

# THE CENTER FOR SLEEP MEDICINE

## Oral Appliance Sleep Study

You have been scheduled for an Oral Appliance SLEEP STUDY. We ask that you arrive promptly at your scheduled time.

For a nighttime study, sleep is monitored until approximately 5:00 a.m. the following morning when the study is complete. You will be ready to leave the sleep center no later than 6:00 a.m. when the facility closes.

### **CANCELLING A SLEEP STUDY:**

If you need to cancel your scheduled sleep study, **you must give the sleep center a 24-hour notice**. Please call by 5:00 p.m. on Friday to cancel a Sunday night study. **A \$250 fee will be charged for all “no shows” or cancellations without a 24-hour notification.** This fee is not covered by insurance or Medicare. To reschedule your study, call (708) 364-0261 Extension 1.

### **PRIOR TO THE SLEEP STUDY:**

- Complete the attached forms/questionnaires prior to your study date.
- **Avoid caffeine or stimulants for 12 hours before your scheduled time of arrival at the sleep center, unless prescribed by your doctor.**
- Make sure your skin and hair are clean, and please do not use any hair products or lotions the night of the study.

### **WHAT TO BRING TO THE SLEEP CENTER:**

- **Completed questionnaires and any doctor’s orders, prescriptions, or referral forms that your doctor has given you.** Present them to the technician upon arrival.
- **Your insurance card(s) and driver’s license or ID.**
- You may bring your own pillow, since some people sleep better with a familiar pillow.
- Bedclothes are necessary. Please wear something loose and comfortable, such as gym shorts and a tee-shirt, sweat pants and a tee-shirt, or pajamas.
- Any needed personal toiletries, and a change of clothes for after the study.
- Any medications, both prescription and over the counter, that you need to take while at the sleep center. Technicians are unable to dispense any medications.
- Reading material, if you typically read before bed.
- If you require a snack before bedtime, plan to bring it with you. Do **not** bring your dinner, since you must be ready to begin your test when you arrive. If you are staying for the daytime nap studies, breakfast and lunch will be provided.
- **Please do not bring any valuables with you to the sleep center.**

The sleep center’s private bedrooms are similar to typical hotel rooms, with private bathrooms available for showering after the study is completed. The rooms are supplied with pillows, blankets, towels, and washcloths.

## **INFORMATION ABOUT YOUR SLEEP STUDY**

### **1. HOW IS THIS ORAL APPLIANCE SLEEP STUDY DIFFERENT FROM A REGULAR POLYSOMNOGRAM (SLEEP STUDY)?**

The only difference between the ORAL APPLIANCE sleep study and a polysomnogram (sleep study) is that, in addition to all of the wires that are used; the technician will ask you to sleep with your oral appliance in place. Our goal during this study is either to document the effectiveness of your fixed position oral appliance or with adjustable appliances, to determine the most effective position with which to treat your sleep apnea.

### **2. WHAT IS A POLYSOMNOGRAM (SLEEP STUDY)?**

A polysomnogram is a study that measures the quality of your sleep. A typical polysomnogram includes the following measures:

- Brain waves (electrodes placed on the scalp)
- Eye movement (electrodes placed on the face, by the eyes)
- Chin muscle tone (electrodes placed on or near the chin)
- Heart rate (electrodes placed on the chest)
- Leg movements (electrodes placed on the legs)
- Breathing (breathing sensor placed near the nose and mouth)
- Breathing effort (two small elastic belts placed around chest and abdomen)
- Oxygen level (small sensor attached to the finger)
- Audio and video recording

### **3. WHY IS IT NECESSARY TO RECORD THE ABOVE FUNCTIONS?**

During sleep, the body functions differently than while awake. Disturbed sleep, such as irregular breathing or lack of sleep consolidation, can interfere with daytime activities, cause daytime sleepiness, and cause serious health problems.

### **4. HOW CAN I SLEEP WITH ALL OF THE ELECTRODES?**

Most people sleep reasonably well. We are looking to obtain a sample of your sleep pattern. The body sensors are applied so that you can move during sleep and change positions during the night. The sleep rooms are set up as comfortable bedrooms, and our staff makes the environment as restful as possible.

### **5. WILL THE SENSORS HURT?**

No. This is a painless and non-invasive (no needles) testing procedure. Paste is applied to your skin and scalp to keep the electrodes in place, but it is easily removed with soap and warm water.

