Please answer the following questions about your facial paralysis:

1. Affected side of the face: □ left □ right □ both

2. Date of onset (as close as possible): ______________________________

3. Was the paralysis: a: □ incomplete (some movement) -OR- □ complete (no movement)
   b: □ rapid onset (within 48 hours) -OR- □ slowly progressed over time

4. Were you seen by a health care provider for your facial paralysis? □ yes □ no
   How long after the paralysis started were you seen? ______________________________
   Were you given medicine(s) for the paralysis (please list):
   __________________________________________________________________________

5. Have you had facial paralysis on this side of your face before? If so, when? ______________
   Have you had facial paralysis on the opposite side of your face before? If so, when? ______________

6. During the facial paralysis, did you have a rash on your ear or face/neck? □ yes □ no
   Did you have □ dizziness □ tinnitus (ringing in the ear) □ hearing loss □ ear drainage □ pain

7. What was the cause of the paralysis: (check one)
   □ Bell's palsy
   □ Brain tumor, such as acoustic neuroma (please list):
   □ Cancer, such as squamous cell carcinoma (please list type and location):
   □ Trauma (please list):
   □ Ramsay Hunt syndrome (shingles):
   □ Other: _____________________________________

8. Have any tests been done to assess the paralysis (MRI, CT or EMG)? Please give details and
   the date and location where testing was done: ______________________________
   __________________________________________________________________________

9. Functional problems (check all that apply):
   □ Eye closure □ Speech □ Undesired facial movements (synkinesis)
   □ Eating or chewing □ Nasal breathing □ Tightness, spasm, or facial pain
   □ Drinking □ Smiling □ Other: ____________________________________
10. Please describe how your face looks compared to the unaffected side (check box):
   - Eye size? □ larger   □ smaller   □ equal
   - Nasolabial fold (crease between nose and corner of mouth)? □ deeper   □ less deep   □ equal
   - Neck cords during smile or pucker? □ present   □ not present

11. Past surgeries on your ear, face, or neck (list and before or after paralysis including dates): __________

12. Past therapy (include dates and location on face): _______________________________________________________________________

13. Past botulinum (Botox or Xeomin) injections (include dates and location on face): _________________

14. Patients with facial nerve paralysis often have symptoms of depression, anxiety, and difficulties coping with changes in how they look. Would you like to be referred to a provider who can talk with you more about how you are coping and adjusting to this medical condition? □ yes   □ no

Signature of Patient/Representative: ____________________________________ Date: _________ Time: ___________

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: ____________________________________________ Relationship: _________________________________

Patient is: □ Minor   □ Incompetent/Incapacitated
Legal Authority: □ Legal Guardian   □ Parent of Minor
            □ Health Care Agent   □ Other ________________________

Reviewed by: ____________________________________________ Date: _________ Time: ___________