Patient Name: ______________________________ Date of Birth: ______________________________

Eyelid Questionnaire

Please circle one response for each question:

Question				
Do you feel a sensation of heaviness of the upper eyelid?	Never	Sometimes	Frequently	Daily
Do you experience an ache or fatigue of your eyebrows or forehead later in the day?	Never	Sometimes	Frequently	Daily
Do other people tell you that your eyes or eyelids look tired and droopy?	Never	Sometimes	Frequently	Daily
Do you notice droopy/heavy eyelids when you view yourself in the mirror or in photos?	Never	Sometimes	Frequently	Daily
Do you notice decreased upper vision that improves when you raise your eyebrows, tilt your head back or lift your eyelids with your fingers?	Never	Sometimes	Frequently	Daily
Do you have difficulty with the following activities?				
1. Seeing elevated traffic or street signs while driving?	Never	Sometimes	Frequently	Daily
2. Working at a computer or reading without raising your eyebrows?	Never	Sometimes	Frequently	Daily
3. Applying eye shadow or mascara due to excess eyelid skin?	Never	Sometimes	Frequently	Daily
4. Performing routine activities, work or hobbies without raising your eyebrows?	Never	Sometimes	Frequently	Daily
On a scale of 0 to 10, please rate your pain, with zero being no pain and 10 be the worst level of pain.	______________________________			

By signing below, I certify the above information is complete and correct to the best of my knowledge

Patient Name: ______________________________________ Date: _______________________

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