TOTAL VISION Family Eye Care

OCULAR WELLNESS QUESTIONNAIRE

At Total Vision Family Eye Care, we are committed to diagnosing and treating conditions that provide our patients with the best vision and eye health possible, for a lifetime. We'd like to learn as much about you and your eyes as possible, please take a moment to complete the following questionnaire.

Name: _____ **Date:** _____

DOB: _____

How **FREQUENTLY** do you experience the following dry eye 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?	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 eye discomfort when reading?	☐	☐
Do you have eye discomfort using a computer?	☐	☐
Do you have eye discomfort while watching television?	☐	☐
Does being outdoors cause glare or watering?	☐	☐
Is your contact lens comfort perfect?	☐	☐
Are you concerned about signs of aging around your eyes or elsewhere on your face (e.g. fine lines, wrinkles, pigment changes, redness, age spots)?	☐	☐
Have you had lash extensions (or considering in the future)?	☐	☐
Are you using a lash lengthening product?	☐	☐

For office use only

Total SPEED score

(Frequency +Severity) =

_____ / 28

1-5 Mild
6-10 Moderate
11-28 Severe

SPEED™ QUESTIONNAIRE
Standard Patient Evaluation of Eye Dryness