**SPEED II® PREOP OSD QUESTIONNAIRE**

**Patient Name:** __________________________________________________________________________

**Date:** ________________________________________________________________________________

1. Report the **FREQUENCY** of your symptoms using the rating list below:

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dryness, Grittiness or Scratchiness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soreness or Irritation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burning or Watering</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Eye Fatigue</td>
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</tr>
</tbody>
</table>

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

2. Report the **SEVERITY** of your symptoms using the rating list below:

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
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- 0 = No problems
- 1 = Tolerable – not perfect but not uncomfortable
- 2 = Uncomfortable – irritating but doesn’t interfere with my day
- 3 = Bothersome – irritating and interferes with my day
- 4 = Intolerable – unable to perform my daily tasks

3. Please check if you have experienced above symptoms:

- [ ] Today
- [ ] Within last 3 days
- [ ] Within past 3 months

- Do you use eye drops for lubrication? [ ] Yes [ ] No If yes, how often? __________________________

- Do you have fluctuating vision? [ ] Never [ ] Sometimes [ ] Frequently [ ] Always

- If yes, does the fluctuating vision improve with blinking and/or lubricating drops? [ ] Yes [ ] No

- Have you been told you have **blepharitis**? [ ] Yes [ ] No

- Have you been treated for a **stye**? [ ] Yes [ ] No

- Have you had any of these symptoms recently? [ ] Eyelid redness [ ] Crusting around lashes [ ] Lid irritation

- Do you wear contact lenses? [ ] Yes [ ] No

- If yes, when was the last time you wore them? __________________________

- If yes, do your eyes feel worse when they’re on? [ ] Yes [ ] No

- Do your eyes itch? [ ] Never [ ] Sometimes [ ] Frequently [ ] Always

- If yes, do you have known environmental allergies or allergic conjunctivitis? [ ] Yes [ ] No

- Are your ocular symptoms symmetric between both eyes? [ ] Yes [ ] No

- If no, which eye is the most symptomatic? [ ] Right [ ] Left

- Do you mind wearing glasses and/or contact lenses for improving your vision? [ ] Yes [ ] No

- If yes, would you be willing to pay out-of-pocket costs to reduce or eliminate your dependence on them? [ ] Yes [ ] No

Please place an “X” on the following scale to describe your personality as best you can:

- [ ] Easy Going

**For office use only:** **Total Speed Score** (Frequency + Severity) = _____ / 28  **Number of Red boxes checked = _____ / 18**