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 **405-359-2477**. 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 (PRE-SCHOOL)

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:_____

GENERAL QUESTIONS:

1. What is the normal bedtime? _____ (a.m. or p.m.)
2. What time is the normal wake up time?_____ (a.m. or p.m.)
3. What does the child do the last 30 minutes before going to bed?_____
4. What type of bed does your child sleep in? (circle one) Crib / Single bed / Other
5. Does your child sleep alone? Yes___ No___ With parent? Yes___ No___
6. Is the child resistant to going to bed? Yes___ No___
7. What do you do to get the child to go to sleep?_____
8. How long does it take your child to go to sleep?_____
9. What prevents the child from falling asleep?_____
10. Do you let your child cry in bed to get to sleep? Yes___ No___

    How often does your child cry himself/herself to sleep? _____ (times per week)

11. If the child gets out of bed, what does he/she do?_____

    How long does your child usually sleep? _____ (hours)

12. Does your child awaken during the night? Yes___ No___

    How long after going to sleep does the child awaken? _____

13. How many times during the night does the child awaken? _____ Why?_____

14. Does your child snore? Yes___ No___ Loudly? Yes___ No___

15. Does your child have respiratory pauses (stop breathing) at night? Yes___ No___

16. Is your child bothered by nightmares or night terror? Yes___ No___

17. After the nightmares/terrors, does the child appear: Confused: Yes___ No____

    Sweaty: Yes___ No___ Does he/she remember the dream? Yes___ No___

18. Does your child sleepwalk? Yes___ No___ How many times per week?_____

19. Does your child talk in his/her sleep? Yes___ No___ How many times per week?_____

20. Does your child wet the bed? Yes___ No___ How many times per week?_____

21. Are there any other movements or behaviors noted in the child during the night?_____

    _____

22. Does your child have "head banging" at night? Yes___ No___

23. Is there a history of seizures/epilepsy? Yes___ No___

24. Does your child appear rested after a night's sleep? Yes___ No___

25. Does your child appear sleepier than other children during the day? Yes___ No___

26. Does the child nap? Yes___ No___ What time? _____

    How long? _____ How often? _____ (times per week)

PAST MEDICAL HISTORY:

1. Does the child have any significant current or past medical problems? Yes___ No___

   Describe:_____

2. Has your child had:

a. ADHD? Yes___ No___

b. Tonsillectomy and/or adenoidectomy? Yes___ No___

c. Seizures? Yes___ No___

d. Lung Disease? Yes___ No___ Asthma? Yes___ No___ Use O2? Yes___ No___

e. Heart disease: Yes___ No___ Type of heart problem:_____

f. Diabetes? Yes___ No___

g. Genetic disorder? Yes___ No___ Type: _____

h. Facial or Jaw development problems? Yes___ No___

   Describe: _____

i. Mental retardation or development problems? Yes___ No___

   Describe:_____

SURGICAL HISTORY: (List all previous surgeries and the date done)

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

MEDICATIONS:

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

Type:_____ Dosage: _____ Date:_____

Reason for medication:_____

Type:_____ Dosage: _____ Date:_____

Reason for medication:_____

Type:_____ Dosage: _____ Date:_____

Reason for medication:_____

Type:_____ Dosage: _____ Date:_____

Reason for medication:_____

Type:_____ Dosage: _____ Date:_____

Reason for medication:_____

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