Patient Name: _____ Date: _____

OREGON TRAIL EYE CENTER, PC

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	TODAY		WITHIN PAST 72 HOURS		WITHIN PAST 3 MONTHS	
	YES	NO	YES	NO	YES	NO
Dryness, Grittiness or Scratchiness	☐	☑	☑	☐	☐	☑
Soreness or Irritation	☐	☑	☐	☐	☐	☐
Burning or Watering	☑	☐	☐	☐	☐	☐
Eye Fatigue	☐	☐	☐	☐	☐	☐

2. Report the **FREQUENCY** of your symptoms using the rating 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 rating 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 use eye drops for lubrication? ☐ YES ☑ NO **If yes, how often?** _____

If your score is greater than 5, it's recommended that you consider seeking a consultation. **OPTIONAL** - You may fill in your contact information below and submit this form to our office for further review.

SCORE: 21

Clear Form

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