STOP-BANG Questionnaire

MYOADVANTAGE

IS IT POSSIBLE YOU HAVE OBSTRUCTIVE SLEEP APNEA (OSA)?

SNORING	Do you **Snore Loudly**? (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)
TIRED	Do you often feel **Tired**, **Fatigued**, or **Sleepy** during the daytime? (such as falling asleep during driving or talking to someone)
OBSERVED	Has anyone **Oberved** you **Stop Breathing** or **Choking/Gasping** during your sleep?
PRESSURE	Do you have or are you being treated for **High Blood Pressure**?
BODY MASS	Is your **Body Mass Index more than 35kg/m^2?**
AGE > 50	Are you **older than 50**?
NECK SIZE	Is your **Neck Size** (measured around Adams apple) or shirt collar 16 inches (40 cm) or larger?
GENDER	Are you **Male**?

FOR GENERAL POPULATION

OSA - LOW RISK **Yes** to 0-2 questions

OSA - INTERMEDIATE RISK **Yes** to 3-4 questions

OSA - HIGH RISK **Yes** to 5-8 questions

or Yes to 2 or more of 4 STOP questions + male gender

or Yes to 2 or more of 4 STOP questions + BMI > 35kg/m^2

or Yes to 2 or more of 4 STOP questions + neck size > 16 inches

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