visit	Within past 72 hours	Within past 3 months
Dryness, Grittiness or Scratchiness			
Soreness or Irritation			
Burning or Watering			
Eye Fatigue			

2. Report the **FREQUENCY** of your symptoms using the ratings 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

3. Report the **SEVERITY** of your symptoms using the ratings list below:

SYMPTOMS	0	1	2	3	4
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

4. Do you experience fluctuating vision that clears after blinking? □YES □ NO
   If yes, how often? ______________________

5. Do you use eye drops for lubrication? □YES □ NO If yes, how often? ________

6. Which eye do you feel is your most symptommatic eye? ____________________

7. Do you wear contacts? □YES □ NO If yes, how long do you wear them per day?
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