### **6. WHAT IS A MULTIPLE SLEEP LATENCY TEST (MSLT)?**

Some people also participate in daytime testing. This test consists of a series of 20-minute naps. Sensors and electrodes are used to record information similar to the polysomnogram test. 20-minute naps are taken every two hours throughout the day. Please bring something to read or work on during the day to help keep you occupied in between naps. A DVD player is available. The MSLT test is usually completed by 6:00 p.m.

### **7. IS THIS STUDY COVERED BY INSURANCE?**

Sleep studies are covered under most medical insurance plans, although deductibles and percentages of coverage vary. Details regarding coverage should be directed to your insurance company. We will verify insurance benefits and coverage prior to your sleep study. Feel free to call The Center for Sleep Medicine at (708) 364-0261 and speak with the Account Coordinator, who is available to answer any remaining questions or concerns you may have.

# THE CENTER FOR SLEEP MEDICINE

## SLEEP SYMPTOM AND MEDICAL QUESTIONNAIRE

### IDENTIFYING INFORMATION

First and Last Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. Height: \_\_\_\_\_ ft./in.

### PRESENTING PROBLEM

Please describe your main complaint by checking one or more of the items below and providing a brief explanation of how you experience these difficulties:

- I have trouble falling asleep  
 I'm sleepy all day  
 I have unwanted behaviors when I'm asleep

2. Explain: \_\_\_\_\_

### SLEEP SCHEDULE

Please describe your *typical* sleep schedule:

- During the *work week*, you go to bed at: \_\_\_\_\_ (AM or PM?), rising at: \_\_\_\_\_ (AM or PM?).
- On *days off/weekends*, you go to bed at: \_\_\_\_\_ (AM or PM?), rising at: \_\_\_\_\_ (AM or PM?).
- When do you usually feel at your best?  Morning  Evening
- How long does it usually take you to fall asleep? \_\_\_\_\_ (Indicate minutes or hours)
- How many times do you wake up during the night? \_\_\_\_\_
- How long are you usually awake when waking at night? \_\_\_\_\_ (Indicate minutes or hours)

### HEALTH HABITS AFFECTING SLEEP

- |  | Never  | Little                   | Weekly                   | 2-3 times/wk             | Daily                    |
|--|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. How often do you <i>usually</i> nap?  | <input type="checkbox"/>                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. How often do you <i>usually</i> exercise?   | <input type="checkbox"/>                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3a. Do you smoke cigarettes <i>or</i> have you smoked in the past?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |                          |                          |                          |
| b. If Yes: How long have you smoked?   | _____ (Indicate years or months)                         |                          |                          |                          |                          |
| c. How much do you smoke each day?   | _____ (Indicate cigarettes or packs)                     |                          |                          |                          |                          |
| d. If you've quit, when did you stop?  | _____ (Indicate years or months)                         |                          |                          |                          |                          |
| 4a. Do you drink alcohol?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |                          |                          |                          |
| b. If Yes, at what time(s), and how much?  | _____  |                          |                          |                          |                          |
| 5a. Do you drink anything with caffeine regularly?<br>( <i>this includes: coffee, tea, soda/pop, energy drinks</i> ) | <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |                          |                          |                          |
| b. If Yes, what do you drink and at what time(s) during the day or night?  | _____  |                          |                          |                          |                          |

## SLEEP SYMPTOM DESCRIPTION

Please help us understand the nature of your sleep difficulties. Check all statements that apply:

1.  I have been told that I snore loudly.
2.  My bed covers are very messed up in the morning.
3.  I usually toss and turn at night and am a restless sleeper.
4.  I have been told that I kick and poke my bed partner during sleep.
5.  My arms or legs move during sleep, sometimes waking me up.
6.  I have hallucinations or dreams while falling asleep or waking up.
7.  I sometimes awaken with a choking sensation.
8.  I have been told that I stop breathing while asleep.
9.  I have fallen out of bed.
10.  I frequently wake from my sleep at night.
11.  I have felt paralyzed or unable to move when waking up.
12.  I have felt paralyzed or unable to move when falling asleep.
13.  I awaken suddenly feeling fearful, anxious, tense or depressed.
14.  When I awaken during the night, I frequently use the bathroom
15.  I feel the quality of my sleep is unsatisfactory.
16.  I have been told that my arms or legs twitch and jerk during my sleep.
17.  I frequently get cramps in my legs.
18.  I sometimes wake up with a headache.
19.  I have trouble falling asleep at night.
20.  I have trouble falling back to sleep when I wake up during the night.
21.  Some nights I never get to sleep no matter how hard I try.
22.  When I try to go to sleep my mind races with thoughts.
23.  I often sleep better in a hotel or at a family member's home.
24.  I have had accidents, or near accidents because of being sleepy or falling asleep.
25.  The muscles in my legs feel tense, and moving my legs and feet relieves the tension.
26.  I feel pain when I try to fall asleep or pain wakes me up at night.
27.  I often need to take sleep pills to fall asleep.
28.  I have a creeping crawling feeling in my legs when I lie down or relax.
29.  I am a very light sleeper, I am awakened easily.
30.  My sleep is disturbed because of my bed partner.
31.  I have had occasions when I feel sudden weakness in my legs.
32.  I can fall asleep at any time, regardless of the situation.
33.  I feel that I sleep too much.
34.  I feel that I sleep too little.
35.  I generally feel sleepy all day.

