

### 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/ Jaws

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_