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Name: ______________________ Age: __________ D.O.B. ________________ Telephone ______________

Address: ___________________________________ City: ___________________ Postal Code: __________

Welcome to Island Oral Facial and Implant Surgery. You have been referred by your orthodontic specialist to assess the need for corrective jaw surgery in combination with your orthodontic treatment. In order for us to assess your problem and your needs, we have provided you with some health history information that you must return to the office in the envelope provided. Some of this will apply to you and some of this may not apply to you at all, especially with respect to the Head-Neck and TMJ history. In order to prepare for your consultation, we ask that you visit our website at http://islandoms.ca. There you will find helpful information as well as maps to our locations.

Patient Motivation Questionnaire

Patients often request changes in their bites or faces and relief from pain or discomfort. Please help us understand your problem by checking the following information;
please be specific (**check the words** backward, less, shorter, etc.)

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

[ ] Straighten the front teeth ( ) upper ( ) lower
[ ] Straighten the back teeth ( ) upper ( ) lower
[ ] Make the upper front teeth ( ) longer ( ) shorter
[ ] 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?

[ ] Get rid of sag under lower jaw ( ) forward ( ) backward
[ ] Move chin ( ) forward ( ) backward
[ ] Move chin to center it ( ) left ( ) right
[ ] Move lower lip ( ) forward ( ) backward
[ ] Move upper lip ( ) forward ( ) backward
[ ] Move the area around my nose ( ) forward ( ) backward
[ ] Make the profile of my nose ( ) longer ( ) shorter
[ ] Make my cheekbones ( ) larger ( ) smaller
[ ] Show ( ) more / ( ) less of my ( ) teeth / ( ) gums when I smile
[ ] Make my lips ( ) closer together / ( ) farther apart when my teeth are touching
[ ] Make my lips not touch and roll out when my teeth are touching
[ ] Reduce the strain in my ( ) chin / ( ) lips when I close my lips
[ ] Make my face more ( ) narrow / ( ) wide
[ ] Reduce the ( ) width / ( ) fullness of my lower jaw behind my mouth
Other ____

Symptoms: If you want to reduce pain or discomfort where would it be located?
Please be specific about the location; circle the right side, left side or both if they apply.

[ ] In front of my ears ( ) right ( ) left
[ ] Below my ears ( ) right ( ) left
[ ] Above my ears ( ) right ( ) left
[ ] In my ears ( ) right ( ) left
[ ] Neck ( ) right ( ) left
[ ] Shoulders ( ) right ( ) left
[ ] Temples ( ) right ( ) left
[ ] Eyes ( ) right ( ) left
[ ] Teeth ( ) right ( ) left
[ ] Sinuses ( ) right ( ) left
Other ____

Airway History

Do you have difficulty breathing through your nose? .... Y ___ N ___ ________
Are you a mouth breather? .... Y ___ N ___ ________
Do you have difficulty closing your lips? .... Y ___ N ___ ________
Do you have dry mouth problems? .... Y ___ N ___ ________
Do you have speech clarity problems? .... Y ___ N ___ ________

Chronology

When did you first notice the above symptom(s)? .... Date________
Have the above symptoms increased with time? .... Y ___ N ___ ________
Do you attribute the symptoms to one incident? .... Y ___ N ___ ________

How do you control your head and neck symptoms? ( ) cold/heat packs ( ) physical therapy ( ) diet change
( ) anti-inflammatory ( ) pain medication ( ) limited jaw movement ( ) injections-joint/muscles
( ) other ________

List medications taken for this problem in the last 12 months ________

____

Have you had treatment for your head and neck symptoms? ( ) physical therapy ( ) TMJ specialist ( ) pain clinic
( ) oral surgeon ( ) orthodontist ( ) general dentist ( ) ears, nose, throat specialist ( ) neurologist
( ) splint ( ) TMJ surgery ( ) occlusal reconstruction ( ) orthodontic care ( ) equilibration
( ) jaw surgery ( ) other

