ORTHOGNATHIC EVALUATION RECORD

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ORAL AND MAXILLOFACIAL SURGERY

Date, ______________________ Phone #: Home: __________

NAME. ____________________ AGE ___ SEX ____ REFERRING DOCTOR ____________________
STREET ____________________ DOB ______ EMPLOYER ____________________
CITY. ____________ STATE ____ ZIP ______ EMPLOYER ADDRESS ____________________
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INSURANCE: MEDICAL ____________________ DENTAL ____________________

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You have been referred for evaluation of your facial and jaw structure. When facial bones are out of balance, many things can be affected including your bite, how you look and your jaw function, like speech, chewing, swallowing and breathing. The following information will help us in determining your situation and your areas of concern. Briefly state in your own words what you would like evaluated. ____________________

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1. How long have you been aware of your condition. ____________________
2. Do you feel it affects the appearance of your face? If yes, how? ____________________

   ____
3. Check any of the following that your condition affects:
   a. chewing ______
   b. swallowing ______
   c. breathing ______
   d. jaw joint motion ______
4. Is your condition causing pain? ____________________
5. If it is, where is the pain?
   a. headache ______
   b. neckpain ______
   c. jaw joint ______
   d. facial ______
   e. chewing ______
6. Check if you have any of the following:
   a. thumbsucking problem ______
   b. tongue thrusting ______
   c. speech problem ______
7 Please check any of the following that apply to you:
   a. sinus condition ______
   b. frequent colds ______
   c. mouth breathing ______
   d. tonsillitis ______
   e. difficulty swallowing ______
8. List in order of importance the conditions which you would like corrected:
   a. bite ______
   b. appearance ______
   c. smile ______
   d. speech ______
   e. improve pain ______
   f. improve jaw function ______
   g. other ______
9. When would you like to have your condition corrected? ____________________