KOKOPELLI
EYE INSTITUTE
OUR VISION IS TO CARE ABOUT YOURS

Patient Name: ______________________________

Date: ______________________________________

SPEED (Standard Patient Evaluation of Eye Dryness) QUESTIONNAIRE

Please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

1. **Report the type of SYMPTOMS you experience and when they occur:**

SYMPTOMS	HOW FREQUENT/SEVERE?			
	0	1	2	3
Dryness, Grittiness, or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

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

2. **Do you use eye drops for lubrication?** ☐ **YES** ☐ **NO**
   a. **If yes, how often?** ________________________________

TOTAL: ________/ 12