ID: _____ Date: _____

Evaluator: _____ Appointment: _____

STOP-BANG Sleep Apnea Questionnaire

1) **S**noring: Do you snore loudly (louder than talking loud enough to be heard through closed doors)?

   Yes (1) No (0)

2) **T**ired: Do you often feel tired, fatigued, or sleepy during daytime?

   Yes (1) No (0)

3) **O**bserved: Has anyone observed you stop breathing during your sleep?

   Yes (1) No (0)

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

   Yes (1) No (0)

5) **B**ody Mass Index more than 35kg/m^2?

   Yes (1) No (0)

6) **A**ge older than 50 years old?

   Yes (1) No (0)

7) **N**eck size large? (Circumference measured around Adams apple greater than 40cm or 16 inches?)

   Yes (1) No (0)

8) **G**ender = Male?

   Yes (1) No (0)

Guidelines for Scoring/Interpretation

Low risk of OSA	Yes to 0-2 questions
Moderate risk of OSA	Yes to 3-4 questions
High risk of OSA	Yes to 5-8 questions OR Yes to 2 STOP questions (# 1-4) AND yes to one of the following: (#5,7, or 9)

Chung F, Yegneswaran B, Liao P, Chung SA, Vairavanathan S, Islam S, Khajehdehi A, Shapiro CM. STOP questionnaire: a tool to screen patient for obstructive sleep apnea. Anesthesiology. 2008 May; 108(5):812-21.