BAOMS BOS Orthognathic PROM

Patient pseudo-identifier | | | | | | | | | | |

Today's date (DD/MM/YYYY) | | | | | | | | |

This questionnaire relates to any concerns you may have about your face and teeth and should be completed PRIOR to the start of your orthognathic treatment.

About you

You are / identify as… Female ☐ Male ☐ Other ☐ I prefer not to say ☐

You are | | years old

Section 1 - Orthognathic Quality of Life Questionnaire

Please read the following statements carefully and select N/A or 1, 2, 3, 4 where:

- N/A means the issue covered by the statement either does not apply to you or it does not bother you at all
- 1 means the issue covered in the statement bothers you a little
- 4 means the issue covered in the statement bothers you a lot
- 2 & 3 lie in between a little and a lot.

1. I try to cover my mouth when I meet people for the first time	N/A	1	2	3	4
2. I worry about meeting people for the first time	N/A	1	2	3	4
3. I worry that people will make hurtful comments about my appearance	N/A	1	2	3	4
4. I lack confidence when I am out socially	N/A	1	2	3	4
5. I do not like smiling when I meet people	N/A	1	2	3	4
6. I sometimes get depressed about my appearance	N/A	1	2	3	4
7. I sometimes think that people are staring at me	N/A	1	2	3	4
8. Comments about my appearance really upset me, even when I know people are only joking	N/A	1	2	3	4
9. I am self-conscious about the appearance of my teeth	N/A	1	2	3	4
10. I don't like seeing a side view of my face (profile)	N/A	1	2	3	4
11. I dislike having my photograph taken	N/A	1	2	3	4
12. I dislike being seen on video	N/A	1	2	3	4
13. I am self-conscious about my facial appearance	N/A	1	2	3	4
14. I have problems biting	N/A	1	2	3	4
15. I have problems chewing	N/A	1	2	3	4

16. There are some foods I avoid eating because the way my teeth meet makes it difficult	N/A	1	2	3	4
17. I don't like eating in public places	N/A	1	2	3	4
18. I get pains in my face or jaw	N/A	1	2	3	4
19. I spend a lot of time studying my face in the mirror	N/A	1	2	3	4
20. I spend a lot of time studying my teeth in the mirror	N/A	1	2	3	4
21. I often stare at other people's teeth	N/A	1	2	3	4
22. I often stare at other people's faces	N/A	1	2	3	4

Section 2. modified V8

How satisfied are you with how your face looks at the moment?

Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very Dissatisfied ☐

How satisfied are you with how your teeth look at the moment?

Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very Dissatisfied ☐

Do you have any numbness, tingling or altered sensations? **Y** ☐ **N** ☐

If yes, where is it? (Tick all that apply)

	Top Lip	Bottom lip	Tongue		
Left	☐	☐	☐	Palate / Roof of mouth	☐
Right	☐	☐	☐	Other (give details below)	☐
				Chin	☐

If yes, how much does it concern you? A lot ☐ A little ☐ Not at all ☐

BAOMS BOS Orthognathic PROM

Patient pseudo-identifier ☐☐☐☐☐☐☐☐☐☐

Today's date (DD/MM/YYYY) ☐☐ ☐☐ ☐☐☐☐

This questionnaire relates to any concerns you may have about your face and teeth and should be completed AFTER the completion of your orthognathic treatment but BEFORE your surgery.

About you

You are / identify as… Female ☐ Male ☐ Other ☐ I prefer not to say ☐

You are ☐☐ years old

Section 1 - Orthognathic Quality of Life Questionnaire

Please read the following statements carefully and select N/A or 1, 2, 3, 4 where:

- N/A means the issue covered by the statement either does not apply to you or it does not bother you at all
- 1 means the issue covered in the statement bothers you a little
- 4 means the issue covered in the statement bothers you a lot
- 2 & 3 lie in between a little and a lot.

1. I try to cover my mouth when I meet people for the first time	N/A	1	2	3	4
2. I worry about meeting people for the first time	N/A	1	2	3	4
3. I worry that people will make hurtful comments about my appearance	N/A	1	2	3	4
4. I lack confidence when I am out socially	N/A	1	2	3	4
5. I do not like smiling when I meet people	N/A	1	2	3	4
6. I sometimes get depressed about my appearance	N/A	1	2	3	4
7. I sometimes think that people are staring at me	N/A	1	2	3	4
8. Comments about my appearance really upset me, even when I know people are only joking	N/A	1	2	3	4
9. I am self-conscious about the appearance of my teeth	N/A	1	2	3	4
10. I don't like seeing a side view of my face (profile)	N/A	1	2	3	4
11. I dislike having my photograph taken	N/A	1	2	3	4
12. I dislike being seen on video	N/A	1	2	3	4
13. I am self-conscious about my facial appearance	N/A	1	2	3	4
14. I have problems biting	N/A	1	2	3	4
15. I have problems chewing	N/A	1	2	3	4

