NW REST

STOP-BANG

Sleep Apnea Screening Questionnaire

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The STOP-BANG Questionnaire is a validated screening tool for Obstructive Sleep Apnea (OSA). Please answer each question honestly to help assess your level of risk. Check "Yes" or "No" for each item.

	Question	Yes	No
S	Do you **snore** loudly (louder than talking or loud enough to be heard through closed doors)?		
T	Do you often feel **tired**, fatigued, or sleepy during the daytime?		
O	Has anyone **observed** you stop breathing during your sleep?		
P	Do you have or are you being treated for **high blood pressure?**		
B	Is your body Mass Index (BMI) more than 35?		
A	Are you **over 50 years old?**		
N	Is your **neck circumference** greater than 17 inches for men or 16 inches for women?		
G	Is your **gender** male?		

Scoring: Each "Yes" answer = 1 point.

0–2 = Low risk for OSA

3–4 = Intermediate risk for OSA

5–8 = High risk for OSA

Total Score: _____

Patient Name: _____ **Date:** _____

This questionnaire is for screening purposes only and does not replace a medical evaluation. Interpretation and treatment recommendations are made by a licensed sleep professional.