

## STOP-BANG Sleep Apnea Questionnaire

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

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

### PATIENT RESPONSES

STOP	YES	NO
Do you <b>SNORE</b> loudly (louder than talking or loud enough to be heard through closed door)?		
Do you often feel <b>TIRED</b> , fatigued, or sleepy in the daytime?		
Has anyone <b>OBSERVED</b> you stop breathing during your sleep?		
Do you have-or are you being treated for high blood <b>PRESSURE</b> ?		
<b>TOTAL</b>		

### DOCTOR'S OFFICE USE ONLY

BANG	YES	NO
<b>BMI</b> higher than 35kg/m <sup>2</sup> ?		
<b>AGE</b> over 50 years old?		
<b>NECK</b> circumference greater than 16 inches (40cm)?		
<b>GENDER: MALE</b> ?		
<b>TOTAL</b>		

#### Risk of OSA:

**High Risk:** 5 - 8 "Yes"     **Intermediate:** 3 - 4 "Yes"     **Low Risk:** 0 - 2 "Yes"