STOP-BANG SLEEP APNEA QUESTIONNAIRE

Last Name _____ First Name _____
Date _____ Sex - M/F
Height _____ Weight _____ Age _____

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	Yes	No
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood **P**RESSURE?	Yes	No

BANG		
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE		

High Risk OF OSA: Yes 5-8
Intermediate Risk of OSA: Yes 3-4
Low Risk of OSA: Yes 0-2