

**Orbit Questionnaire**

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| # | **HISTORY** | **Response** |
| 1 | Which side is affected? | [ ] Right[ ] Left[ ] Both |
| 2 | Briefly describe your diagnosis, to the best of your knowledge |  |
| 3 | How long has this issue been present for? |  |
| # | **SYMPTOMS** | **No** | **Yes** |
| 4 | Are you experiencing any double vision? | □ | □ |
| 5 | Have you lost any vision? |  |  |
| 6 | Are you experiencing any new flashing lights or floaters? | □ | □ |
| 7 | Have you noticed changes your eyes’ appearance? | □ | □ |
| 8 | Do you experience double vision? | □ | □ |
| 9 | Do your eyelids appear red? | □ | □ |
| 10 | Do your eyelids appear swollen? | □ | □ |
| 11 | Do you think your appearance has changed? | □ | □ |
| 12 | Do you have pain with eye movement? | □ | □ |
| 13 | Do you have eye pain without moving your eyes? | □ | □ |
| 14 | Does the surface of your eyes appear red? | □ | □ |
| 15 | Was a CT/MRI performed? | □ | □ What facility performed this? |
| 16 | Have you had any eyelid/orbit surgeries? | □ | □ What? |
| 17 | Are you being treated with any medications for this condition? | □ | □ Which medications? |