MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Drooping of one or both eyelids

Structured history, interpretation & clinical review

Symptom 47 of 94
Clinical educational workbook
Version 1.0 · October 2026

Not for clinical use. This guide cannot diagnose, triage, or exclude an emergency. Seek emergency care for severe, sudden, or worsening symptoms.

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> **Document purpose**
> A structured educational history and diagnostic-reasoning workbook. Treatment is outside its scope.

Scope and safe use

Drooping eyelids are assessed by onset, pupil size, double vision, variability, orbital signs, fatigue, and lifelong versus acquired appearance.

Not for clinical use.
This educational workbook does not diagnose, triage, estimate probability, replace examination, or exclude an emergency. If a safety-screen answer is Yes or uncertain, follow the stated action rather than continuing routine interpretation.

How to complete the workbook

- Record the current episode and the person’s usual baseline; use a witness account for events with impaired awareness.
- Check one option per question unless a clinician documents a different combination. “Not sure” is unresolved information, not a negative answer.
- Complete the safety screen before all other sections. Record exact onset or last-known-well time for sudden deficits.
- Use Section 2 only after the form is complete. More than one pattern may be relevant; urgency takes precedence.
- Use Section 3 to plan focused examination and clinician-selected investigations. No test is automatic or universally required.

Specific escalation rule

New severe headache, new focal weakness or numbness, new speech/language difficulty, reduced consciousness, a prolonged seizure, severe breathing or swallowing difficulty, sudden visual loss, or rapidly progressive weakness requires emergency assessment. Call 911 in the United States.

Section 1: Input form

Checkbox history for Drooping of one or both eyelids

1A. Immediate safety screen

Is there sudden visual loss, a curtain or missing field, or a new large shower of floaters or flashes?

☐ No ☐ Yes ☐ Not sure

If Yes: Contact an emergency eye service or emergency department now.

Is there a painful red eye, halos, vomiting, marked light sensitivity, or pain with eye movement?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek same-day emergency eye assessment; sudden visual loss requires emergency care now.

Is there new double vision with weakness, severe headache, confusion, imbalance, or difficulty speaking?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now and record onset or last-known-well time.

Is there eye protrusion, fever, eyelid swelling, new inability to move the eye, or recent eye trauma?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency eye/orbital assessment now.

> **Stop rule:** Any Yes answer triggers the action printed under that question. Any Not sure answer requires prompt in-person clarification; do not treat it as No.

1B. Timeline

How did the symptom begin?

☐ Suddenly, over seconds or minutes ☐ Over hours to days ☐ Gradually over weeks or months ☐ Longstanding or since childhood ☐ Not sure

Use the first occurrence for recurrent episodes; use the current episode for a changing symptom.

What is the overall course?

☐ One persistent episode ☐ Separate recurrent episodes ☐ Steadily worsening ☐ Fluctuating or variable ☐ Currently resolved

Has this exact pattern been assessed before?

☐ Definitely new ☐ The same pattern occurred before ☐ Present and stable for a long time ☐ Not sure

1C. Discriminating features

Which lid is affected?

☐ One eyelid ☐ Both eyelids ☐ Side or severity varies ☐ Not sure

Are the pupils unequal or is vision/double vision affected?

☐ Smaller pupil on the drooping side ☐ Larger pupil or double vision ☐ Visual loss ☐ None

Does drooping worsen with activity or later in the day and improve with rest?

☐ Yes ☐ No ☐ Not sure

Is there new head/neck/orbital pain, swelling, or protrusion?

☐ Head, face, or neck pain ☐ Swelling or protrusion ☐ Neither

1D. Associated findings

Are there other neurological symptoms—weakness, numbness, speech change, double vision, swallowing difficulty, or severe imbalance?

☐ Yes ☐ No ☐ Not sure

Are there systemic clues—fever, weight loss, cancer, infection risk, pregnancy/postpartum status, or a new medication?

☐ Yes ☐ No ☐ Not sure

How much does this affect daily activity?

☐ Noticeable but activities continue ☐ Some activities are limited ☐ Cannot perform usual activities ☐ Not sure

1E. Clinical context

Who is being assessed?

☐ Adult or adolescent ☐ Child under 12 ☐ Adult aged 65 or older

Could a medicine, substance, withdrawal, or recent dose change be relevant?

☐ No plausible contributor ☐ Yes or possibly ☐ Not reviewed

Include sedatives, dopamine-blocking drugs, stimulants, decongestants, anticholinergics, alcohol, and non-prescribed substances when relevant.

Is there a relevant neurological, muscular, metabolic, cardiovascular, autoimmune, or sleep disorder?

☐ No known relevant condition ☐ Yes ☐ Not sure

What prior information is available?

☐ A previous examination or investigation ☐ Prior records but no clear explanation ☐ No useful prior assessment ☐ Not sure

Additional history and documentation

Record exact dates/times, witness details, relevant medication doses and changes, prior investigation reports, and the person’s baseline function.

Section 2: Interpreting the input form

Answer combinations generate a differential and an assessment pathway—not a diagnosis.

