**Speed II Questionnaire for Dry Eye Disease/Ocular Surface Disease**

Name: ______________________________ Date of Birth: ___/___/_____ Male/Female Date: ___/___/___

Dry Eye Disease is the most frequent reason the patients visit eye doctors. We are concerned that you may be suffering with this condition as well. Therefore, we ask that you take a few moments and thoughtfully complete the questions below.

Repot the **FREQUENCY** of the dry eye symptoms. How many times are you experiencing the symptoms?

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>Never 0</th>
<th>Sometimes 1</th>
<th>Often 2</th>
<th>Constant 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dryness, Grittiness or Scratchiness</td>
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<tr>
<td>Soreness or Irritation</td>
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<td>Eye Fatigue</td>
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Report the **SEVERITY** of the dry eye symptoms

Never = No problems  
Tolerable = not perfect but not uncomfortable  
Uncomfortable = irritating but does not interfere with my day  
Bothersome = irritating and interferes with my day  
Intolerable = unable to perform my daily tasks

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Please mark and X if you have experienced these symptoms”

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

Do you use eye drops and/or ointments? YES NO  
Have you used them today? YES NO

Name of drops: ______________________________  
How long are they effective? __________________________

Do the drops last 4 hours? YES NO  
Do any gels last 12 hours? YES NO

Did you use Moisturizer, lotions or creams around eyes today? YES NO

Did you use makeup today? YES NO  
Have you touched/rubbed your eye(s) today? YES NO  
If yes, when? __________, How? __________________________

Have you ever been told you have BLEPHARITIS? YES NO  
STYE? YES NO

Do you have fluctuating vision problems (that’s gets better with BLINKING)  
Never, Sometimes, Frequently, A lot/always

OFFICE USE ONLY

Total Speed Score  
(Frequency + Severity) =