

STOP BANG Questionnaire

Name _____ Age _____
 Height _____ inches Weight _____ lbs. BMI _____
 Collar size of shirt: ☐ S ☐ M ☐ L ☐ XL, or _____ inches
 Neck circumference (measured by staff) _____ cm

Snooring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?

☐ Yes ☐ No

Tired: Do you often feel tired, fatigued, or sleepy during the day?

☐ Yes ☐ No

Observed: Has anyone observed that you stop breathing during your sleep?

☐ Yes ☐ No

Blood **p**ressure: Do you have or are you being treated for high blood pressure?

☐ Yes ☐ No

BMI more than 35 kg/m²?

☐ Yes ☐ No

Age over 50 years?

☐ Yes ☐ No

Neck circumference greater than 40 cm?

☐ Yes ☐ No

Gender, male?

☐ Yes ☐ No

High risk of obstructive sleep apnea = answering “yes” to 3 or more questions

Low risk of obstructive sleep apnea = answering “yes” to less than 3 questions

Adapted from:

STOP Questionnaire: A Tool to Screen Patients for Obstructive Sleep Apnea

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