For Office Use Only: SPEED SCORE _____

MargolisVision
State-of-the-Art Center for Medical, Surgical & Cosmetic Ophthalmology

Date: / /

SPEED Questionnaire:

Name: **DOB**:

How **FREQUENTLY** do you experience the following dry eye symptoms?

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

How **SEVERE** are your dry eye symptoms?

Symptoms	No problems (0)	Tolerable – not perfect but not uncomfortable (1)	Uncomfortable – irritating but does not interfere with my day (2)	Bothersome – irritating and interferes with my day (3)	Intolerable – unable to perform my daily tasks (4)
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

WHEN have you experienced these symptoms?

( ) Today ( ) Within the past 72 hours ( ) Within the past 3 months

Activities	Yes	No
Do you have difficulty reading?		
Do you have difficulty using a computer?		
Do you have difficulty driving?		
Do you have difficulty watching television?		
Do you have difficulty wearing contact lenses?		
Do you have difficulty being outdoors?		
Do your symptoms worsen throughout the day?		

Continued on Back Side

1. Do you have “Dry Eye” Symptoms? Yes No If Yes, how long? _____
2. Do you use drops and/or ointment? Yes No (Circle) If yes, which drops and/or ointment do you use? _____How Frequently?_____
3. Do you experience blurred or fluctuating vision? Yes No (Circle)
4. Do you wear Contact Lenses? Yes No (Circle) How many hours can you wear comfortably? _____
   - Do you experience dry eye symptoms when you are not wearing your contact lenses? Yes No (Circle)

MEDICAL CONDITIONS (CHECK ALL THAT APPLY)

	Diabetes		Sjogrens		Chemo / Radiation
	Hypertension		Bell’s Palsy		Rheumatoid Arthritis
	Thyroid: hyper / hypo		Allergies / Hypersensitivity		Arthritis
	Hepatitis C		Rosacea / Dermatitis		Sarcoidosis
	Facial Herpes / shingles		Acne		Autoimmune Disease
	Androgen deficiency		Stevens Johnson Syndrome		Sclerodermas
	Depression		Sleep disorders / CPAP		Lupus / Fibromyalgia
	Multiple Sclerosis				

SYMPTOMS (CHECK ALL THAT APPLY)

	Dry Mouth		Fatigue/Body Aches		Inability to Concentrate
	Unexplained Fatigue		GI Distress		Numbness of Arms and Legs
	Joint Pain		Muscle Weakness		

MEDICATIONS (CHECK ALL THAT APPLY)

	Antihistamines		Antidepressants		Diuretics
	Active bladder therapy		Birth control pills		Beta-blockers
	Hormone replacement		Accutane Now or Past		Retinol / Retinoids
	Fish oil / flaxseed oil		Botox injections		

OCULAR MEDICATIONS (CHECK ALL THAT APPLY)

	Glaucoma Drops……		Xiidra		FML
	Allergy Drops		Lotemax		Autologous Serum Tears
	Restasis		Pred Forte		

ENVIRONMENTAL IRRITANTS (CHECK ALL THAT APPLY)

	Reading		Computer / Device use >4 Hrs		Work Environment
	AC / Heat (home and car)		Wind		Fluorescent Lighting
	Ceiling fans		Department stores		Air Travel > 2 x per month

SPECIAL CONSIDERATIONS (CHECK ALL THAT APPLY)

	Eye Surgery – When?		Lasik or PRK – When?		Cataract Surgery – When?
	Alcohol Use – How Often?		Eyes irritated upon awakening?		Eyes irritated middle of night?
	Occupation?				