Vision Source

EYECARE CONSULTANTS

DRY EYE SPEED II Questionnaire

Date: _____

(Office use only)

Total SP | |

Name: _____
(Last) (First)

Date of Birth: _____ Sex: M F (Cirlce One)

*Report the **FREQUENCY** of any dry eye symptoms you are experiencing using the grid below.*
Please check ( ) one box per line

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

*Report the **SEVERITY** of any dry eye symptoms you are experiencing using the gride below.*
Please check ( ) one box per line

SYMPTOMS	No Problem (0)	Tolerable (1)	Uncomfortable (2)	Bothersome (3)	Intolerable (4)
5. Dryness, Grittiness or Scratchiness					
6. Soreness or Irritation					
7. Burning or Watering					
8. Eye Fatigue					

9. Please mark if you have experienced any of the above symptoms:
_____Today _____Within the past 72 hours _____Within the past 3 months

10. Do you have fluctuating vision problems that improve if you blink?
_____Never _____Sometimes _____Fequently _____A Lot or Always

11. Do your symptoms affect your daily activities?
_____ Yes _____ No

12.Which activities seem to make your symptoms worst?
_____Reading _____Computer Use _____Close-Up Work _____Watching TV
_____Outdoor Activities _____Other

13. How long can you do the activity before your eyes start bothering you? _____

Eye drops and/or oniments used: **Y N** Today? **Y N** Past 4 Hours? **Y N** How long are they effective?_____
Name of drops / ointments / gels: _____
Any moisturizers, lotions or facial creams today? **Y N** Any make-up today? **Y N**
Any history of blepharitis or stye? **Y N**
Are you a Contact lens wearer? **SCL's (soft)** **RGP's (hard)**
How long have you been suffering with Dry Eye Symptoms?_____