STOP-BANG
Sleep Apnea Questionnaire

Name: _____

Height:_____ Weight:_____ Age: _____ Sex: ☐ Male ☐ Female

PATIENT RESPONSES

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

TOTAL

DOCTOR'S OFFICE USE ONLY

BANG	YES	NO
BMI higher than 35kg/m2?		
AGE over 50 years old?		
NECK circumference greater than 16 inches (40cm)?		
GENDER: MALE?		

TOTAL

Risk of OSA:

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