

# Eyelid Symptom Questionnaire

Please read each question below and circle all responses that apply.

Please write down any specific comments about your eyelids - the more detailed the better the doctor will be able to address your concerns.

**My eyelid(s) feel:**

Normal      Heavy      Tired      Droopy      Like they are closing

**My peripheral vision is:**

Normal      Decreased by my eyelids

**I have difficulty with reading or looking down because my eyelid(s) is/are in the way:**

No      Yes

**I have difficulty with driving because my eyelid(s) is/are in the way:**

No      Yes

**I feel I have to open my eye(s) wide in order to see well:**

No      Yes

**I sometimes lift my eyelid(s) with a finger in order to see well:**

No      Yes

**I feel I have to tilt my chin up in order to see well:**

No      Yes

**I am unhappy with the appearance of my upper or lower eyelids:**

No      Yes

Comments

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