Emery Sleep Solutions
2151 East Semoran Boulevard
Apopka, Fl 32703
Phone: 407-936-0195 Fax: 407-936-0196

Dear: _____,

Your physician, _____, has ordered a sleep study for you. Your appointment is _____ at **7:30 PM.** We want you to feel comfortable and well prepared for your study please refer to the following information and complete all forms sent to you. If possible please arrange for a ride to and from this study especially if you take any medication to help you sleep.

What to bring on the night of your test:

1. Insurance cards, drivers license, and co-payment.
2. All completed paperwork.
3. Comfortable cotton two-piece sleepwear (Please do not wear silk) such as shorts and a t-shirt or pajamas
4. Toiletries, books, tape/tape recorder or anything else to help you relax
5. Your pillow, if preferred
6. **Medications:** take as you normally do and bring your night time medications with you. Please bring an updated list of all medicines you are currently taking, prescription and over-the-counter. We recommend you bring something for a headache, an upset stomach or indigestion if you think you may need it.

Preparing for your test:

1. Shower and wash your hair before the test. Men should be freshly shaven, however, full beards are allowed.
2. **DO NOT** nap on the day of your test.
3. **DO NOT** apply lotion to your skin.
4. **DO NOT** wear any hairpieces, wigs or weaves.
5. **DO NOT** apply any hair gels, spray or oil to hair or scalp.
6. **DO NOT** wear fingernail polish or acrylic nails.
7. **DO NOT** use any caffeinated products on day of test.

Reminders:

1. Family members are not permitted to stay in your room overnight except if pre-arranged for assistance with handicap needs.
2. Contact your insurance representative if you have questions about coverage prior to the test.
3. **Generally**, you will be awakened at 5 AM and will have the opportunity to shower prior to departure.
4. If you were given a sleep aide by your physician for this test you should arrange to have someone drop you off and pick you up.

Questions about your test or to reschedule your appointment, **please call 407-936-0195.** We look forward to working with you in the Sleep Disorders Laboratory. ***There is a $250.00 no show fee for patients who do not show up and who do not call 48 hours prior to their appointment***

is located in the Wekiva Riverwalk at the Intersection of Wekiva Springs Road and Route 436/Semoran Blvd.

Frequently Asked Questions About Your Sleep Study

What is a Sleep Study?

When you sleep your body functions differently than when you are awake. Daytime activities and health risk may be affected by disrupted sleep. Your physician has ordered a diagnostic test called a sleep study. During testing the length and quality of your sleep are measured and analyzed.

What can I expect?

Your test will be performed in a comfortable, private room. You will be asked to complete a short bedtime questionnaire before changing into your night clothes. The technician will attach small recording sensors/electrodes on your scalp, face, arms and legs. These electrodes do not hurt and you can move freely while sleeping. You will not be given any type of sleep aid unless ordered by your physician. This will be a prescription you will fill and bring with you the night of your study.

You may read or watch TV until you are ready for bed. An intercom will allow you to contact the technician to assist you with any needs. The technician will be observing you while you sleep through a small TV camera. This is necessary to record any movement during sleep.

You will be awakened at approximately 5:00AM. Shower facilities are available for your use.

What is recorded while I sleep?

1. EEG or brain wave activity
2. EKG or heart rate and rhythm
3. Eye movement
4. Muscle movement in legs or arms
5. Breathing pattern and effort
6. Blood oxygen levels
7. Body position and activity

Emery Sleep Solutions

2151 East Semoran Boulevard
Apopka, Fl 32703
Phone: 407-936-0195 Fax: 407-936-0196

Directions From Downtown Orlando

1. Take Interstate 4 (I-4) East toward Daytona Beach
2. Take the SR 436 (Exit 92) toward Altamonte Springs / Apopka
3. Turn Left onto SR 436 W / E Altamonte Dr / Semoran Blvd
4. Continue to follow SR-436 W / Semoran Blvd. 5.2 miles
5. Emery is on the Right in Wekiva Riverwalk

