STOP-BANG Sleep Apnea Questionnaire

Name: _____ DOB:_____ Age: _____

Height: _____ Weight: _____ BMI:_____ Male / Female

Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No	0 / 1
Do you often feel TIRED, fatigued, or sleepy during daytime?	Yes	No	0 / 1
Has anyone OBSERVED you stop breathing during your sleep?	Yes	No	0 / 1
Do you have or are you being treated for high blood PRESSURE?	Yes	No	0 / 1

STOP Score

BMI more than 35 kg/m2?	Yes	No	0/1
AGE over 50 years old?	Yes	No	0/1
NECK circumference > 16 inches (40cm)?	Yes	No	0/1
GENDER: Male?	Yes	No	0/1

BANG Score

TOTAL SCORE: _____

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