INLAND EMPIRE
ORAL & MAXILLOFACIAL SURGEONS

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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? ☐never ☐ 1 time ☐ 2 times ☐ 3 times

How many times have you had jaw surgery? ☐ never ☐ 1 time ☐ 2 times ☐ 3 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: _____

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%)

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: _____

Patient Name: _____ Date of birth: _____

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 _____

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

Patient Name: _____ Date of birth: _____

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

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 you 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 clinicans 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

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	Select
Watching TV	Select
Sitting inactive in a public place	Select
Being a passenger in a motor vehicle for an hour or more	Select
Lying down in the afternoon	Select
Sitting and talking to someone	Select
Sitting quietly after lunch (no alcohol)	Select
Stopped for a few minutes in traffic while driving	Select
Total score	0

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

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

Patient Name: _____ Date of birth: _____