STOP-BANG Questionnaire

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

5. **Body** Mass Index (BMI) more than 35 (use the formula to calculate your BMI)?

   ☐ Yes ☐ No

   BMI Formula: $BMI = \frac{\textit{(your weight in pounds X 703)}}{\textit{(your height in inches X your height in inches)}}$

6. **Age** over 50 yr old?

   ☐ Yes ☐ No

7. **Neck** circumference greater than 40 cm?

   ☐ Yes ☐ No

8. **Gender** male?

   ☐ Yes ☐ No

Scoring:

Answering "**yes**" to **three or more** of the 8 questions indicates that you are at **High Risk** for OSA. Answering "**yes**" to **less than three** questions indicates that you are at Low Risk for OSA. If you scored in the **High Risk for OSA** category, a **sleep study** or an **evaluation** by a **sleep specialist** may be warranted.