Directions From Sanford

1. Take Interstate 4 (I-4) West toward Orlando
2. Take the SR 436 (Exit 92) toward Altamonte Springs / Apopka
3. Merge onto SR-436 W / Semoran Blvd. toward Apopka. 5 miles
4. Emery is on the Right in Wekiva Riverwalk

Directions From Ocoee/Clermont

1. Take FL 429 N toward Apopka (portions toll). Merge onto US 441 S toward Apopka
2. Stay left on SR-436 E / Semoran Blvd. 2 miles
3. Emery is on the Left in Wekiva Riverwalk

Directions From Mt. Dora

1. US 441 S / Orange Blossom Trail
2. Continue to follow US 441 S
3. Stay left on SR-436 E / Semoran Blvd. 2 miles
4. Emery is on the Left in Wekiva Riverwalk

Emery Sleep Solutions
2151 East Semoran Boulevard
Apopka, Fl 32703
Phone: 407-936-0195 Fax: 407-936-0196

Patient Name: _____ Date of Birth: _____

Age: _____ Sex: _____ Height: _____ Weight: _____

Referring Physician: _____ Primary Care Physician:_____

Please consult your bed partner when answering the following questions. Answer them like you are describing a typical night or sleep pattern. In answering the questions about frequency, circle one of the choices or write your own choice. This information is confidential. Please answer as completely as possible.

1) **What is your main concern regarding your sleep?**
   _____
   _____

2) **What is the most you have weighed? _____**
   What did you weigh 1 year ago? _____ 5 years ago? _____

3) **When did your sleep problems begin?_____**

4) **Have you had a sleep study before? Yes No If yes, when? _____**
5) **Where? _____ What test did you have? _____**

6) **List Medications:**

Medications	**Dose Frequency**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

7) **My ideal amount of sleep is _____ hours per night.**

8) **During the week I usually: go to bed at _____ get up at _____**

9) **During the weekend I usually: go to bed at _____ get up at _____**
10) **My work hours are: _____**
11) **It takes me _____ minutes to fall asleep, and I wake up _____ times a night.**

For the following questions please answer
0= Never, 1= Occasionally, 2= Frequently 3= Always

12) **I have difficulty going back to sleep once I wake up:_____**
13) **I snore: _____**
14) **I snore in all positions: Yes No My snoring is: Light Moderate Loud**
15) **I have problems with my nose or nasal breathing. Yes No**
16) **I wake up at night gasping, wheezing, short of air, or feeling like I cannot breathe: _____**
17) **I have been told I toss and turn at night:_____**

Emery Sleep Solutions
2151 East Semoran Boulevard
Apopka, Fl 32703
Phone: 407-936-0195 Fax: 407-936-0196

18) **Immediately after falling asleep I dream:_____**

19) **I have been told I talk or scream in my sleep: _____**

20) **I have been told I grind my teeth in my sleep:_____**

21) **I wake up with a sour or stomach acid taste in my mouth:_____**

22) **I wake up with my heart beating irregularly:_____**

23) **I wake up at night with muscle or joint aches or pains:_____**

24) **I have burning or tingling in my legs or my legs feel restless: _____**

25) **I feel sudden weakness in my knees, neck, jaw, or arms when I get angry, laugh, am sad, or when emotional:_____**

26) **I have episodes of doing strange things without realizing it or losing periods of time:_____**

27) **I see or hear things that are not real when lying in bed but not asleep:_____ Type of sound or visualization_____**

28) **I dream during my naps: _____**

29) **After a typical night's sleep, I feel stiff or achy:_____**

30) **After a typical night's sleep, I feel:_____**

31) **I fight sleep uncontrollably for short periods of time while sitting:_____**

32) **This occurs when: WATCHING TV DURING MEETINGS MOVIES RIDING IN CARS**

33) **I have lost interest in sex or have trouble functioning sexually:_____**

34) **My spouse or bed partner has noted that I stop breathing at night: _____**

35) **I feel like I can not move after lying down, before going to sleep: _____**

