COLORADO SPRINGS
ORAL & FACIAL SURGERY

Patient Name_____
Date_____
Orthodontist_____

Orthognathic (Corrective Jaw) Surgery Questionnaire

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

□ bite correction □ joint pain □ joint function □ jaw function □ muscle pain □ sleep apnea □ facial appearance □ dental appearance □ speech difficulty □ other _____

What functional deficits do you have? (check all that apply)

□ Do you have difficulty or pain relating to chewing foods, check any of the following:

□ Apples □ Lettuce □ French bread □ Corn on the cob □ Raw vegetables

□ Sandwiches □ Other _____

□ Jaw or TMJ pain

□ Chronic mouth breathing

□ Xerostomia (dry mouth)

□ Facial muscle fatigue and/or pain

□ Poor lip competence (difficulty closing lips together)

□ Difficulty swallowing

□ Speech impairments

□ Sleep apnea

□ Dental pain (functional overload of poorly distributed masticatory force)

Braces Treatment History

□ Y □ N Are you currently wearing braces?

□Y □ N Was the bite corrected to your satisfaction?

□Y □N Did the bite/teeth relapse after treatment?

□Y □N Have you had joint surgery?

□Y □N Have you had teeth taken out?

□Y □N Have you ever worn headgear or another functional appliance?

□Y □N Did you ever have a roof of the mouth appliance (expander)?

Comments: _____