Your child/adolescent has been scheduled for an overnight sleep study (polysomnogram) at the St. Anthony’s Hospital Sleep Disorder’s Center.

You should arrive at the St. Anthony’s Sleep Disorders Center at 8:00 p.m. (enter through the ground floor parking garage). You will be finished with the test and ready to leave by no later then 6:30 a.m. the following morning. Before the test, you will be shown a video about the treatment of sleep apnea and your questions will be answered. You will be hooked up to some wires before bedtime (11:00 p.m.). You will be able to get out of bed during the night if necessary.

A map and instructions to follow before your sleep study are enclosed. If you are scheduled for a nap study the next day please read the attached information sheet.

If you cannot keep this appointment, you must contact our scheduling office 48 hours prior to your study date. If your normal sleeping hours are not during the night due to your work schedule, please contact our office as soon as possible. The scheduling office is open Mon. – Fri., 8:00 a.m. – 4:00 p.m., phone (727) 820-7424.

*THE LEGAL GUARDIAN MUST STAY ALL NIGHT WITH THE MINOR*

We will provide the bedding

**Overnight Sleep Study**

**Night & Date:**

**Time:** 8:00 P.M.

**Place:** The Sleep Disorders Center  
St. Anthony’s Hospital  
1200 7th Avenue North  
St. Petersburg, FL 33705-1300

- Press the white button at the parking garage entrance and tell the operator “who you are and that you are here for a Sleep Study”.

Preparing for a sleep study

INSTRUCTIONS TO FOLLOW THE NIGHT/DAY BEFORE YOUR SLEEP STUDY:

1. Keep your usual bedtime schedule the night/day before your study.

2. Avoid “sleeping in” or napping on the day of your study.

3. Avoid any activities that may interfere with your sleep on the night/day of your study.

4. Avoid any beverages or food items containing caffeine on the day/night of your study.

5. It is best to avoid alcohol for 1 week prior to your study.

6. Take all medications as prescribed by your physician unless told otherwise by your physician. **Bring prescribed medications, over-the-counter products, head-ache medicines, diabetes supplies and breathing treatment supplies that you need to take or use at night with you in its original labeled bottle/package, we are not a nursing department and do not have medications on hand. **If you are taking any sleeping medications, we recommend that you do not drive following the test.

7. You should shower and wash your hair prior to coming to the Sleep Center, do not use any oils, mousse, tonics or hairspray on your hair.

What To Bring:

1. You must bring your Insurance Card, Photo ID and your Sleep Study Prescription (if you have one).

2. Bring loose comfortable clothing to sleep in (i.e. pajamas, a baggy sweat suit, or shorts and a T-shirt). Long nightgowns are not suggested they may interfere with testing. Technologist reserve the right to not perform the sleep study if you DO NOT bring sleeping clothes with you. Sleeping in the nude is NOT permitted.

3. Bring any toiletries you may want before/after the study. There are restrooms and a shower in the Sleep Disorders Center.

4. Please eat your evening meal/breakfast before arriving. Bring any special diet snack foods that you may require before bed. We will have light snacks and ice water, juice, hot decaf coffee or tea available. If you are scheduled for daytime testing the following day, breakfast and lunch will be provided. Please let us know in advance if you require a special diet (i.e. diabetic, vegetarian, etc.).

5. Bring any items such as a good book or favorite pillow that will make your stay more comfortable. A TV is located in the patient living room for viewing. Bedtime will be no later than 11:00 PM/8:00 AM.

6. Do not bring any jewelry or valuables with you.

WE REQUIRE 48 HRS. NOTICE TO CANCEL OR RESCHEDULE YOUR APPOINTMENT

For any other questions call the Sleep Disorder’s Center at 727-820-7424
Child/Adolescent

SLEEP QUESTIONNAIRE

Name: ____________________________ Date of Birth: ______________ Date: ______________________

Guardian(s): ____________________________ Relationship to patient: ____________________________

Please complete this questionnaire and bring it with you to the sleep study. In answering the questions be as complete as possible. The more information that is given the more complete will be the evaluation of your child’s condition. Circle the most appropriate answers in the questionnaire.

