20/20 Vision Center

Dry Eye Questionnaire

Date:____/____/_____

Name:_____, _____
(First) (Last)

Date of Birth:_____/____/_____ Sex: M F (circle one)

(Office Use Only)
Total SPEED Score: _____
(Frequency + Severity)

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*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				

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*Report the **SEVERITY** of any dry eye symptoms you are experiencing using the grid 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					

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9. Please mark if you have experienced any of the above symptoms:
___Today ___Within the past 72 hrs ___Within the past 3 months

10. Do you have fluctuating vision problems that improve if you blink?
___Never ___Sometimes ___Frequently____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?_____