> **Precedence:** Emergency safety answers override every pattern below. Otherwise, the highest-urgency fully matched pattern takes precedence. If entries are incomplete, contradictory, or match no pattern, use the unresolved-information pathway.

Pattern 1: Ptosis with larger pupil or diplopia

Are the pupils unequal or is vision/double vision affected? Larger pupil or double vision

Emergency warning pattern — Now

Ptosis with a larger pupil or diplopia follows the third-nerve emergency pathway.

Differential to review:

- Third-nerve palsy or compressive ocular-motor lesion

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Pattern 2: Painful Horner-pattern presentation

Are the pupils unequal or is vision/double vision affected? Smaller pupil on the drooping side
Is there new head/neck/orbital pain, swelling, or protrusion? Head, face, or neck pain

Emergency warning pattern — Now

Ptosis with a smaller pupil and new head/neck pain requires emergency carotid assessment.

Differential to review:

- Horner syndrome or carotid/sympathetic pathway lesion

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Pattern 3: Fatigable ptosis pattern

Does drooping worsen with activity or later in the day and improve with rest? Yes
What is the overall course? Fluctuating or variable

Urgent assessment pattern — Same day

Fatigable or variable ptosis follows a neuromuscular-junction assessment pathway.

Differential to review:

- Myasthenia gravis

Action: Arrange same-day medical assessment. If symptoms are rapidly worsening or severe, call 911.

Pattern 4: Orbital mechanical pattern

Is there new head/neck/orbital pain, swelling, or protrusion? Swelling or protrusion

Urgent assessment pattern — Same day

Ptosis with swelling or protrusion requires prompt orbital assessment.

Differential to review:

- Aponeurotic, congenital, mechanical, or orbital ptosis

Action: Arrange same-day medical assessment. If symptoms are rapidly worsening or severe, call 911.

Pattern 5: Stable longstanding ptosis

How did the symptom begin? Longstanding or since childhood
Are the pupils unequal or is vision/double vision affected? None
Does drooping worsen with activity or later in the day and improve with rest? No

Structured clinical review pattern — Routine review

Longstanding stable ptosis without pupil or ocular-motor signs fits an eyelid/congenital assessment pathway.

Differential to review:

- Aponeurotic, congenital, mechanical, or orbital ptosis

Action: Arrange a routine in-person clinical review. New, severe, or worsening symptoms change this pathway.

Unresolved-information pathway: The entries need structured in-person characterization.

Urgent assessment pattern — Same day

Do not guess missing answers or convert uncertainty into reassurance. Document what is unknown, perform an in-person examination, clarify the timeline with a witness or records when available, and reassess if any new feature appears.

Action: Arrange same-day medical assessment. If symptoms are rapidly worsening or severe, call 911.

Section 3: Clinical review

Diagnostic modules and focused investigation logic

The examination comes before a test list. Select investigations only after localization, urgency, comorbidity, pregnancy status, renal function, anticoagulation, and prior results have been considered.

3.1 Third-nerve palsy or compressive ocular-motor lesion

Discriminating features: Ptosis with a larger pupil, diplopia, or ophthalmoplegia.

Logical investigations: Emergency neurovascular imaging and ocular-motor assessment for acute acquired signs.

3.2 Horner syndrome or carotid/sympathetic pathway lesion

Discriminating features: Smaller pupil on the ptosis side, impaired dark dilation, possible sweating change; pain suggests dissection.

Logical investigations: Urgent carotid/vascular imaging for painful acquired Horner pattern; specialist pupil testing must not delay imaging.

3.3 Myasthenia gravis

Discriminating features: Variable/fatigable uni/bilateral ptosis with diplopia, bulbar or proximal fatigability.

Logical investigations: Fatigability examination and specialist antibody/electrodiagnostic testing; respiratory/bulbar assessment when indicated.

3.4 Aponeurotic, congenital, mechanical, or orbital ptosis

Discriminating features: Longstanding, age-related, lid/orbital swelling, or mechanical causes without pupil/neurological signs.

Logical investigations: Ophthalmic eyelid/orbital examination and old-photo comparison; new neurological findings redirect the pathway.

Reassessment and documentation

- If the symptom pattern changes, repeat the safety screen and timeline rather than carrying forward an earlier interpretation.
- If a test is unrevealing but the deficit persists or progresses, revisit localization and seek specialist review; a normal result does not automatically end assessment.
- If symptoms resolve, document duration, completeness of recovery, recurrence, and any residual deficit. Resolved sudden focal symptoms can still require urgent vascular assessment.
- If the history and examination conflict, obtain collateral information and in-person review rather than forcing a single diagnostic label.

Selected references

Sources provide background standards and do not replace local emergency pathways or current specialist guidance. Accessed October 2026.

1. National Institute for Health and Care Excellence. (2019, updated 2023). *Suspected neurological conditions: recognition and referral (NG127)*. https://www.nice.org.uk/guidance/ng127

2. American Academy of Ophthalmology. (2020). *Preferred Practice Pattern: Comprehensive Adult Medical Eye Evaluation*. https://www.aao.org/preferred-practice-pattern/comprehensive-adult-medical-eye-evaluation-ppp