1. Please describe in your own words as briefly as possible your child’s main problem.
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

2. When was the very first time this problem began? _____ years ago

3. List any medications that your child/teen is currently taking to help with the sleep problem:

   Medication:             Dose:             Time:       How long:       Effect:             Stopped:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

4. Describe what your child/teen usually does during the last 30 minutes before bedtime:
_______________________________________________________________________________________
_______________________________________________________________________________________
5. Does your child/teen do any of the following in bed at night?
   - Read
   - Watch TV
   - Listen to the radio
   - Other: ______________________________________________________________________________

6. Will your child/teen fall asleep alone in bed?  
   YES / NO

7. In order to sleep, does your child/teen often need a special toy or object?  
   YES / NO
   If so, describe: ________________________________________________________________________

8. Does your child/teen often need a bottle in order to go to sleep?  YES / NO

9. What type of bed does your child sleep in?
   - Crib / Single bed / Double bed / Other: _______________________________________________

10. Does your child sleep alone?  YES / NO
    If not, who with? ______________________________________________________________________

11. Which side of the body does your child/teen sleep on?  
    - Left side / Right side / Back / Face down

12. What time is the bedroom light turned off?  
    _______ am / pm

13. Does a guardian or the child/teen turn the light off?  
    - Guardian / Child

14. Is your child/teen bothered by environmental noises?  YES / NO
    If so, please explain: __________________________________________________________________

15. As an infant, was your child/teen “colicky”?  YES / NO

16. As an infant, did your child/teen require any of the following devices to get to sleep?
    - Swing / Snuggly / Car ride / Being held / Other: _______________________________________

17. On average how long does it take your child/teen to fall asleep?  
    _______ Hrs. _______ Min.

18. What is the quickest time it has taken your child/teen to fall asleep in the last two weeks?  
    _______ Hrs. _______ Min.

19. What is the longest time it has taken your child/teen to fall asleep?  
    _______ Hrs. _______ Min.

20. What do you think prevents your child/teen from falling asleep?  
    - Fears / Loneliness / Not sleepy / Worries / Other: ______________________________________

21. Do you get annoyed/angry when your child/teen cannot sleep?  YES / NO

22. How often does your child/teen cry him/herself to sleep?  
    _______ times/week
Name: ___________________________ Date of Birth: _________________________

23. Do you ever let your child/teen cry in bed in order to get to sleep?  YES / NO
   If so, how long do you let the child/teen cry: 10 / 20 / 30 minutes / as long as it takes

24. When unable to fall asleep, does your child/teen get out of bed?  YES / NO
   If so, how long after getting into bed: ________ Hours ________ Minutes

25. Once out of bed, what does your child/teen do? ________________________________________________

26. How long is your child/teen up for? ________ Hours ________ Minutes

27. When your child/teen returns to bed, how long does it take to fall asleep again?
   ________ Hours ________ Minutes

28. If the child/teen does not get out of bed, how long does it take to fall back to sleep?
   ________ Hours ________ Minutes

29. Once having fallen asleep, how long does your child/teen sleep for? ________ Hrs. ________ Mins.

30. Does your child/teen awaken during the night? YES / NO
   If so, on average how long will your child/teen be awake for? ________ Hrs. ________ Mins.

31. How often does your child/teen awaken during the night? ________ Times

32. What time does your child/teen finally awaken in the morning/afternoon? ________ am / pm

33. What time does your child/teen get out of bed in the morning/afternoon? ________ am / pm

34. How does your child/teen seem on awakening in the morning/afternoon?
   __________________________________________________________________________________________
   __________________________________________________________________________________________

35. How does a poor nights sleep affect your child/teen the next day?
   __________________________________________________________________________________________
   __________________________________________________________________________________________

36. Does your child/teen feel sleepy during the day? YES / NO

37. Does your child/teen nap during the day? YES / NO
   If so, how often and for how long? ___________________________________________________________

38. What time of day does your child/teen nap? ________ am ________ pm

39. If there are no naps, what time of day does your child/teen feel most tired? ________ am ________ pm

40. What time of day does your child/teen seem most alert? ________ am ________ pm

41. As the sleep period approaches, does your child/teen become more alert? YES / NO

42. Do you think a poor night’s sleep effects your child’s/teen’s school performance the next day? YES / NO

43. Has the teacher commented on this? YES / NO
44. Does your child/teen toss and turn in bed?  
   YES / NO

45. Have you ever noticed your child’s/teen’s head rocking from side to side at night? YES / NO
   If yes, please describe: __________________________________________________________
   ____________________________________________________________________________

46. How often does this behavior occur?  
   _____ times

47. What time of night is this activity likely to occur? 
   _____ am/pm

48. Does your child/teen complain of aching legs at bedtime?  
   YES / NO

49. Does your child/teen move his/her legs around in bed at night?  
   YES / NO / Don’t Know

50. Do your child’s/teen’s legs jerk while he/she is asleep at night?  
   YES / NO / Don’t Know

51. Does your child/teen have nightmares?  
   YES / NO
   If so, at what age did they begin?  
   _____ years
   How often do they occur?  
   _____ times per night

