MICHIANA EYE CENTER

SPEED Questionnaire Date: ___ /___ /___

Name: _____ DOB: ___ /___ /___ Sex: M F

Report the **FREQUENCY** of symptoms you are experiencing by checking one box in each row

SYMPTOMS	0 Never	1 Sometimes	2 Often	3 Constant
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

Report the **SEVERITY** of the symptoms you are experiencing by checking one box in each row

SYMPTOMS	0 Never	1 Tolerable	2 Uncomfortable	3 Bothersom	4 Intolerable
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

Total Score_____

Do you have fluctuating vision as a result of the above symptoms? Yes No (circle)

How many hours per day do you use computers, smartphones or tablets? 0-2hrs 3-7hrs 8hrs+ (circle)