STOP-BANG
Sleep Apnea Questionnaire

STEP 1: Please complete the following questionnaire by answering all fields and questions below:

Name: _____ ____ Feet ____ Inches (Height) _____ (Weight) _____ (Age) ☐ Male ☐ Female

STOP

1. Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?
☐ Yes ☐ No

2. Do you often feel TIRED, fatigued, or sleepy during daytime?
☐ Yes ☐ No

3. Has anyone OBSERVED you stop breathing during your sleep?
☐ Yes ☐ No

4. Do you have or are you being treated for high blood PRESSURE?
☐ Yes ☐ No

BANG

1. BMI more than 35kg/m2?
☐ Yes ☐ No

2. AGE over 50 years old?
☐ Yes ☐ No

3. NECK circumference greater than 15.75 inches (40cm)?
☐ Yes ☐ No

4. Male GENDER?
☐ Yes ☐ No

TOTAL SCORE: ☐

STEP 2: Calculate OSA Risk

Greater or equal to 3 "Yes" answers: High-risk for OSA
Less than 3 "Yes" answers: Low-risk for OSA

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