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STOP BANG Questionnaire

Screening for Obstructive Sleep Apnea

Answer only the STOP portion of this questionnaire.

STOP		
Do you Snore loudly? (Louder than talking or loud enough to be heard though 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/m^2	**YES**	**NO**
Age over 50 years old?	**YES**	**NO**
Neck Circumference > 15.75in. (40cm)?	**YES**	**NO**
Male Gender	**YES**	**NO**

TOTAL SCORE	

OSA RISK

≥ 3 yes answers: high-risk for OSA

< 3 yes answers: low risk for OSA

Office Use Only:

BMI: _____ Neck Circumference: _____cm

_____ _____

Patient Signature Date