



Mercy Sleep Center

4345 W. Memorial Rd.
Oklahoma City, OK 73134
405.936.5208
fax 405.936.5417

Mercy Sleep Center - Logan

200 S. Academy Road
Guthrie, OK 73044
405.936.5208
fax 405.936.5417



How to prepare for your overnight sleep study

1. **We have scheduled a Registered Sleep Technologist to work the night of your study specifically for you. If you are unable to make your appointment for any reason, we ask that you call us so that we may notify the Sleep Technologist that they do not need to come to the Sleep Lab. 405.936.5208 Thank you, We appreciate your consideration.**
2. **Do not** drink anything with caffeine in it after 2 p.m. on the day of your study (*this includes coffee, tea, soft drinks, ETC.*)
3. **Do** wash and dry your hair without gels or hair spray.
4. **Do** take your medications as prescribed by your doctor, unless otherwise directed by your doctor, if you take any medications that may make you sleepy please do not take until you arrive at the sleep center. The Sleep Center doesn't have the ability to dispense any medication, including any over-the-counter medications such as aspirin.
5. **Do** bring insurance card and picture ID.
6. **Do** bring co-pay or estimated amount due.
7. **Do** wash your face to remove any oils and makeup before arrival.
8. **Do** bring your own pillow if you feel it will help you sleep.
9. **Do** bring comfortable pajamas or loose-fitting clothing to sleep in (*If you have no sleepwear, you will be provided a hospital gown*).
10. **Do** plan to be awakened early (*6 a.m.*). You will be ready to depart by 7 a.m.
11. **Do** call Mercy Sleep Lab if you have any questions at 405.936.5208 after 8 p.m.
12. **If the patient is a minor, a parent or legal guardian must also plan to spend the evening.**
13. **Please notify us of any cancellations within 48 hours of your scheduled appointment.**

*** Please note: The Sleep Technicians arrive nightly at 8 p.m.**



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When in bed, does your child: Watch t.v. Read Listen to radio

When sleeping, does your child...

Ever Snore? Yes No

Snore more than half the time? Yes No

Snore loudly? Yes No

Have heavy or loud breathing? Yes No

Awaken with snoring , snorting, sound? Yes No

Have brief leg jerks, or kicking at regular intervals Yes No

Have restless sleep (*toss and turn move around, etc*) Yes No

Get out of bed at night? Yes No

Has your child ever stopped breathing at night? Yes No

If yes, how often: _____

Have you ever had to shake or move your child to get them to breathe again? Yes No

When was the last time this occurred? _____

Does your child sleep in a room alone? Yes No If not, with whom _____

Is there regular "lights out", bedtime each night? Yes No When? _____

Who turns the lights out? Adult Child

On average, how long does it take your child to fall asleep? _____

Is there difficulty or bad behavior at bed time? _____

How often does your child wake up at night? 1-3 times 4-6 times more

Does your child wake up and go to the restroom at night? Yes No

Does your child wet the bed? Yes No How Often? Nightly Weekly Sometimes

What time does your child get up in the morning? _____

Is the child difficult to awaken? Yes No Sometimes

Has your child ever has "sleep walking" episodes? Yes No

Have you ever been awakened by the sound of your child, screaming or crying at night? Yes No



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Has your child ever come to you at night because of "bad dreams"? Yes No

When asleep, does your child rock his/her body? Yes No

When asleep, does your child bang his/her head on the pillow? Yes No

Does your child regularly nap during the day? Yes No

If yes, when and how long: _____

How long do you think children the same age as your child should sleep each night? _____

Has a teacher ever told you that your child "day dreams" or has difficulty paying attention in school?
 Yes No When? _____

Has your child ever fallen asleep in school? Yes No If yes, when: _____

Has your child ever simply stopped his/her activity and taken a nap where he/she was?

Yes No How often? Daily Weekly Monthly

Has your child ever seemed to be dreaming (*seeing images or hearing sounds*) while still awake?

Yes No How often? Daily Weekly Monthly

On average, how many caffeinated beverages (*cola, tea, coffee*) does your child drink?

Daily: _____ Weekly: _____

Does your child use tobacco products of any kind? Yes No What type? _____

Has your child ever seemed to lose control of his/her arms (*dropping objects*) or leg (*stumbling*) involuntarily?

Yes No How often? _____

Has your child ever become weak or unsteady when excited, surprised or emotional (*laughing or crying*)?

Yes No How often? _____

Does your child still have Tonsils? Yes No When were they removed? _____

Has a health professional ever said that your child has Attention-Deficit Disorder (ADD) or Attention-Deficit Hyperactivity Disorder (ADHD)?

Yes No When? _____



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How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, think about how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

- 0 = Would never doze or sleep
- 1 = Slight chance of dozing or sleeping
- 2 = Moderate chance of dozing or sleeping
- 3 = High chance of dozing or sleeping

Circle the most appropriate number for each situation:

1. Sitting and reading	0	1	2	3
2. Watching television	0	1	2	3
3. Sitting inactive in a public place <i>(for example, a movie theater or classroom)</i>	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon when circumstances permit.	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after lunch	0	1	2	3
8. Doing homework or taking a test	0	1	2	3