

## SPEED II® PREOP OSD QUESTIONNAIRE

Dry Eye Disease is a common reason that patients visit eye doctors, and it can have an impact on surgical outcomes. Please take a moment to thoughtfully complete the questionnaire.

| Patient Name: | <br> |  |
|---------------|------|--|
| Date:         |      |  |

| <ol> <li>Report the FREQUENCY</li> </ol> | of your s | ymptoms using | the rating | list below: |
|--|-----------|---------------|------------|-------------|
|--|-----------|---------------|------------|-------------|

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

| SYMPTOMS                            | 0 | 1 | 2 | 3 | 4 |
|-------------------------------------|---|---|---|---|---|
| Dryness, Grittiness or Scratchiness |   |   |   |   |   |
| Soreness or Irritation              |   |   |   |   |   |
| Burning or Watering                 |   |   |   |   |   |
| Eye Fatigue                         |   |   |   |   |   |

**0** = No problems

1 = Tolerable – not perfect but not uncomfortable

2 = Uncomfortable - irritating but doesn't interfere with my day

Perfectionist >

**3** = Bothersome – irritating and interferes with my day

**4** = Intolerable – unable to perform my daily tasks

|  | 3. | Please | check if | vou have | experienced | above symptoms: |
|--|----|--------|----------|----------|-------------|-----------------|
|--|----|--------|----------|----------|-------------|-----------------|

**■ Easy Going** 

| 5. Flease check if you have experienced above sym     | iptoms.        |                      |                |                      |      |
|---|----------------|----------------------|----------------|----------------------|------|
| □ Today □ Within last 3 days □ Within p               | oast 3 month   | S                    |                |                      |      |
| Do you use eye drops for lubrication?                 | □ Yes          | □ No If yes,         | how often?     |                      |      |
| Do you have fluctuating vision?                       | ☐ Never        | Sometimes            | ☐ Frequently   | y 🔲 Always           |      |
| If yes, does the fluctuating vision improve with blin | nking and/or   | lubricating drops?   | □ Yes □        | □ No                 |      |
| Have you been told you have <i>blepharitis</i> ?      | □ Yes          | □ No                 |                |                      |      |
| Have you been treated for a <i>stye</i> ?             | Yes            | □ No                 |                |                      |      |
| Have you had any of these symptoms recently?          | Eyelid r       | edness 🗖 Crust       | ing around las | hes 🔲 Lid irritation | 1    |
| 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   | y 🔲 Always           |      |
| If yes, do you have known environmental allergies     | or allergic co | njunctivitis?        | □ Yes □        | □ No                 |      |
| Are your ocular symptoms symmetric between bo         | th eyes?       | ☐ Yes ☐ No           | 0              |                      |      |
| If no, which eye is the most symptomatic?             | □ Right        | □ Left               |                |                      |      |
| Do you mind wearing glasses and/or contact lense      | es for improvi | ng your vision?      | □ Yes [        | □ No                 |      |
| If yes, would you be willing to pay out-of-pocket c   | osts to reduc  | e or elimminate you  | ır dependence  | on them?             | □ No |
| Please place an "X" on the following scale to descr   | ibe your pers  | sonality as best you | can:           |                      |      |
| ļ   |                | 1                    |                |                      |      |
| <b>+</b>  |                | -                    |                |                      |      |

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