The STOP BANG Questionnaire

A Tool to screen patients for Obstructive Sleep Apnea (OSA)

1.	**S** (Snoring):	Do you snore loudly?	Yes ____ No ____
2.	**T** (Tired):	Do you often feel tired or Sleepy?	Yes ____ No ____
3.	**O** (Observed):	Has anyone observed you stop breathing during your sleep?	Yes ____ No ____
4.	**P** (Blood Pressure):	Do you have or are you being treated for High Blood Pressure?	Yes ____ No ____
5.	**B** (BMI):	**B**ody **M**ass **I**ndex > 35kg/m2	Yes ____ No ____
6.	**A** (Age):	Age over 50 years old?	Yes ____ No ____
7.	**N**(Neck):	Neck Circumference >16 inches?	Yes ____ No ____
8.	**G** (Gender):	Gender Male?	Yes ____ No ____

HIGH Risk for OSA: Answering YES to 3 or more items.
Evaluation by a sleep specialist may be warranted.