16. There are some foods I avoid eating because the way my teeth meet makes it difficult	N/A	1	2	3	4
17. I don't like eating in public places	N/A	1	2	3	4
18. I get pains in my face or jaw	N/A	1	2	3	4
19. I spend a lot of time studying my face in the mirror	N/A	1	2	3	4
20. I spend a lot of time studying my teeth in the mirror	N/A	1	2	3	4
21. I often stare at other people's teeth	N/A	1	2	3	4
22. I often stare at other people's faces	N/A	1	2	3	4

Section 2. modified V8

How satisfied are you with how your face looks at the moment?

Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very Dissatisfied ☐

How satisfied are you with how your teeth look at the moment?

Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very Dissatisfied ☐

Do you have any numbness, tingling or altered sensations? **Y** ☐ **N** ☐

If yes, where is it? (Tick all that apply)

	Top Lip	Bottom lip	Tongue		
Left	☐	☐	☐	Palate / Roof of mouth	☐
Right	☐	☐	☐	Other (give details below)	☐
				Chin	☐

If yes, how much does it concern you? A lot ☐ A little ☐ Not at all ☐

BAOMS BOS Orthognathic PROM

Patient pseudo-identifier | | | | | | | | | | |

Today's date (DD/MM/YYYY) | | | | | | | | |

This questionnaire relates to any concerns you may have about your face and teeth and should be completed 4-8 weeks AFTER your surgery.

About you

You are / identify as… Female ☐ Male ☐ Other ☐ I prefer not to say ☐

You are | | years old

Has your treatment been impacted by the COVID-19 pandemic? **Y** ☐ **N** ☐

If 'Yes', which part of your treatment was impacted? (Tick all that apply)

- Your initial consultation ☐
- Your orthodontic treatment (braces) ☐
- Your surgery ☐

Did you have orthodontic treatment (i.e. treatment to realign your teeth) before you had surgery?

- I had orthodontic treatment prior to surgery ☐
- I had surgery first and no orthodontic treatment ☐

How long did your orthodontic treatment last? (approximately in months) | |

Section 1 - Orthognathic Quality of Life Questionnaire

Please read the following statements carefully and select N/A or 1, 2, 3, 4 where:

- N/A means the issue covered by the statement either does not apply to you or it does not bother you at all
- 1 means the issue covered in the statement bothers you a little
- 4 means the issue covered in the statement bothers you a lot
- 2 & 3 lie in between a little and a lot.

1. I try to cover my mouth when I meet people for the first time	N/A	1	2	3	4
2. I worry about meeting people for the first time	N/A	1	2	3	4
3. I worry that people will make hurtful comments about my appearance	N/A	1	2	3	4
4. I lack confidence when I am out socially	N/A	1	2	3	4
5. I do not like smiling when I meet people	N/A	1	2	3	4
6. I sometimes get depressed about my appearance	N/A	1	2	3	4
7. I sometimes think that people are staring at me	N/A	1	2	3	4

8. Comments about my appearance really upset me, even when I know people are only joking	N/A	1	2	3	4
9. I am self-conscious about the appearance of my teeth	N/A	1	2	3	4
10. I don't like seeing a side view of my face (profile)	N/A	1	2	3	4
11. I dislike having my photograph taken	N/A	1	2	3	4
12. I dislike being seen on video	N/A	1	2	3	4
13. I am self-conscious about my facial appearance	N/A	1	2	3	4
14. I have problems biting	N/A	1	2	3	4
15. I have problems chewing	N/A	1	2	3	4
16. There are some foods I avoid eating because the way my teeth meet makes it difficult	N/A	1	2	3	4
17. I don't like eating in public places	N/A	1	2	3	4
18. I get pains in my face or jaw	N/A	1	2	3	4
19. I spend a lot of time studying my face in the mirror	N/A	1	2	3	4
20. I spend a lot of time studying my teeth in the mirror	N/A	1	2	3	4
21. I often stare at other people's teeth	N/A	1	2	3	4
22. I often stare at other people's faces	N/A	1	2	3	4

Section 2 - BODY-Q(TM) - SATISFACTION WITH INFORMATION

Provide only one answer per line. These questions ask about information you received from your medical team (e.g. surgeon, nurse, other staff) **about your jaw surgery procedure**. How **satisfied or dissatisfied** were you with the information you received in relation to the following:

