

## STOP BANG Questionnaire

NAME: \_\_\_\_\_

Height \_\_\_\_\_ inches/cm Weight \_\_\_\_\_ lb/kg

Age \_\_\_\_\_

Male/Female

BMI \_\_\_\_\_

Collar size of shirt: S, M, L, XL, or \_\_\_\_\_ inches/cm

Neck circumference\* \_\_\_\_\_ cm

### 1. Snoring

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

Yes            No

### 2. Tired

Do you often feel tired, fatigued, or sleepy during daytime?

Yes            No

### 3. Observed

Has anyone observed you stop breathing during your sleep?

Yes            No

### 4. Blood pressure

Do you have or are you being treated for high blood pressure?

Yes            No

### 5. BMI

BMI more than 35 kg/m<sup>2</sup>?

Yes            No

### 6. Age

Age over 50 yr old?

Yes            No

### 7. Neck circumference

Neck circumference greater than 40 cm?

Yes            No

### 8. Gender

Gender male?

Yes            No

\* Neck circumference is measured by staff

*High risk of OSA:* answering yes to three or more items

*Low risk of OSA:* answering yes to less than three items

Adapted from:

### **STOP Questionnaire**

#### *A Tool to Screen Patients for Obstructive Sleep Apnea*

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