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://islandsms.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
- [ ] Straighten the back teeth
- [ ] Make the upper front teeth longer
- [ ] Move upper teeth forward
- [ ] Move lower teeth 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
- [ ] Move chin forward
- [ ] Move chin to center it left
- [ ] Move lower lip forward
- [ ] Move upper lip backward
- [ ] Move the area around my nose forward
- [ ] Make the profile of my nose longer
- [ ] Make my cheekbones larger
- [ ] 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
- [ ] Below my ears
- [ ] Above my ears
- [ ] In my ears
- [ ] Neck
- [ ] Shoulders
- [ ] Temples
- [ ] Eyes
- [ ] Teeth
- [ ] Sinuses

**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

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of Dozing or Sleeping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td></td>
</tr>
<tr>
<td>Watching TV</td>
<td></td>
</tr>
<tr>
<td>Sitting inactive in a public place</td>
<td></td>
</tr>
<tr>
<td>Being a passenger in a motor vehicle</td>
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<tr>
<td>for an hour or more</td>
<td></td>
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<tr>
<td>Lying down in the afternoon</td>
<td></td>
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<tr>
<td>Sitting and talking to someone</td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after lunch (no alcohol)</td>
<td></td>
</tr>
<tr>
<td>Stopped for a few minutes in traffic</td>
<td></td>
</tr>
<tr>
<td>while driving</td>
<td></td>
</tr>
<tr>
<td><strong>Total score (add the scores up)</strong></td>
<td></td>
</tr>
<tr>
<td>(This is your Epworth score)</td>
<td></td>
</tr>
</tbody>
</table>
**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