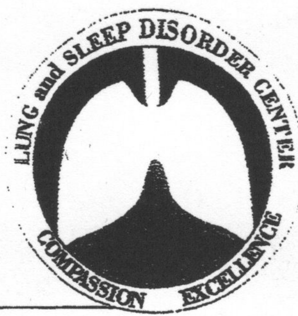

Name: ______________________________

Height: ____________ Weight: ____________ BMI: ____________

Age: ____________ Male/Female: ____________

STOP-BANG Sleep Apnea Questionnaire

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

Bang		
BMI more than 35kg/m2	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 17 inches (M) >16 inches (F)	Yes	No
GENDER: Male?	Yes	No
TOTAL SCORE		

****** If your score is intermediate/high, you may need to discuss that with your physician. They may refer you to a sleep specialist or order a sleep study if indicated ******

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

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