36) **I have fallen asleep driving: Yes No If yes, how many times _____**

37) **After my naps I feel: REFRESHED FAIRLY RESTED SOMEWHAT TIRED VERY DROWSY**

38) **34. Drowsiness is greatest in the: Morning Afternoon Evening**

39) **Within the last year, depression, anxiety, or stress has interfered with my sleep:**

40) **Yes No , If yes please explain:**

_____

_____

41) **Is there a family history of sleep apnea, difficulty sleeping, excessive daytime sleepiness or snoring?_____**

_____

42) **I have headaches in the morning: Yes No**

43) **Do you smoke or have you smoked? Yes No If yes, how many years have you smoked or did you smoke? _____ How many cigarettes during the day? _____ When did you quit? _____**

Emery Sleep Solutions
2151 East Semoran Boulevard
Apopka, Fl 32703
Phone: 407-936-0195 Fax: 407-936-0196

44) **Do you drink caffeinated beverages? Yes No If yes, how many cups or cans per day?**
_____ Usual beverage COFFEE TEA SODA

45) **I consume alcohol: Yes No, I usually drink in the: Morning Afternoon Evening**
46) **My usual beverage is: _____**
47) **My usual amount is: _____**

Epworth Sleepiness Scale

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, try to work our how they would have affected you. Use the following scale to choose the ***most appropriate*** number for each situation.

0	=	would **never** doze
1	=	**slight** chance of dozing
2	=	**moderate** chance of dozing
3	=	**high** chance of dozing

1. Sitting and reading _____

2. Watching television _____

3. Sitting inactive in a public place _____

4. As a passenger in a car for an hour without a break _____

5. Lying down to rest in the afternoon when circumstances permit. _____

6. Sitting and talking to someone _____

7. Sitting quietly after lunch without alcohol _____

8. In a car, while stopped, for a few minutes in traffic _____

Total Score _____

Emery Sleep Solutions

2151 East Semoran Boulevard
Apopka, Fl 32703
Phone: 407-936-0195 Fax: 407-936-0196

Patient's Name: _____ Date_____

MEDICAL HISTORY:

Have you ever been diagnosed with or treated by a physician for any of the following? Circle answers and state when you had it:

Angina (heart pain/chest pain)	No	Yes _____
Attention Deficit Disorder	No	Yes _____
Cardiac Arrhythmia (heart irregularities)	No	Yes_____
Chronic Lung Disease (asthma, bronchitis, emphysema)	No	Yes _____
Congestive Heart Failure	No	Yes _____
Coronary Heart Disease (hardening of the arteries)	No	Yes _____
Depression	No	Yes _____
Deviated Nasal Septum	No	Yes _____
Diabetes	No	Yes _____
Edema	No	Yes _____
Gastric Reflux (heartburn)	No	Yes _____
Hay Fever or Allergies	No	Yes _____
Hepatitis	No	Yes _____
Hiatal Hernia	No	Yes _____
HIV	No	Yes _____
Hypertension (high blood pressure)	No	Yes _____
Hypothyroidism	No	Yes _____
Myocardial infarction (heart attack)	No	Yes _____
Nasal Polyps	No	Yes _____
Polycythmia (excessive red blood cells)	No	Yes _____
Pulmonary Hypertension	No	Yes _____
Vocal Cord Disease	No	Yes _____
Head or Neck Surgery (tonsillectomy, deviated septum, etc)	No	Yes _____

Past Surgeries? If yes, what and when: _____
_____
_____
_____

Known drug allergies: _____

I hereby authorize Emery Sleep Solutions to release the results of my study to any physician participating in my care or to the home health care agency designated by my physician to perform any follow-up care. I hereby give Emery Sleep Solutions permission to photograph and video tape my study for the sole use of using those recordings to help in my diagnosis and treatment.

_____ _____
Patient's or Guardian's signature Date