Speed Questionnaire

Carolina Vision Center

total score

Name:	Date: / /
DOB: / /	Sex: M F

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

Report the FREQUENCY of dry eye checked symptoms you are experiencing as Never, Sometimes Often or Constant using the numbering system below: (check one)

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 your Symptoms using the rating list below:
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

SYMPTOMS	0= no problems	1 = tolerable	2 = uncomfortable	3 = bothersome	4 = intolerable
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

Please mark with an X if you have experienced symptoms:

1) Today _____ 2) Within the last 72 hours _____ 3) Within past 3 months _____

Do you use eye drops and/or ointment		YES	NO	(circle)
If yes, which drops do you use?				
Have you been treated for a stye		YES	NO	
What time of day is your dry eye worst?		Morning	Afternoon	Night
Do you have fluctuating vision problems that can be corrected with blinking?	Never	Sometimes	Frequently	A lot/ Always

hwb 10/12