

# STOP BANG Questionnaire

Name \_\_\_\_\_ Age \_\_\_\_\_

Height \_\_\_\_\_ inches      Weight \_\_\_\_\_ lbs.      BMI \_\_\_\_\_

Collar size of shirt:  S     M     L     XL, or \_\_\_\_\_ inches

Neck circumference (measured by staff) \_\_\_\_\_ cm

**S**nooring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?

Yes       No

**T**ired: Do you often feel tired, fatigued, or sleepy during the day?

Yes       No

**O**bserved: Has anyone observed that you stop breathing during your sleep?

Yes       No

**B**lood pressure: Do you have or are you being treated for high blood pressure?

Yes       No

**B**MI more than 35 kg/m<sup>2</sup>?

Yes       No

**A**ge over 50 years?

Yes       No

**N**eck circumference greater than 40 cm?

Yes       No

**G**ender, male?

Yes       No

High risk of obstructive sleep apnea = answering "yes" to 3 or more questions

Low risk of obstructive sleep apnea = answering "yes" to less than 3 questions

Adapted from:

**STOP Questionnaire: A Tool to Screen Patients for Obstructive Sleep Apnea**

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