CLEAR VIEW EYE ASSOCIATES

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Speed Questionnaire

Name: _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____

Do you have any of the following symptoms?

☐ Dryness
☐ Grittiness/Scratchiness
☐ Burning/Stinging
☐ Watering
☐ Eye Fatigue
☐ Soreness/Irritation
☐ Redness
☐ Itching
☐ Fluctuating vision
☐ Contact lens discomfort
☐ Light sensitivity
☐ Stringy mucus

Report the **FREQUENCY** of the symptoms you are experiencing:

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:

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					

How often do you experience symptoms?

1) Every Day 2) Once per Week 3) Once per Month