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Corrective Jaw / Orthognathic Patient Information

Please provide <u>detailed answers</u> and explanations. Your information is essential to your treatment.

Name | Date of Birth

Do you feel you have an impairment directly related to a skeletal problem?

Has your bite caused your diet to change in ways that you feel may be harmful to your health?

Have you lost weight?

Are you able to *completely* chew your food?

Do you have chewing problems that result in gastrointestinal (digestive) problems?

Do you have headaches when you chew or after you have eaten?

Do you have tightness in your jaw or difficulty opening your mouth?

Do you frequently bite your cheeks?

Do you feel you have a speech or articulation problem related to your bite/anomaly?

Do you feel as though you get restful sleep at night?

Do you snore?

Have you had a sleep study?

Patient Signature | Date