STOP-BANG Sleep Apnea Questionnaire

yes	no	
☐	☐	**SNORING:** Do you snore loudly?
☐	☐	**TIRED:** Do you often feel tired, fatigued, or sleepy during the daytime?
☐	☐	**OBSERVED APNEA:** Has anyone witnessed you stop breathing during your sleep?
☐	☐	**PRESSURE:** Do you have or are you being treated for high blood pressure or hypertension?
☐	☐	**BMI (Body Mass Index):** Do you weigh more for your height than is shown on the table below?
☐	☐	**AGE:** Are you over 50 years old?
☐	☐	**NECK SIZE:** Is your neck size greater than 16 inches?
☐	☐	**GENDER:** Are you a male?

HEIGHT IN FEET AND INCHES

4′10″	4′11″	5′0″	5′1″	5′2″	5′3″	5′4″	5′5″	5′6″	5′7″	5′8″	5′9″	5′10″	5′11″	6′0″	6′1″	6′2″	6′3″	6′4″	6′5″
167	173	179	185	191	197	204	210	216	223	230	237	243	250	258	265	272	279	287	295

WEIGHT IN POUNDS

SCORE: Total number of "yes" answers ☐

INTERPRETATION: 0-2: Low risk of Obstructed Sleep Apnea

3-8: High risk of Obstructed Sleep Apnea

Patient Printed Name _____

Patient Signature/Date _____

Chung et.al, "STOP Questionnaire: A Tool to Screen Patients for Obstructive Sleep Apnea", Anesthesiology. 2008; 108(5):812-821

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