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**Eyelid Malposition Questionnaire**

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| # | **HISTORY** | **Response** | |
| 1 | How long has this issue been present for? |  | |
| 2 | Which side is affected? | [ ] Right  [ ] Left  [ ] Both | |
| 3 | Which best describes your condition? | [ ] Eyelid turns outward (lid droops forward)  [ ] Eyelid turns inward (lashes towards eye)  [ ] Eyelid too low/high | |
| # | **MALPOSITION QUESTIONS** | **No** | **Yes** |
| 4 | Have you had prior surgery to address the issue | □ | □ What/when: |
| 5 | Are you using medications to treat the issue? | □ | □ Which medications?  (Please circle if currently using) |
| 6 | Are you experiencing tearing? | □ | □ |
| 7 | Are you experiencing eye irritation? | □ | □ |
| 8 | Are you experiencing eye redness? | □ | □ |
| 9 | Do you sleep on the affected side(s) | □ | □ |
| 10 | Do you rub your eye(s)? | □ | □ |
| 11 | Do you use a CPAP, or snore? | □ | □ |
| 12 | Do you have a history of thyroid disease? | □ | □ |