EAST LANSING FAMILY EYECARE

SPEED – Standardized Patient Evaluation of Eye Dryness

DRY EYE QUESTIONNAIRE

Today's date: _____/_____/_____

Name:_____ DOB:_____/_____/_____ (age = _____)

Dry Eye Disease and its related symptoms are one of the most common findings during eye exams. Please take a moment to thoughtfully complete this questionnaire.

√ Report the <u>FREQUENCY</u> of your symptoms by checking the box:

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

SYMPTOMS	0	1	2	3
Dryness, grittiness, or scratchiness				
Soreness or irritation				
Burning or watering				
Eye fatigue				

√ Report the <u>SEVERITY</u> of your symptoms using the following ratings:

0 = No Problem
1 = Tolerable; not perfect but not uncomfortable
2 = Uncomfortable; irritating but does not interfere with my day
3 = Bothersome; irritating and can interfere with my day
4 = Intolerable; unable to perform my daily tasks

SYMPTOMS	0	1	2	3	4
Dryness, grittiness, or scratchiness					
Soreness or irritation					
Burning or watering					
Eye fatigue					

Do you use lubricating eye drops and/or ointments? ___Yes ___No
If YES, how long are they effective? _____

Do you wear contact lenses that are NOT one-day disposable? ___Yes ___No
Did you use moisturizer, lotion, or cream around your eyes today? ___Yes ___No
Does your visual focus fluctuate often (improves right after blinking)? ___Yes ___No
Have you ever had an eyelid "stye"? ___Yes ___No

OFFICE USE ONLY total SPEED score: