Screening for Obstructive Sleep Apnea STOP BANG Questionnaire

SLEEP GROUP SOLUTIONS

Patient Name: _____ Date of Birth: _____

I have already been diagnosed with sleep apnea. YES ☐ NO ☐
(If yes, you do not need to complete the rest of this form.)

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1. **S**noring: Do you snore loudly (loud enough to be heard through closed doors)? YES ☐ NO ☐
2. **T**ired: Do you often feel tired, fatigued, or sleepy during daytime? YES ☐ NO ☐
3. **O**bserved: Has anyone observed you stop breathing during your sleep? YES ☐ NO ☐
4. Blood **P**ressure: Do you have or are you being treated for high blood pressure? YES ☐ NO ☐
5. **B**MI: BMI more than 35 kg/m^2? YES ☐ NO ☐
6. **A**ge: Age over 50 yr old? YES ☐ NO ☐
7. **N**eck circumference: Neck circumference >40 cm? YES ☐ NO ☐
8. **G**ender: Male? YES ☐ NO ☐

High risk of Obstructive Sleep Apnea: Yes to 5-8 questions
Intermediate risk of Obstructive Sleep Apnea: Yes to 3-4 questions
Low risk of Obstructive Sleep Apnea: Yes to 0-2 questions

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