SADDLE ROCK INSTITUTE

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Orthognathic Surgery Questionnaire

What is the reason for your visit?

☐ difficulty with eating ☐ difficulty with breathing ☐ speech difficulty ☐ TMJ symptoms

☐ bite correction ☐ joint pain ☐ joint function ☐ muscle pain ☐ facial pain ☐ sleep apnea

☐ facial appearance ☐ dental appearance ☐ cleft palate repair ☐ other

If other, please list: _____

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 not currently… 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 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 surgery? ☐ Y ☐ N

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

Patient Name: _____ Date: _____