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STOP-BANG Sleep Apnea Questionnaire

Name _____ Age _____ Male / Female _____
Height _____ Weight _____ Date _____

Total Score_____

	Points	
	0	**1**
1. Q1. Do you **SNORE** loudly (louder than talking or loud enough to be heard through closed doors)?	No	Yes
2. Do you often feel **TIRED**, fatigued, or sleepy during daytime?	No	Yes
3. Has anyone **OBSERVED** you stop breathing during your sleep?	No	Yes
4. Do you have or are you being treated for high blood **PRESSURE**?	No	Yes
5. **BMI** more than 35kg/m2?	No	Yes
6. **AGE** over 50 years old?	No	Yes
7. **NECK** circumference > 16 inches (40cm)?	No	Yes
8. **GENDER:** Male?	No	Yes

Interpreting STOP-BANG Sleep Apnea Questionnaire Total Scores*		
Yes 0 – 2	Yes 3 – 4	Yes 5 -8
Low risk of OSA	Intermediate risk of OSA	High risk of OSA

*Source: Chung F et al Anesthesiology 2008 and BJA 2012