## SLEEPINESS

Please indicate how likely you are to fall asleep in each situation:

- |  | No<br>chance<br>(0)      | Slight<br>chance<br>(1)  | Moderate<br>chance<br>(2) | High<br>chance<br>(3)    |
|--|--------------------------|--------------------------|---------------------------|--------------------------|
| 1. Sitting and reading   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| 2. Watching TV   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| 3. Sitting inactive in a public place (e.g. theater, meeting)    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| 4. As a passenger in a car for an hour without a break           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| 5. Lying down to rest in the afternoon when circumstances permit | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| 6. Sitting and talking to someone                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| 7. Sitting quietly after a lunch without alcohol                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| 8. In a car, while stopped for a few minutes in traffic          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |

## YOUR MEDICAL CONDITIONS

1. Please indicate if you have, or have had, any of the following conditions?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Thyroid disease     | <input type="checkbox"/> Large tonsils or adenoids             |
| <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Liver disease       | <input type="checkbox"/> Deviated septum, crooked/broken nose  |
| <input type="checkbox"/> Chronic pain   | <input type="checkbox"/> Undergoing dialysis | <input type="checkbox"/> Dizziness or passing out              |
| <input type="checkbox"/> Fibromyalgia   | <input type="checkbox"/> Multiple sclerosis  | <input type="checkbox"/> Irregular heart beat                  |
| <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Acid reflux         | <input type="checkbox"/> High blood pressure                   |
| <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> Sinus problems      | <input type="checkbox"/> Anxiety, nervousness or panic attacks |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Large uvula         | <input type="checkbox"/> Depression                            |
| <input type="checkbox"/> Pacemaker      | <input type="checkbox"/> Morning headaches   | <input type="checkbox"/> Menopause or perimenopause            |
| <input type="checkbox"/> Defibrillator  | <input type="checkbox"/> Chronic headaches   | <input type="checkbox"/> Irritable bowel, ulcers, stomach pain |
| <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Cancer (type): _____                  |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Other: _____                          |

2. Please describe any other medical conditions or current physical complaint: \_\_\_\_\_

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3. Please list all medications that you take.

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4. Have you undergone upper airway or sinus surgeries? If yes, please describe any surgeries performed on the nose, mouth, throat, neck or head:  Yes  No

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5. Please list any allergies: \_\_\_\_\_

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## FAMILY HISTORY

Does anyone else in your family have sleep problems?  Yes  No

If yes, describe their relationship to you (e.g. mother, father, sister) and their condition:

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## OTHER INFORMATION

1. Please describe any other information you feel may affect your sleep, or your treatment with us:

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Patient Name: \_\_\_\_\_

**Pre-Study Adult Sleep Log**

For the week prior to your appointment, please complete the following sleep log **each day** as accurately as you can.

	<b>Sample</b>	<b>Night 1</b>	<b>Night 2</b>	<b>Night 3</b>	<b>Night 4</b>	<b>Night 5</b>	<b>Night 6</b>	<b>Night 7</b>
Indicate date and day of the week:	<b>10/5 Monday</b>							
What time did you get into bed?	<b>10:30 pm</b>							
What time did you get up for the day?	<b>6:30 am</b>							
Approximately how many hours did you sleep last night?	<b>7.5 hrs</b>							
What was the quality of your sleep? (1-5) 1 = Very Poor; 2 = Poor; 3 = Fair; 4 = Good; 5 = Very Good	<b>2</b>							
Bed partner's assessment of your sleep:	<b>Loud snoring</b>							
How long did it take you to fall asleep?	<b>5 min</b>							
How many times did you awaken?	<b>5</b>							
Total time awake after sleep onset?	<b>25 min</b>							
List the time and duration of any naps you took during the day?	<b>4:30 pm. (2 hours)</b>							
List any over-the-counter or prescription sleep medication you took last night:	<b>None</b>							
Other information about your sleep:	<b>Tried not to nap, but had to</b>							