52. Does your child/teen ever awaken suddenly with a scream and appear inconsolable?  
   YES / NO / Don’t Know  If so, how often?  _____ times per month

53. Does your child/teen sleepwalk?  YES / NO  If so, how often?  _____ times per week

54. If your child/teen sleepwalks, has he/she ever injured him/herself?  
   YES / NO

55. Does your child/teen ever wet the bed?  
   YES / NO
   If so, how often?  
   _____ times per week

56. Does your child/teen snore at night?  
   YES / NO

57. Does the snoring occur every night?  
   YES / NO
   If not, how often does it occur?  
   _____ times per week

58. Does your child/teen ever seem to stop breathing while asleep?  
   YES / NO
   If so, for how long?  
   _____ seconds

59. Has your child/teen ever had a tonsillectomy or an adenoidectomy?  
   YES / NO
   If so, please give the date: ___________________________________

60. Please state when your child/teen was last able to sleep consistently without any problems:  
   Never / _____ years old / _____ months old

61. What time did your child/teen go to bed then?  
   _____ pm
   How long did it take your child/teen to fall asleep?  
   _____ hrs./min.

62. Did your child/teen awaken during the night?  
   YES / NO
   If so, how often and for how long:  
   _____ times _____ hrs. / mins.
63. What time did your child/teen awaken in the morning/afternoon? _____ am
64. At what time would you like your child/teen to fall asleep now? _____ pm
65. How long would you like your child/teen to sleep for? _____ hours
66. What time would you like your child/teen to awaken in the morning? _____ am
67. For how long do you think normal children/teens of your child’s/teen’s age sleep? _____ hours
68. Do you consider your child’s/teen’s sleep problem to be: Mild / Moderate / Severe
69. Please add any other comments about your child’s/teen’s sleep problem that you think are relevant:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
70. Please list all people whom you have consulted about your child’s/teen’s sleep problem. Starting with the first, list the date, name, degree/specialty, investigations, treatment and outcome of all treatment.

*Date: ______________ Name: ____________________________ Degree/Specialty: ____________________
Investigations: _____________________________________________________________________________
_________________________________________________________________________________________
Treatment: ________________________________________________________________________________

Date: ______________ Name: ____________________________ Degree/Specialty: ____________________
Investigations: _____________________________________________________________________________
_________________________________________________________________________________________
Treatment: ________________________________________________________________________________

Investigations: _____________________________________________________________________________
_________________________________________________________________________________________
Treatment: ________________________________________________________________________________

71. Please list all medical illness that your child/teen has been treated for in the past or is now under treatment for. Give the date, name of illness, treatment and outcome.
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Name: _______________________________________________ Date of Birth: _________________________

72. Please list any operations that your child/teen has had:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

73. Please give the following family information:

<table>
<thead>
<tr>
<th>AGE</th>
<th>ILLNESSES</th>
</tr>
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<tbody>
<tr>
<td>Mother: __________</td>
<td>____________________________________________________________</td>
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<tr>
<td>Father: __________</td>
<td>____________________________________________________________</td>
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<tr>
<td>Brother(s): __________</td>
<td>____________________________________________________________</td>
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<tr>
<td>Sister(s): __________</td>
<td>____________________________________________________________</td>
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74. Please list any illnesses that run in the family, such as diabetes, hypertension, heart disease, psychiatric disorders, etc.:

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>FAMILY MEMBER</th>
<th>TREATMENT</th>
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Thank you for your help, please bring this questionnaire to the sleep study appointment.
1. Enter the UNDERGROUND Parking Garage on 7th Avenue (not the main entrance in front but the back entrance of the garage). There is a blue sign that reads “Physician’s Parking”. You must stop at the gate and press the white button.

2. If an operator asks you to identify yourself, respond by telling them who you are and that you are here for a sleep study. If you are not asked to identify yourself and the entrance arm raises, enter the garage and drive forward and turn right at the last row.

3. Park near the CENTER entrance to the hospital. You may park in the Parking Area Reserved for Physicians.

4. DO NOT use the elevators at the far end of the parking garage. You must enter at the Center entrance on the ground level. There will be a sign that reads “Sleep Disorders Center”.

The Sleep Technologist will meet you at the double doors. If the technologist is not there, call 820-7424 and inform the technologist that you are here.