

STOP BANG Questionnaire

Name: _____ Date: _____

Occupation: _____ Work Hours: From _____ to _____

Family MD: _____ Referring MD: _____

Height: _____ inches/cm Weight: _____ lb/kg

Age: _____

Male / Female

BMI: _____

Collar size of shirt: S M L XL or _____ inches/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 sleep during the 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

Is your BMI greater than 35 kg/m²? Yes / No

6. Age

You are over 50 years of age? Yes / No

7. Neck Circumference (neck circumference measured by staff)

Is your neck circumference greater than 40 cm? Yes / No

8. Gender

Are you male? Yes / No

If you answered “Yes” to 3 or more items, you are at high risk of developing OSA.