STOP-BANG Sleep Apnea Questionaire

Name: ______________________________

Height: ______________

Weight: ______________

Age: ______________

Male /Female (circle)

STOP		
Do you SNORE loudly (louder than talking or loud enough through closed doors)?	YES	NO
Do you often feel TIRED, fatigued, or sleepy during the 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 > 16 inches (40 cms)?	YES	NO
GENDER: Male?	YES	NO

TOTAL SCORE		

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

www.sleepmedicine.com/files/stopbang-questionaire.pdf