	Very dissatisfied	Somewhat dissatisfied	Somewhat dissatisfied	Very dissatisfied
How well your questions were answered?	☐	☐	☐	☐
The amount of written information they gave you to read?	☐	☐	☐	☐
The activities you should avoid during your recovery?	☐	☐	☐	☐
How the surgery would be done?	☐	☐	☐	☐
The amount of time it would take to heal and recover?	☐	☐	☐	☐
Options for how the surgery could be done?	☐	☐	☐	☐
The kinds of complications that could happen?	☐	☐	☐	☐
What other patients like you experience after surgery?	☐	☐	☐	☐
How long it would take for you to feel like yourself again?	☐	☐	☐	☐

How much pain you might feel during your recovery? ☐ ☐ ☐ ☐

Section 3. modified V8

Do you currently have fixed braces on your teeth? **Y** **N**

How long have they been in place?
0-1 month ☐ 1-6 months ☐
6-12 months ☐ More than 12 months ☐

How satisfied are you with how your face looks at the moment?

Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very Dissatisfied ☐

How satisfied are you with how your teeth look at the moment?

Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very Dissatisfied ☐

Do you have any numbness, tingling or altered sensations? **Y** **N**

If yes, where is it? (Tick all that apply)

	Top Lip	Bottom lip	Tongue
Left	☐	☐	☐
Right	☐	☐	☐

Chin ☐
Palate / Roof of mouth ☐
Other (give details below) ☐

If yes, how much does it concern you? A lot ☐ A little ☐ Not at all ☐

BAOMS BOS Orthognathic PROM

Patient pseudo-identifier | | | | | | | | | | |

Today's date (DD/MM/YYYY) | | | | | | | | |

This questionnaire relates to any concerns you may have about your face and teeth and should be completed 1 year AFTER your surgery.

About you

You are / identify as… Female ☐ Male ☐ Other ☐ I prefer not to say ☐

You are | | years old

Section 1 - Orthognathic Quality of Life Questionnaire

Please read the following statements carefully and select N/A or 1, 2, 3, 4 where:

- N/A means the issue covered by the statement either does not apply to you or it does not bother you at all
- 1 means the issue covered in the statement bothers you a little
- 4 means the issue covered in the statement bothers you a lot
- 2 & 3 lie in between a little and a lot.

1. I try to cover my mouth when I meet people for the first time	N/A	1	2	3	4
2. I worry about meeting people for the first time	N/A	1	2	3	4
3. I worry that people will make hurtful comments about my appearance	N/A	1	2	3	4
4. I lack confidence when I am out socially	N/A	1	2	3	4
5. I do not like smiling when I meet people	N/A	1	2	3	4
6. I sometimes get depressed about my appearance	N/A	1	2	3	4
7. I sometimes think that people are staring at me	N/A	1	2	3	4
8. Comments about my appearance really upset me, even when I know people are only joking	N/A	1	2	3	4
9. I am self-conscious about the appearance of my teeth	N/A	1	2	3	4
10. I don't like seeing a side view of my face (profile)	N/A	1	2	3	4
11. I dislike having my photograph taken	N/A	1	2	3	4
12. I dislike being seen on video	N/A	1	2	3	4
13. I am self-conscious about my facial appearance	N/A	1	2	3	4
14. I have problems biting	N/A	1	2	3	4
15. I have problems chewing	N/A	1	2	3	4

16. There are some foods I avoid eating because the way my teeth meet makes it difficult	N/A	1	2	3	4
17. I don't like eating in public places	N/A	1	2	3	4
18. I get pains in my face or jaw	N/A	1	2	3	4
19. I spend a lot of time studying my face in the mirror	N/A	1	2	3	4
20. I spend a lot of time studying my teeth in the mirror	N/A	1	2	3	4
21. I often stare at other people's teeth	N/A	1	2	3	4
22. I often stare at other people's faces	N/A	1	2	3	4

Section 2. modified V8

Do you currently have fixed braces on your teeth? **Y** **N**

How long have they been in place? 0-1 month ☐ 1-6 months ☐ 6-12 months ☐ More than 12 months ☐

How satisfied are you with how your face looks at the moment?

Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very Dissatisfied ☐

How satisfied are you with how your teeth look at the moment?

Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very Dissatisfied ☐

Do you have any numbness, tingling or altered sensations? **Y** **N**

If yes, where is it? (Tick all that apply)

	Top Lip	Bottom lip	Tongue
Left	☐	☐	☐
Right	☐	☐	☐

Chin ☐

Palate / Roof of mouth ☐

Other give details below) ☐

If yes, how much does it concern you? A lot ☐ A little ☐ Not at all ☐

Would you recommend your treatment to another patient? **Y** **N**

Do you have any further comments or suggestions for improvements to our service?