

Orthognathic Surgery Questionnaire

What is the reason for your visit? (check all that apply)

- bite correction
- joint pain
- joint function
- muscle pain
- facial pain
- sleep apnea
- facial appearance
- dental appearance
- speech difficulty
- cleft palate repair
- other

What is your impression of the type of treatment needed (check all that apply)

- orthodontics only
- lower jaw surgery
- upper jaw surgery
- both jaw surgery
- cosmetic surgery
- sleep-apnea surgery
- joint surgery
- cleft repair surgery

Have you had another surgical opinion? Y N

Have you had an orthodontic opinion? Y N

Braces Treatment History

Are you currently wearing braces? Y N

If NO.... braces will be placed in _____ months I have not committed to braces yet

How many times have you had braces in the past? 1 time 2 times 3 times 4 times

How many times have you had jaw surgery? 1 time 2 times 3 times 4 times

Was the bite corrected after treatment? Y N

Did the bite relapse after treatment? Y N

Have you had joint surgery? Y N

Have you worn a splint? Y N

Did you have upper teeth taken out? Y N

Did you have lower teeth taken out? Y N

Did you ever wear a headgear or other functional appliance? Y N

Did you ever have a roof of the mouth appliance? Y N

Prior knowledge of orthognathic surgery

Have you done personal research (internet, books) on jaw corrective surgery? Y N

Do you know anyone personally who has undergone jaw corrective surgery? Y N

Are you aware of the benefits of jaw corrective surgery? Y N

Are you aware of the risks of jaw corrective surgery? Y N

Patient Name: _____ Date of birth: _____

INLAND EMPIRE

ORAL & MAXILLOFACIAL SURGEONS

MATTHEW DUDZIAK, DDS, MD | BRUCE HICKE, DDS | MARVIN JENSEN, DDS, MD | CHRISTOPHER CHOI, DDS, MD

What are your fears of jaw corrective surgery? pain swelling hospitalization numbness
undergoing anesthesia not waking up from anesthesia drastic appearance change I have no fears

What is your perception of the cost of jaw corrective surgery?

my insurance will cover it all my insurance will cover part of it
my out of pocket will be: <\$5,000 \$5,000 – 10,000 \$10,000 – 15,000 > \$15,000

Certainty I will proceed with surgery (as percentage): Little to no chance (0 – 25%) Possibly (26 – 50%)
Probably (50 – 75%) Most Likely (76 – 99%) Definitely (100%)

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Patient Motivation Questionnaire

Teeth: If your teeth could be changed, how would you like them to change?

- move upper teeth *forward* *backward*
- move lower teeth *forward* *backward*
- make the line of the upper front teeth more level
- move the midline of the *upper* *lower* teeth to the *left* *right*
- other:

Face: If your facial appearance could be changed, what would you change?

- move chin *forward* *backward* *left* *right*
- move lower lip *forward* *backward*
- move upper lip *forward* *backward*
- move the area around my nose *forward* *backward*
- move the area under my eyes *forward* *backward*
- get rid of sag under lower jaw
- show *more* *less* of my *teeth* *gums* when smiling
- reduce the strain on my chin/lips when I close my lips
- how much time do you spend thinking about your appearance? *Never* *rarely* *often* *all the time*
- other:

TMJ or muscle symptoms: If you want to reduce pain or discomfort where would it be located?

- in front of my ears *right* *left*
- above my ears *right* *left*
- below my ears *right* *left*
- in my neck *right* *left*
- other:

Obstructive sleep apnea: Which obstructive sleep apnea symptoms do you want corrected?

- day time sleepiness or fatigue night time snoring increased blood pressure or irregular heart beat
- depression other

Patient Name: _____ Date of birth: _____

Head/Neck/TMJ History

Disc History

What sounds do you hear in your joints when you open and close your mouth?

Popping

R L not applicable

Clicking

R L not applicable

Grinding

R L not applicable

Has the size of your mouth opening decreased?

Y N

Do you have pain in your ears?

R L

Have you ever been stuck open and unable to close your mouth?

Y N

If yes, how many times? 1 time 2 times 3 times ≥ 4 times

Have you ever been stuck closed and unable to open your mouth?

Y N

If yes, how many times? 1 time 2 times 3 times ≥ 4 times

Muscle History

Do you have headaches?

Y N

Do you clench or grind your teeth?

Y N

Do you wake up with facial pain?

Y N

Do you wake up with mouth opening limitations?

Y N

Do you posture your lower jaw forward?

Y N

Do you have pain below your ears?

Y N

Do you pain in your temples?

Y N

Are you in an emotional or stressful period in your life?

Y N

Have you had ulcers or stomach problems?

Y N

Joint Change History

Has your bite changed?

Y N

Has your chin moved backwards?

Y N

Do your teeth hit unevenly?

Y N

Have you had injury to your face, head, neck or jaw?

Y N

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Are any of your arms, legs, feet, hands or finger joints painful, swollen or stiff? Y N

Have you ever taken steroid medications? Y N

Are your periods regular? Y N

Do you take birth control pills? Y N

How do you control your head and neck symptoms?

cold/heat packs physical therapy diet change anti-inflammatory medication pain medication

limited jaw movement injections-joint other

What type of clinicians have treated your head and neck symptoms? physical therapist TMJ specialist

pain clinic oral surgeon orthodontist general dentist ENT neurologist

What type of treatment have you had for your head and neck symptoms? splint TMJ arthrocentesis

TMJ surgery occlusal reconstruction braces physical therapy jaw surgery other

Patient Name: _____ Date of birth: _____

Airway History

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations during your usual way of life recently?

- 0 = never doze or sleep
- 1 = slight change of dozing or sleeping
- 2 = moderate change of dozing or sleeping
- 3 = high change of dozing or sleeping

Sitting and reading

Watching TV

Sitting inactive in a public place

Being a passenger in a motor vehicle for an hour or more

Lying down in the afternoon

Sitting and talking to someone

Sitting quietly after lunch (no alcohol)

Stopped for a few minutes in traffic while driving

Total score _____

Obstructive Sleep Apnea History

- Do you fall asleep during the day? Y N
- Do you suffer from daytime fatigue? Y N
- Do you fall asleep while driving regularly? Y N
- Has your spouse seen you stop breathing during sleep? Y N
- Do you snore at night? Y N
- Do you have disrupted sleep? Y N
- Do you urinate frequently during the night? Y N
- Do you drink alcoholic beverages? Y N
- Do you take sedative type medications Y N
- Do you have high blood pressure? Y N
- Do you have an irregular heart beat? Y N

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Have you received medical or dental consultation for your sleep apnea? Y N

Did you ever undergo a sleep study? Y N

If yes, the severity of my sleep apnea is mild moderate severe I don't know

What professionals have seen for your sleep apnea? medical doctor general dentist orthodontist

oral surgeon pulmonologist ENT bariatric surgeon

What type of treatment have you tried for your sleep apnea? weight loss CPAP oral appliance

soft palate surgery nasal surgery jaw surgery other

Do you understand the long term complications from untreated sleep apnea? Y N

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