Patient Name

DOB:

MR #

UW Health
(University of Wisconsin Hospitals and Clinics Authority)

FACIAL CLINIMETRIC EVALUATION (FACE) SCALE WORKSHEET

Date: _____

You may have answered these or similar questions before. Please answer ALL QUESTIONS as best you can.
The following statements are about how you think your face is moving.

(CIRCLE only ONE number)	One side	Both sides	I have no difficulty
When I try to move my face, I find that I have difficulty on:	1	2	0

(If you have problems on BOTH sides, answer the questions in the remainder of the survey with regard to the more affected side, or with regard to both sides if they are equally affected.)

In the PAST WEEK:

(CIRCLE only ONE number on each line)	Not at all	Only if I concentrate	A little	Almost Normally	Normally
1. When I *smile*, the affected side of my mouth goes up	1	2	3	4	5
2. I can raise my eyebrow on the affected side	1	2	3	4	5
3. When I *pucker* my lips, the affected side of my mouth moves	1	2	3	4	5

The following are statements about how you might feel because of your FACE OR FACIAL PROBLEM.

Please rate how often each of the following statements applied to you during the PAST WEEK.

(CIRCLE only ONE number on each line)	All of the time	Most of the time	Some of the time	A little of the time	None of the time
4. Parts of my face feel tight, worn out, or uncomfortable	1	2	3	4	5
5. My affected eye feels dry, irritated, or scratchy	1	2	3	4	5
6. When I move my face, I feel tension, pain, or spasm	1	2	3	4	5
7. I use eye drops or ointment in my affected eye	1	2	3	4	5
8. My affected eye is wet or has tears in it	1	2	3	4	5
9. I act differently around people because of my face or facial problem	1	2	3	4	5
10. People treat me differently because of my face	1	2	3	4	5
11. I have problems moving food around in my mouth	1	2	3	4	5
12. I have problems with drooling, or keeping food or drink in my mouth or off my chin and clothes	1	2	3	4	5

The following are statements about how you might have **felt or been doing** in the **PAST WEEK** because of your face or facial problem.

Please rate how much you agree with each statement:

(CIRCLE only ONE number on each line)	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
13. My face feels tired or when I try to move my face, I feel tension, pain, or spasm	1	2	3	4	5
14. My appearance has affected my willingness to participate in social activities or to see family or friends	1	2	3	4	5
15. Because of difficulty with the way I eat, I have avoided eating in restaurants or in other people's homes	1	2	3	4	5

Kahn JB, Gliklich RE, Boyev KP, Stewart MG, Metson RB, McKenna MJ. Validation of a patient-graded instrument for facial nerve paralysis: the FaCE scale. Laryngoscope. 2001;111(3):387-398.