Name ________________________________
Height ____________ **Weight** ___________
Age ___________ **Gender** ________________

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/m^2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference greater than 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE	

High risk of OSA: Score 5-8

Intermediate risk of OSA: Score 3-4

Low risk of OSA: Score 0-2