How do you control your sleep apnea? ( ) restrict alcohol beverages ( ) restrict sedative medication ( ) diet change
( ) sleep on side ( ) sleep on back ( ) sleep with special pillow position

Have you had treatment for your sleep apnea? ( ) weight loss ( ) c-pap ( ) dental appliance
( ) soft palate surgery ( ) nasal surgery other ________

Have you had x-rays for the problem? .... Y ___ N ___ Clinic ________
Are you currently under litigation for this problem? .... Y ___ N ___ ________

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = would **never** doze or sleep
1 = **slight** chance of dozing or sleeping
2 = **moderate** chance of dozing or sleeping
3 = **high** chance of dozing or sleeping

Situation	Chance 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 (add the scores up) (This is your Epworth score)	

Head-Neck and TMJ History

Disc History

Have you heard popping sounds in your ear(s)? .... right____ left____
Has the popping stopped? .... right____ left____
Has the size of your jaw opening decreased? .... right____ left____
Do you hear clicking sounds in your ear(s)? .... right____ left____
Do you hear grinding sounds in your ear(s)? .... right____ left____
Do you have pain in your ear(s)? .... right____ left____
Does your jaw only open part way? .... right____ left____
When your jaw opens part way, can you manipulate it to open fully? .... right____ left____
Does your jaw open and then not close? .... right____ left____

Muscle History

Is your jaw opening limited? .... Y ___ N ___ ________
Does the amount you can open vary week to week? .... Y ___ N ___ ________
Do you have headaches? .... Y ___ N ___ ________
Is your opening limitation most in the morning? .... Y ___ N ___ ________
Do you wake up with facial pain? .... Y ___ N ___ ________
Do you posture your lower jaw forward? .... Y ___ N ___ ________
Do you have pain below your ear(s)? .... Y ___ N ___ ________
Do you have pain in your temples? .... Y ___ N ___ ________
Do you clench or grind your teeth? .... Y ___ N ___ ________
Do you have lower neck aches or backaches? .... Y ___ N ___ ________
Are you in an emotional or stressful period of your life? .... Y ___ N ___ ________
Have you had ulcers, stomach problems or bowel 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 jaw surgery or orthodontic treatment? .... Y ___ N ___ ________
Do you clench or grind your teeth? .... Y ___ N ___ ________
Have you heard popping sounds in your ear(s)? .... Y ___ N ___ ________
Have you had an injury to your face, head, neck or jaw? .... Y ___ N ___ ________
Are you female? .... Y ___ N ___ ________
Are you between 12 and 17 years old? .... Y ___ N ___ ________
Are any of your arms, legs, feet, hands or finger joints painful, swollen or stiff? .... Y ___ N ___ ________
Are you taking or have you taken corticosteroids? .... Y ___ N ___ ________
Do you or have you had hyperparathyroidism? .... Y ___ N ___ ________

Obstructive Sleep Apnea History

Do you fall asleep during the day? .... Y ___ N ___
Do you have high blood pressure? .... Y ___ N ___
Have you fallen asleep while driving? .... Y ___ N ___
Do you have disrupted sleep? .... Y ___ N ___
Do you urinate frequently during the night? .... Y ___ N ___
Do you snore heavily at night? .... Y ___ N ___
Do you kick or poke your partner while sleeping? Y ___ N ___
Do you suffer from daytime fatigue? .... Y ___ N ___
Do you experience daytime sleepiness? .... Y ___ N ___
Have you had a recent weight gain? .... Y ___ N ___

Do you have restless legs while lying in bed? .... Y ___ N ___
Do you take blood pressure medication? .... Y ___ N ___
Have you had an irregular heartbeat? .... Y ___ N ___
Do you suffer from depression? .... Y ___ N ___
Do you have headaches when you wake up? .... Y ___ N ___
Has your spouse seen you stop breathing during sleep? Y ___ N ___
Do you drink alcoholic beverages? .... Y ___ N ___
Do you take sedative type medication? .... Y ___ N ___

Would you accept being given blood products if necessary for your surgery?

☐ **Yes** ☐ **No**