

Patient Name: _____

DOB: _____

Physician: _____

Date: _____

STOP-BANG Questionnaire

Snoring?

Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?

☐ Yes ☐ No

Tired?

Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?

☐ Yes ☐ No

Observed?

Has anyone **Observed** you **Stop Breathing or Choking/Gasping** during your sleep?

☐ Yes ☐ No

Pressure?

Do you have or are being treated for **High Blood Pressure**?

☐ Yes ☐ No

BMI?

Body Mass Index more than 35 kg/m²?

☐ Yes ☐ No

Age?

Age older than 50?

☐ Yes ☐ No

Neck size large? (Measured around Adams apple)

Is your shirt collar 16 inches/40cm or larger?

☐ Yes ☐ No

Gender = Male?

☐ Yes ☐ No

STAFF: *ADD TOTAL "YES" ANSWERS* _____ out of 8