Eyelid and Brow Questionnaire

eye surgical associates

Patient Name:_____ Chart #:_____

Eyelids: BOTH Right Left Upper Lower

VISUAL FUNCTIONING

Do you have difficulty with the following activities due to your EYELIDS, EYEBROWS OR EYELASHES?

1. Driving? YES ☐ NO ☐
2. Reading? YES ☐ NO ☐
3. Computer? YES ☐ NO ☐
4. Difficulty getting eyeglasses to fit? YES ☐ NO ☐
5. Are other activities an issue? (Please list those related to eyelids, brow or lashes):
   a. _____
   b. _____
   c. _____

SYMPTOMS

Have you been bothered by:

1. Eyelids or eyelid skin blocking your vision:
   a. All the time? YES ☐ NO ☐
   b. Only when looking up? YES ☐ NO ☐
2. Eyelashes in your vision? YES ☐ NO ☐
3. Drooping brow? YES ☐ NO ☐
4. Does fatigue cause any of the above to worsen? YES ☐ NO ☐
5. Does eyelid skin seem more irritated because of any of the above? YES ☐ NO ☐
6. Do you have to tip your head to see better? YES ☐ NO ☐
7. Brow or forehead ache? YES ☐ NO ☐
8. Uncontrollable eyelid or brow spasm? YES ☐ NO ☐
9. Is one SIDE or EYE worse than the other? YES ☐ NO ☐
   If so, which is worse? Right ☐ Left ☐
10. Do you feel that your symptoms are worse during the evening? YES ☐ NO ☐

How long have any of these problems been an issue for you?
(Circle 1): Less than 6 months 6 months to a year More than a year

If the only way to improve your symptoms is to have surgery, do you feel your problem is bad enough to consider this type of surgery now? YES ☐ NO ☐

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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