pediatric sleep center
OF OKLAHOMA

Scheduled Appointment Information

Date and Time: _____AT _____PM

Location: 1800 S. Renaissance Blvd. Edmond, OK 73013

Please arrive at **Summit Medical Center. Enter through the main entrance and take the elevator to the 2nd floor.** If there is not a receptionist available, please have a seat in the waiting room and your technician will come out to greet you at the time of your study.

- **Due to the increased volume of patients if you arrive more than 15 minutes after your scheduled time, the appointment may be given to someone else. If you are running late the night of your study, please contact a technician at 405-844-3319 to hold your spot.**

IMPORTANT: **All minors must have a parent or guardian stay with them throughout the entire test.**

*** Reminder:** If possible, no naps or caffeine the day of the study. Please make sure to bring everything your child will need for the entire evening.

Things to bring with you:

1. The enclosed questionnaire – (please complete prior to arrival)
2. Something comfortable to sleep in and any other necessities for your child throughout the night.
3. A list of medications that the child is currently taking- (please have them written down prior to arrival)
4. The child's insurance card and a form of identification, such as a picture I.D.

Things to remember:

1. Questions regarding your medications should be referred to your physician.
2. Please administer all of your child's medications as you normally do, unless otherwise directed by your physician.
3. Please bathe and wash your child's hair prior to arrival. Avoid hair products and excessive lotions.
4. We have pillows; however, please feel free to bring your own to add to your comfort.
5. Bring an overnight bag with the items you would normally use for an overnight stay.
6. Smoking materials, tobacco, and firearms are prohibited in our facility.
7. Please complete all smoking prior to coming up to the sleep disorders center.
8. You should contact our office, and speak directly to our staff, if you have any of the following on the day you are scheduled for your sleep study: Flu, diarrhea, fever, severe nasal congestion, or migraine headache. If you feel you need to reschedule your sleep study, please contact our staff at **405-949-0060**.

Insurance & Financial Information:

If you have any questions regarding your financial responsibility please feel free to call Summit Medical at **405-509-7341**. You will be responsible for the actual contracted amount if the claim is not paid in full. We urge you to contact your insurance provider member services to verify the information above.

Any scheduling questions should be directed to Sleep Solutions, M-F 8-5, at 405-949-0060 or 866-748-4350. Our patient care coordinator will be happy to answer any questions you may have.

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PEDIATRIC SLEEP QUESTIONNAIRE (0-1 year)

Patient (Child's) Name:_____ Date:_____

Name of person completing questionnaire:_____

Relationship to child (please circle one)? Mother Father Legal Guardian

Date of Birth:_____ Age:_____ Sex: M F Height:_____ Weight:_____ BMI:_____

Referring Physician /Provider:_____

Primary Care Physician/Provider:_____

SLEEP HISTORY:

1. Does your child sleep alone? ____ Yes ____No With parent? ___Yes ___No
2. What time is your child usually **put to bed**?_____ p.m./a.m.
3. How long does it usually take your child to **fall asleep**? _____hours _____minutes
4. What time does your child **wake-up**? _____ a.m. / p.m.
5. How much does your child's bedtime and wake-up time change from day to day?

   Please circle **one**: Less than 15 min 15 to 30 min. 30 to 60 min. More than 60 min.
6. How many times does your child usually wake-up at night? _____ How long are the wakings? _____
7. How often does your child have difficulty returning to sleep after a night waking?

   Please circle **one**: Always Frequently Sometimes Occasionally Rarely/never
8. On average**, how long does your child sleep** during the night? ____hours _____minutes
9. How many **naps** a day does your child typically take? _____ Please list nap times

   _____

10. Has your child ever taken over-the-counter or prescription medications at bed time to help her/him calm down and/or fall asleep? ____Yes ____No

    If yes, please list the medication(s) and dose:_____

11. In the past (or typical) month, how often has your child:

	Never/rarely	1-2 times week	3–5 times week	Every day
Had a regular bedtime routine?				
Shared a bedroom with another family member?				
Fallen asleep in your bed?				
Resistant going to bed?				
Needed a parent to be with him/her to fall asleep?				
Needed to be nursed/fed to fall asleep?				
Seemed very restless during sleep?				
Snored?				
Had difficulty breathing during sleep?				
Had breathing pauses during sleep?				
Choked or gasped during sleep?				
Awakened by him/herself in the morning?				
Awakened in a negative mood (e.g. cranky, irritable)?				
Seemed overly sleepy or tired much of the day?				

Please list any additional comments about your child's sleep.

_____

_____

_____

_____

HEALTH HISTORY:

1. Did you or your doctor note any problems with pregnancy (e.g., drug/alcohol abuse, cigarette use, high blood pressure)?_____
2. Child was born at _____ weeks gestation.
3. Please list any known complications in the newborn period:_____

   _____
4. Was your child intubated (had a breathing tube/breathing machine)? ___Yes ___No
5. Was your child sent home on an apnea monitor? ___Yes ___No ____Has currently
6. Has your child **ever** had (circle all that apply):

   Oxygen therapy CPAP/BiPAP Caffeine/theophylline Tracheostomy
7. Does your child **currently** have (check all that apply):

   Oxygen therapy CPAP/BiPAP Caffeine/theophylline Tracheostomy
8. Have your child's tonsils and/or adenoids been removed? ____Yes ____No
   a. Tonsils Date(s)_____
   b. Adenoids Date(s)_____
   c. Both Date(s)_____
   d. For what reason?:_____
   e. Describe briefly any changes you noticed in your child's sleep or waking behavior after removal of tonsils and/or adenoids:_____

      _____

      _____
9. Has your child ever had an operation (other than removal of tonsils and adenoids)? ___Yes ___No

   If yes, please list type/date(s):_____
10. Has your child ever had a head injury/concussion requiring medical evaluation? ____Yes ___No

    If yes, please list date(s) and briefly describe:_____

11. Has your child ever had a serious injury (other than head injury)? ___Yes ____No

    If yes, please list type/date(s):_____

12. Please indicate if your child has had or currently has any of the following: (check all that apply):

	Currently	At any time in the past
Nasal congestion/difficulty breathing through nose		
Frequent colds/respiratory infections like bronchitis		
Frequent ear infections		
Frequent sinus infections		
Allergies If yes, to what?		
Asthma		
Bronchopulmonary dysplasia (BPD)		
Episodes of stopping breathing/turning blue		
Other respiratory problems If yes, please specify:		
Eczema/skin allergies		
Colic		
Heartburn/frequent vomiting after meals		
Diagnosed acid (gastroesophageal) reflux		
Poor or slow growth		
Overweight/obesity		
Seizures/convulsions		

13. Does your child have a history of health problems? ___Yes ___No

    If so, please list:_____

    _____

14. Please list any additions comments about your child's health:_____

    _____

    _____

MEDICATIONS:

Please list any prescription or over-the-counter medications your child is currently taking:

Type:_____ Reason for medication:_____

Type:_____ Reason for medication:_____

Type:_____ Reason for medication:_____

Type:_____ Reason for medication:_____

Type:_____ Reason for medication:_____

Type:_____ Reason for medication:_____

Type:_____ Reason for medication:_____

Type:_____ Reason for medication:_____