Sleep Health
Group

# STOP-BANG Questionnaire

| | |
|---|---|
| Date | |
| Name | |
| Date of Birth | |

## Questions

| Questions | YES | NO |
|---|---|---|
| | Type X in Either Box | |
| Do you **snore** loudly?<br>(Loud enough to be heard through closed doors, or your bed partner elbows you for snoring at night). | | |
| Do you often feel **tired**, fatigued or sleepy during the daytime?<br>(such as falling asleep in a car or talking to someone). | | |
| Has anyone **observed** you stop breathing or choking / gasping during your sleep? | | |
| Do you have, or are being treated for, high blood **pressure**? | | |
| Are you older than 50 years of **age**? | | |
| **Neck** Circumference: If you are male, is it greater than 43cm? If you are female, is it greater than 41cm? | | |
| Gender : Are you male? | | |
| Is your BMI over 35? | | |

## Total score of YES column

What is your **height**? __________ cm

What is your **weight**? __________ kg

Score Interpretation

0 - 2 Low Risk of OSA 3 - 4 Intermediate Risk of OSA 5 - 8 High Risk of OSA

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