Eyelid Evaluation Questionnaire

Patient Name: _____ DOB _____

Do you have difficulty with the following activities due to your eyelids?

	YES	NO
Driving?		
Reading?		
Computer?		
Difficulty getting eyeglasses to fit?		

Are other activities an issue? (please list those related to eyelids)

a._____

b._____

c._____

d._____

Have you been bothered by:

	YES	NO
Eyelids or eyelid skin blocking your vision?		
All the time?		
Some of the time?		
Only when looking up?		
Eyelashes in your vision?		
Does fatigue cause any of the above to worsen?		
Does eyelid skin seem more irritated due to excess skin?		
Do you have to tip your head back to see better?		
Brow or forehead ache?		
Do your eyes seem smaller or not to open fully?		
Is one side or eye worse than the other? If so, which side is worse? _____		

How long have any of these problems been an issue for you? (circle one)

Less than 6 months 6 months to a year More than a year

Please Circle any of the following areas which you may be interested in improving:

Drooping eyelids puffy lower eyelids looking "tired"

Excess eyelid skin lines between eyes dark circles under eyes

Removal of moles

Have you had Botox injected? ___Yes ___ No Please **circle** where: Brows/Crows Feet/Forehead

When was your last treatment? _____

Have you had filler injected? ___Yes ___ No Which one? _____

Please **circle** where it was injected: Upper Lids/Lower Lids/ Brow/Cheeks/ Jawls

Patient Name: _____ DOB: _____

Signature: _____ Date: _____