KIRK EYE CENTER

Speed Questionnaire

Name _____ Date _____/_____/_____

DOB _____/_____/_____ Sex ❑ M ❑ F

How **FREQUENTLY** do you experience 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?		

Do you use drops and/or ointment? ❑ Yes ❑ No

If yes, which drops and/or ointment do you use? _____

How frequently do you use the drops and/or ointment? _____

For the following questions, CIRCLE ONLY ONE ANSWER AND ROUND TO THE NEAREST HOUR

How many hours of sleep did you get last night?

<3 3 4 5 6 7 8 9 10 >10

On average, how many hours of sleep do you get each night?

<3 3 4 5 6 7 8 9 10 >10