For office use only: **Total Speed Score** (Frequency + Severity) =_____

SPEED II Questionnaire

Name: _____, _____ **Date**: _____/_____/_____
(Last) (First)

Date of Birth: _____/_____/_____ **Sex:** M F (Circle)

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 ask that you take a few moments and thoughtfully complete the questionnaire below.

Report the **FREQUENCY** of dry eye symptoms you are experiencing by checking Never, Sometimes, Often or Constant using the numbering system below:

0 = Never, 1 = Sometimes, 2 = Often, 3 = Constant

SYMPTOMS	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

Report the **SEVERITY** of your symptoms using the ratings 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	1	2	3	4
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 past 72 hours _____ 3) Within past 3 months_____

Do you use eye drops and/or ointment? YES NO (Circle) Today? Y N
If yes, which drops do you use?_____ Last 4 hours? Y N
Any Gels Last 12 Hours? Y N Moisturizers, Lotion & Facial Creams Today? Y N
Have you touched/rubbed your eye(s) today?? If so when & show us how you rub them
How long ago did you touch/rub them? Any make up today? Y N
What Omegas do you take?_____ Do you have Punctal plugs? Y N

Have you been told that you have blepharitis or have you been treated for a stye?
Blepharitis YES NO (Circle)
Stye YES NO (Circle)

Do you have fluctuating vision problems? (That can be corrected with blinking)
Circle: Never Sometimes Frequently A Lot/Always

FOR WEBSITE (POSITIVE SELF-TESTING PATIENT), CLINIC SCHEDULING, AND SWITCH BOARD/PHONE RECEPTION

TearScience LipiView System Patient Pre-Testing Instructions:

1. **No eye gels the night before or the day of testing**
2. **No Dry Eye drops the day of testing**
3. **No Eye medications less than two hours before testing (i.e. Glaucoma Meds)**
4. **No contact lens wear the day of testing, OK after testing**
5. **No eye make up, facial moisturizers, lotions before testing, the day of testing**
6. **No direct rubbing or touching your eyes two hours before testing**